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Systemic work with clients with a diagnosis of Borderline Personality Disorder

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Clients who are diagnosed with Borderline Personality Disorder are likely to engage with clinicians in compelling ways. They challenge us with an urgency that helps us to define ourselves as we work with them. They confront us with the limitations of our treatment approaches, requiring a genuineness of interaction and a flexibility that can be both challenging and uncomfortable. While therapists have made great strides over the past few decades in their treatment approaches with this population, there is a gap in the literature on the use of systemic approaches with these clients. This article examines some of the issues that arise in work with people with a diagnosis of Borderline Personality Disorder and offers an application of a larger systems perspective to the development of viable treatment options for these clients.

Introduction

Clients who carry a diagnosis of Borderline Personality Disorder (BPD) have historically been viewed as difficult to work with. They have difficulty engaging in treatment, present with complicated and thorny problems, and often have limited successes in their interactions with helpers. Recent literature examines the interface between BPD and Post-Traumatic Stress Disorder (PTSD) (Herman, 1992; Miller, 1996; Pointon, 2004; Spinazzola *et al*., 2005; van der Kolk, 2005; van der Kolk *et al*., 1996, 2005), BPD and Bipolar Illness (Birnbaum, 2004; Bolton and Gunderson, 1996; MacKinnon and Pies, 2006), and BPD and substance abuse (Linehan *et al*., 1999; Rosenthal, 2006), highlighting some of the enormous complexities involved in working with these clients.

This article offers a discussion of some of the issues that arise in treatment with people diagnosed with BPD and presents a systemic approach that I have found to be useful in my work with these clients.

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This approach seeks to engage members of the treatment team as participants in a reparative therapeutic family system that works with BPD clients in efforts to offer a level of containment (Bion, 1967) or a holding environment (Winnicott, 1965) to these clients so that they can do the work they need to do to grow and to heal.

Background

We have, it appears, come to an inclusive point in our evolution as a profession, at which we no longer have to work with exclusive models of practice, but can rather embrace multiple knowledges and practices in our work (Flaskas, 2005a, 2005b). In the spirit of contextualization, it is important to articulate and own our personal narratives of where we have come from as we pull a chair up to the table and locate ourselves in the discourse. Our work no longer requires that we leave ourselves at the door as we enter into therapeutic relationships with our clients and with our colleagues. We are no longer required to be purely scientists, but can acknowledge that we are also artists whose instruments include our whole selves in the relational processes of therapeutic interaction (Larner, 2004; McNamee, 2004).

One of my clients tells the story of a turning point in his training in art school. He was instructed to draw a still-life from his perspective. As he was drawing a careful representation of the still-life set out on a table at some distance from him, his instructor came and stood beside him, asking that he include his perspective in the drawing and capture all that he saw before him. He began drawing the edges of his glasses, the end of his nose, wisps of hair that he could see, and on down his body, across the room and then the still-life, the table, and what he was able to see behind it. He did not include what was in his mind, body or psyche, or the people standing behind him or those who had come before, though they informed what he saw and ways in which he saw it.

As a clinician who trained during the 1970s in psychodynamic psychotherapy in a social work programme, during the 1980s in systemic and narrative family therapy at a family therapy institute, during the 1990s in Jungian psychotherapy at a Jung Institute, and who was in therapy for years with a psychoanalyst, I embody a number of frameworks when working with clients. I agree with Flaskas that 'practice grounds theory' (2005a, p. 127), and seek to have my practice and the complexity of issues presented by my clients inform my choices of useful ideas as I work with them and with their particular situations.

Through the years, I have worked in a halfway house, a day treatment programme, on a number of inpatient psychiatric units, in several outpatient clinics, and I now work in a private practice and teach practice and family therapy courses in an MSW programme at a university. Most of the settings in which I have worked have been multidisciplinary settings in which different views, positionings, theoretical backgrounds and ways of working have been welcomed. A number of the settings were teaching venues where diversity was encouraged, as were new and creative ideas and practices.

All of this informs my practice. It does not define it. My work is eclectic; I am not purely a this or a that (as the clients I work with are not purely thises and thats). I am constantly evolving as a clinician and I work to position myself in a way that is open to a multiplicity of voices and perspectives (Anderson, 1997; Anderson and Gehart, 2007). My inner world is peopled by clients I have worked with, students I have worked with, supervisors and teachers, colleagues, friends and family members. Over the years I have learned to trust and to draw more openly upon whatever comes to me as I sit with clients and work in different ways with what is of use at the moment. I integrate theories and frames to work with inner and outer systems (Jenkins, 2006; McNamee, 2004; Pocock, 2006) as I move my lens in and out, working psychodynamically and systemically with individuals, couples and families as seems appropriate to what is needed. I think, communicate and act in the multiple languages I have learned, and work in a way that may appear to be chaotic, but is experienced by me as an ordered and clear approach. I cultivate in myself and in my work a level of organization at which disorganization is possible, as I believe this promotes a richness and creativity that would not otherwise be accessible to me or to the work in which I participate with clients. The language of this article is thus a mixture of psychodynamic and systemic constructs that I have found to be of use.

Terms and labels

Systemic ideas are about contextualizing issues and examining relationship patterns in human systems (Jenkins and Asen, 1992). While systemic ideas are those that focus on interpersonal processes and interpersonal contexts of individual experience, psychodynamic ideas focus on intrapersonal and intrapsychic processes (Flaskas, 2005a, p. 126).

I am not a clinician who believes in labelling clients. However, I practise in a context in which insurance plans require that I assign diagnoses in order to be reimbursed for services rendered. I also practise in a context in which diagnoses are a part of the language through which therapists communicate with one another about clients (Allen, 2004). I make it a practice to offer my clients choices about how they are to be labelled: 'We have to decide on a diagnosis to use for insurance purposes. Would you rather be called a this or a that?' We go over the categories in the DSM IV (American Psychiatric Association, 2000) and together decide which more closely captures what is going on for the client. While diagnostic categories can be useful in locating a client on a spectrum of possibilities, I find it more useful in my interactions with other clinicians and with clients to describe behaviours, situations and dynamics that clients find difficult to negotiate in their lived experience.

Borderline Personality Disorder and trauma

The DSM IV (American Psychiatric Association, 2000) defines people with BPD as manifesting difficulty in a number of areas: relationship instability, problems dealing with anger, suicidality and/or self-destructive behaviours, identity disturbance, chronic emptiness or boredom, and abandonment issues.

People who carry a diagnosis of BPD tend to come from families in which there has been some kind of trauma. Often a texture of trauma exists that has repeated for generations. They grow up in families in which there are alcohol and/or drug abuse, incest, physical abuse, major mental illness and other situations that have rendered people unable to cope well with their lives. I think of people with a diagnosis of BPD as having developed in an inconsistent, unpredictable, and therefore unsafe environment (Byng-Hall, 1995; Dallos, 2004; Hill *et al*., 2003; Main, 1991; Stern, 1998). They are walking wounded: people who have been unable to integrate their experiences and whose adaptations to their lives have required certain patterns of acting out, projecting, raging 'against the dying of the light' (Thomas, 1952, pp. 207–208). They are survivors.

Individual treatment considerations

Individual theorists (Adler, 1985; Bateman, 2004; Bateman and Tyrer, 2004; Gunderson, 2002, 2004; Hellerstein *et al*., 2004; Herman, 1992;

Leibovich, 1981; Linehan, 1993; Livesley, 2005a, 2005b; Miller, 1996; Paris, 2005; Russell, 1975; Teicholz and Kriegman, 1998; Winnicott, 1947, 1965) locate the developmental failure in people with a diagnosis of BPD as occurring in the area of relationships. They identify inconsistent parenting that vacillates between smothering and abandonment and offers little in the way of object constancy. Winnicott coined the term 'holding environment' (1965) to describe an optimal environment in which, what he called 'good-enough mothering' (I would add fathering) offered the developing child the opportunity to identify with and internalize the mother. He spoke of the importance of being able to 'destroy the object' and have it survive in order to be able to progress and move on (Winnicott, 1947).

Because of an inconsistent availability of good-enough parenting for people with BPD, they become caught in a web of identification, idealization, and attempts to destroy relationships with significant people in their worlds, including treatment team members, hoping that these significant others will be able to survive these painful interactions and remain constant enough to offer them a chance to grow and to heal.

Crises and containment

Crises occur quite regularly in work with people with BPD. I think of these crises as failures in containment (Bion, 1967). This is a useful psychodynamic construct in that it implies an interactive component. Russell (1975) spoke of a 'crunch' (p. 2) in therapy with the client with BPD, in which the client renders into the treatment his or her repetition compulsion in a way that requires the therapist to offer an experience of containment that is a very real risk for both the therapist and the client. He says:

> It is as if the patient chooses the treatment crisis, the potential rupture of the therapy relationship, to try to convey that which is most important to him. And worse yet, he does so not in words, but by recreating the anguish for which he came into treatment to begin with. Crises represent the resistance of the borderline. And so, there is a paradox. A situation arises where the need for some kind of understanding and containment is at its greatest, and yet the situation is such that it is least likely to occur.
> (Russell, 1975, p. 3)

It seems it is for this reason that clinicians have such strong responses to these clients. They are either attracted to or repelled by them in

very basic ways, probably for remarkably personal reasons. The issues with which these clients must contend often take on a life-and-death urgency requiring that we join with them in ways in which we might not otherwise choose to engage. People with BPD have a proclivity for putting all of us, as individuals, as members of systems, as representatives of our larger contexts, through numerous tests. They help us to define ourselves and them through their pulls for both merger and for the clear and strong limits and boundaries through which they are able to feel contained. If we are to work with them, we must be willing to do both: merge with them and contain them by offering firm limits and boundaries.

The relationship

For clients diagnosed with BPD, their repetition compulsion is, it seems, to struggle almost constantly with the basic questions that most of us become aware of only at our most creative and/or despairing moments. The raw vitality of overwhelming affect (theirs as well as our own) both compels and frightens us. They are able, in a close to psychotic way, to know our most vulnerable and private conflicts, and require us to render them into the treatment in a mutual way. The crux of the matter seems to be that it is the relationship that is always at stake, as the relationship is always somehow the focus of the work.

Clients with BPD tend to require a certain kind of relationship with their therapists. They pull for a very real interaction and a certain genuine intimacy. I think of working with people with BPD as akin to having a good workout, a psychic wrestling match in which both the client and I come out breathing hard, sweating, and enjoying the exchange of energy. We share a mutual respect and admiration for being able to bear the affects engendered and to survive, even revel, in the interaction.

Embarrassing moments

Clients with BPD push our buttons. They require a level of organization at which disorganization is possible. We must be willing to venture with them into the unknown and assume a not-knowing position with them (Anderson, 1997) in order to be of help. We must be willing to be creative in our work with them as we discover together what is helpful. Some of my most embarrassing moments as a clinician have been those through which I have been able to be most helpful to my clients. These are moments in which I have become emotionally engaged and have felt and/or expressed surprisingly charged anger

or love. They are moments in which I have been moved to tears by a client's story or in which I have found myself involved in an intense argument. As Bridges (2005) has written, it is important to be able to move beyond our comfort zones with clients in order to be able to work effectively with them. I believe that it is a hallmark of work with clients diagnosed with BPD that they interact in such a way as to make the clinician and/or the treatment system extremely uncomfortable and anxious. They are the clients with whom we are prone to engage in an exceptional manner. We find ourselves behaving in ways that are not our usual style, and this tends to make us nervous. It should make us nervous. Indeed, clients with BPD are known for their testing of boundaries and for their vulnerability to boundary violations in inappropriate and sometimes sexualized relationships with practitioners (Herman, 1992; Miller, 1996).

Clinicians become extremely concerned about the dangers and liabilities of working with these clients and will often, for these reasons, refuse to engage with them in the treatment process. I have a great deal of respect for the capacity of the client with BPD to challenge us all. If we can rise to the challenge, we may be able to develop ourselves and our theoretical constructs enough to flexibly contain and accommodate the needs of these clients. There are no untreatable clients, there are only inadequate treatment modalities.

Illustration

> Recently, as I was sitting with one of my clients, Rebecca, a 22-year-old nurse with whom I had been working for a few months, I found myself at a total loss as to how to respond to her request that I move my chair closer to hers. Rebecca's prior therapy had been with a male therapist who reportedly had sat very close to her and held her during their sessions. During our first interview, having heard some of the history of the repeated failures of containment she had experienced in her prior therapies, and hearing about her increasing sense of herself as 'too much', 'different', 'inappropriate', I began moving my chair closer to hers. I asked her to let me know when I had reached a point at which the distance was right for her. She asked me to stop about a foot away from her and we proceeded without further comment on this basic adjustment.
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> Several months later a crisis arose in the treatment. Rebecca had been having difficulty in her relationship with her boyfriend. As she was discussing their interactions, ours took on a texture that was very similar.

> She asked me to move my chair closer. I asked her to talk about it. She became oddly silent for several minutes, then burst into tears and told me that she was afraid I would hit her or leave. She then began to talk about her mother, a chronically psychotic woman who would intermittently physically abuse her and abandon her. She could not clearly articulate why she needed me to move my chair closer. I did, and then she asked me to move it back, suddenly unable to find an optimal distance.
>
> I tried to provide a frame within which we could understand what was happening. I spoke of this as, perhaps, a test of the safety of the relationship. The session ended with both of us feeling raw, helpless and confused about what had happened. It was clear to me that this was a point at which the relationship could founder. It was not until the next session, when the shared affect had subsided, that we were able to have an interaction in which some reparative work could occur.

I would be embarrassed if someone were to observe me sitting so close to a client, or actually moving back and forth to accommodate her, but it seemed that this was the only way that a meaningful adaptation could take place for her, and so I complied.

One of my colleagues tells a story of a client with whom she has sat in treatment for a number of years. The client has made remarkable progress, except for the fact that she continues to hold my colleague's foot through each session, a practice she began way back in the beginning of their therapeutic relationship. She also has a habit of leaving angry and inappropriate messages on my colleague's answering machine. These behaviours are light-years away from her alcohol abuse, cutting, parasuicidal behaviours and inability to hold down a job. They may, perhaps, be understood as more adaptive acting-out behaviours that will also end as she is able to replace them with others in an ongoing upward spiral. One client's cutting may serve the same function as another's overeating or accumulation of parking tickets.

These are the unclear areas into which many clinicians would argue that it is better not to venture, the areas in which, out of their own anxiety, clinicians may prefer to adhere rigidly to frameworks provided by theory, ethics and standards of practice, and in which the client may be lost. Once again the opportunity will have presented itself and there will have been a failure in containment. Both client and clinician may be left feeling inadequate and hopelessly helpless (Adler, 1972). It is in these areas that modalities must be developed that will bridge the gap, modalities that encompass a flexibility, a

stability and a circularity with which to contain the challenging interactions that are bound to arise.

Larger systems

One of the bizarre feelings I have as I sit with a client with a diagnosis of BPD is that I am sitting with an entire family of people. Perhaps this is because clients with BPD are so adept at moving in and out of unintegrated aspects of themselves. Or perhaps it is because they are keyed into my wish to be kept on my toes. Regardless, I find myself sitting with these clients in a very similar way to that in which I sit with families. There is a heightened energy, a sense of stepping out of the interaction and into a position of observing patterns, looking at process, thinking always about the particular context and the multiple levels of meaning.

BPD clients tend to invest a tremendous amount of energy into changing constantly in order to remain the same. They are in vibrating fluctuation as they move through dramatic ripples in order to remain stuck, thus maintaining a kind of dynamic or provisional equilibrium (Palazzoli *et al*., 1978). My response to these dramatic ripples is to attempt to anchor myself in a larger treatment system that feels equally powerful, and that is able to create constant fluctuations and dramatic ripples of its own. Because of the enormous differences in each BPD client's organization, a response to the differences in their individual contexts, it is imperative that each client has a treatment system designed to fit with and flexibly respond to his or her distinctive needs, as illustrated below.

I think of clients with a diagnosis of BPD as inevitably rendering into the therapy a recapitulation of the fabric of their family dynamics. I therefore attempt to create for each client a therapeutic system able to contain them and me as we work together in such a way as to keep the ripples flowing in an evolving spiral that has at its centre the repetition compulsion of whatever failures in containment the person has experienced and must repeat within the context of the treatment system. I work to create a treatment system that will not fail the client.

Clients with BPD tend to think of themselves as having too much affect, too many problems, and too little control. I try to organize a treatment system that offers each client an opportunity to spread around and titrate these overwhelming symptoms so that the weight of the treatment is shared by a number of clinicians and the client has a

number of objects with which to interact. In working through a recapitulation of the family dynamics, the treatment system is able to hold and contain the client in ways that were previously impossible. The liaison and communication between clinicians offers a gathering-in of affects and projections so that the client is able, hopefully, to have an experience of an integration of self heretofore unheard of. It is of vital importance that clinicians are able to acknowledge openly their counter-transference responses, and that they have enough of a mutually respectful relationship with colleagues to be able to discuss dynamics rather than playing them out. It is often at this meta-level that the treatment can be done, and I find that I invest a great deal of energy in interventions at this level. These may consist of frequent phone contact, treatment team meetings and larger systems consultations.

The sequence of communications that ripple outward from the one-to-one interactional sphere offers a containment to the treatment that can catch the aftershocks and ripples of fall-out from explosive interactions that are inevitable with the BPD client: the fights, the running from the room, the expressions of pain. Just as a team behind the one-way mirror titrates the intensity of working with a family, offering a relative objectivity, distance and vision (Andersen, 1992; Tomm, 1984a, 1984b), a treatment family system can offer the same to a therapist working with these clients. It is critical to create a division of labour such that no one person is left feeling overwhelmed, and the client's experience can be one of having multiple resources and alternatives.

With some of my clients I have inadvertently developed a practice of familiarizing myself with as many aspects of their lives as I possibly can. This has involved performing home visits, meeting pets, meeting families of origin, and meeting significant others. All of this is in addition to periodic meetings with other professionals in their lives. I do this for a number of reasons. It seems that these clients have difficulty verbalizing who they are and, as with very small children, would like us to look at and get to know every inch of them from head to toe. As they tend to be, to varying degrees, unable to convey their worlds to me, I have found it helpful to see for myself the contexts in which they exist. It has also proven to be helpful to meet with significant people in their worlds in order to let them know that I concretely know who they are talking about and also to engage these significant others in a process of working together with me on the issues at hand.

This, of course, does not prevent the ultimate loyalty conflicts and splits from occurring, but it can help to lay the groundwork for clearer communication. I have found that if I don't venture out to meet significant people and places in these clients' lives, they are inevitably brought to me, usually in the form of a crisis (Palazzoli *et al*., 1980).

Family work

I have had little success in engaging in traditional family work with these clients and their families. My experience has been that it is very difficult to keep everyone in the same room at one time. It is almost 95 per cent certain, in my experience, that someone will run out of the room during a session, usually not the person with the diagnosis. The BPD client is often left feeling responsible, guilty, toxic, and it typically takes a long while to recover from the experience.

It is my contention that the highly charged affects, the relative lack of differentiation of these family members, the pain and the texture of trauma that exist in these families make it extremely difficult, if not impossible, to do ongoing family work with families of clients diagnosed with BPD. I therefore engage in systemic work with the individual client in a way that keeps the therapy system open to the possibility of significant others joining us at any time (Boscolo and Bertrando, 1996; Jenkins and Asen, 1992). I tend to meet with family members only intermittently and in very focused ways for brief pieces of work as an adjunct to the individual work.

Inpatient treatment systems

Inpatient treatment of clients with BPD is a huge area that warrants an entire paper of its own. For the purposes of this discussion, it is important to address a few issues, as I believe that inpatient systems demonstrate a microcosm of what can happen in the treatment of a person with BPD.

All too often the inpatient system is symbolic of the 'end of the line', the 'last-ditch effort', a desperate attempt at offering safety to a client who is escalating out of control.

Staff working in inpatient systems, like all of those involved in working with this population, tend to believe that they bear the ultimate responsibility for these people's lives. This belief can lead to a serious failure in containment. The inpatient staff catch the wave of this urgency and the danger is that the affect of the BPD client will ricochet through the system and leave the staff feeling overwhelmed,

out of control, helpless, hopeless, frustrated and angry, with the client and with one another.

The person with BPD will come to be discharged appearing much improved, pulled together, and pleased with a piece of work well done. The most unfortunate scenario is one in which the person has no understanding of what has happened during admission. He or she will leave the hospital feeling relieved; there will have been some form of basic containment, but there will have been little or no sense of how it happened. The staff will be left feeling as though a tornado has cycled through the unit. They will also feel relieved. Relieved that the person with BPD has left, and they will then have to pick up the pieces, recover from the painful interactions they have participated in, and move on to attempt to contain the next person diagnosed with BPD.

This sequence of events may happen in an individual treatment, in a day treatment programme, a sheltered workshop or an emergency room. Somehow, the BPD clients' urgency compels us all, if we engage with them, to believe that we are their only hope, that if we don't 'save' them nobody can, that no one can understand them or help them like we can. They can walk into an office, engage in an interaction that leaves us experiencing their affect, and leave feeling 100 per cent better while we feel devastated. It is difficult to remember how fleeting their feelings of desperation are, how quickly they recompensate, and it is for these reasons that it is important to develop a huge container for the therapy (Carlyle and Evans, 2005). It is important to develop a treatment system in which healthy communication can occur and limits can be set sensitively and implemented without reservation, a system that can help us to contain our anxieties about the work we do with BPD clients.

Illustration

Mara, a 28-year-old woman with whom I have been working for the past five years, is a chronically suicidal person who struggles with many issues in her life. She grew up in a chaotic and violent family in which she was raped and molested regularly by her brother and her father from age 6 to age 25 and, as is typical in these families, she became a scapegoat and a target for the unneutralized rage of all of the family members. She internalized a negative self-concept and now cuts herself, overdoses, stops taking her medication, hallucinates at times, and carries a knife to ward off potential enemies.

When I began working with her, Mara had been in a day treatment programme for five years. She had been only peripherally involved in

the programme, however, as she had achieved the status of 'special patient' in which she was allowed to attend only individual sessions with her case manager (CM) in order to get her medication. She had engaged her CM in repetitive chase scenes in which the CM would go to her house or drive around looking for her when she threatened suicide. The CM had also developed a pattern of talking with her on the phone in an unlimited way.

Mara had never had a therapist who was not a member of the staff of the day treatment programme. She had, however, known me, as I had been the director of the programme for three of her five years there. She was assigned a new CM who referred her to me at the office where I had recently begun working. The new CM and I developed a treatment plan that incorporated the notion of using coordinated larger systems as a treatment container for Mara. The CM and I developed an administrator/therapist split in which she laid down the law around Mara's participation in day treatment and also around the parameters of her treatment with me. Essentially we developed a system of containment that required Mara to attend and engage in all aspects of her treatment plan.

One of the parameters of Mara's plan was that she was required to have a physical exam prior to my working with her. This held us up for a number of weeks, as Mara had never had a physical and had a fear of them, given her incest history. We found a woman physician who specialized in working with people with BPD diagnosis and enlisted her as a member of the treatment team. She offered several appointments in which she performed parts of her exam in order to systematically desensitize the procedure for Mara.

Another parameter involved our appointments being contingent on Mara's participation in the day treatment programme. This required that her CM be in touch with me on a regular basis. There were many times when I would meet Mara in the waiting room to tell her that we could not meet that day as she had not been attending her day treatment programme. She would respond to the limit by kicking the furniture in the waiting room on her way out the door.

A third parameter included a home visit and a family assessment. This proved to be a major milestone, as no one had ever met Mara's family or gone to her house. I found that her most significant family member was her dog. The dog sat at our feet while I talked with her and her family, then got up and barked at the end of the hour, signalling me to leave.

Mara was very curious to learn how the back-up system would work in this new therapeutic situation. She asked many questions about how to access help if she needed it and, in fact, made many dry runs to test out the new system. The structure was that she could reach me or her CM during business hours, and that she could otherwise access the crisis team or several hotlines depending on what kind of help she needed. If she

accessed me, she had to be prepared to be admitted to hospital if we determined together that that was the best way to help her. She used her CM to discuss self-soothing methods and ways to structure her life. In addition to being able to access people for help, Mara was also encouraged to access us to talk about her successes.

Mara began by making several calls to me from a phone booth near some railway tracks and saying she was going to jump. She refused to tell me where she was, so I could not send help. I would ask her to go home, saying that I would call within a period of time to make sure that she had arrived safely. By the time I would call, the crisis would be over. She would answer the phone saying that she felt 'safe'.

Mara was admitted to hospital for the first time in several years. I learned that she had, in the past, been able to overdose, go to an emergency room or an intensive care unit, and somehow convince people not to admit her to a psychiatric unit. I found that I could tolerate her cutting behaviours and her suicidal ideation, but when it came to overdoses and intensive care units I had to draw a line and help her get to a place where she would be safe. I began acting in ways in which her family had not acted. I responded to her behaviours, which I viewed as cries for help. My image of her family, from the home visit and from stories Mara had told, was that they would sit and watch television while she cut herself and bled in front of them. They would tell her to move so that they could see their programme, and to not bleed on the rug. She had learned to up the ante in order to get people to respond to her. The system had inadvertently colluded in replicating her family situation by not responding to her overdoses. Each time Mara let me know that she was in a crisis I would make sure that she was admitted to hospital and that she received the help she needed.

From this point on, the treatment took a turn for the better. Mara was able to leave day treatment and began attending a sheltered workshop. She moved out of her parents' house and into her own apartment, and began tentatively to explore relationships.

What has been significant over time is Mara's increasing capacity to tolerate affect, to engage in relatively healthy relationships, to use ever-widening circles of support, and to grow and change.

Conclusion

Practice principles for working with clients with a BPD diagnosis

Although tremendous strides have been made in the treatment of people with a diagnosis of BPD in the past few decades, there remain gaps in the systemic literature on how to work with this population. A

systemic approach that responds to and contains the BPD client and creates a reparative family out of the treatment system that is capable of flexible and healthy communication helps to move the client along the road towards healing. The following are a few basic principles that I use in order to organize myself in this work:

Therapist/administrator split. It is often useful to design a split in the treatment system such that one person becomes 'the heavy', the limit-setter who will develop and institute meaningful consequences to unproductive behaviours. This administrator may be a medication doctor, a group leader, a case manager, an emergency room staff person or an inpatient therapist. It must not be the primary therapist.

Coordination of multiple brief treatments. A long-term therapist who remains constant throughout can carve out doable pieces of work with clients with BPD such that they are able to experience tolerable small successes (Leibovich, 1981). I encourage clients to try new things: to become involved in a group, take a course, participate in a day treatment programme, do some volunteer work or join a workshop. I then become the primary person who helps to organize and contain clients while they venture into the unknown and then return to process what has happened.

Separation of safety issues from the treatment. I make it clear to my BPD clients that I am here to help them live their lives more fully, not to help them decompensate or die. I make myself available for crisis intervention in a limited way. I make it clear that hotlines, emergency rooms and hospitals are available to help deal with dangerous situations, and I often respond to a call for help by sending an ambulance and/or the police.

Benevolent neutrality. It is important to frame statements in a neutral and disengaged way. For example, 'It is unfortunate that you had to make the choice to go into hospital. I can't help you to get out of there.' It is also important when setting limits to state matter-of-factly that they are 'the way I do things' or 'a matter of policy'.

Not working harder than one's client. I find that BPD clients are masters at inducting their treatment team members to become more invested in their lives than they are. They are also masters at rejecting before an anticipated rejection. It is important to stand back and allow clients to

come forward and risk engagement in being hopeful about their lives and about their treatment.

Finding a way to go on. It is important to pave ways back into the treatment when there are inevitable empathic breaks or failures in containment. These failures must be anticipated and allowed for, and brought into the realm of verbal interaction rather than leaving them in the unspoken world of acting-out behaviours. As we say to 2-year-olds, 'use your words'.

Consultation and team work. Healthy communication and open conversation are important when working with BPD clients. They keep us honest and help us to spread the load so that we don't feel isolated, overwhelmed, misunderstood, murderously or impotently rageful, or anxious. They also offer our clients the new information that it is possible to get help with issues, that they are not in it alone, and that talking helps.

Be real. Genuineness is of the utmost importance. Clients will pull for it through negative interaction if it is not readily accessible.

Don't feed the borderlines. (This is a sign that hangs on the wall of a local hospital emergency room, somewhat irreverent, but offering some wisdom.) Limit what is offered. Do not overstimulate, abandon or smother your client. A pattern often evolves with BPD clients of offering more than can be delivered, and then retracting what is offered when it gets to be too much. The therapist gets inducted into an interaction with the client in which neither can win, an old stuck place.

Limited expectations. If we expect less we will succeed more.

References

Adler, G. (1972) Helplessness in the helpers. *British Journal of Psychoanalysis*, **45**: 315–325.

Adler, G. (1985) *Borderline Psychopathology and its Treatment*. New York: Jason Aronson.

Allen, C. (2004) Borderline personality disorder: towards a systemic formulation. *Journal of Family Therapy*, **26**: 126–141.

American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn). Washington, DC: Author.

Andersen, T. (1992) Reflections on reflecting with families. In S. McNamee and K. Gergen (eds) *Therapy as Social Construction*. London: Sage.

Anderson, H. (1997) *Conversation, Language and Possibilities: Postmodern Approach to Therapy*. New York: Basic Books.
Anderson, H. and Gehart, D. (eds) (2007) *Collaborative Therapy: Relationships and Conversations that Make a Difference*. New York: Routledge.
Bateman, A. (2004) Psychodynamic psychotherapy for borderline personality disorder. *Psychiatric Times*, **21**: 51–57.
Bateman, A. and Tyrer, P. (2004) Psychological treatment for personality disorders. *Advances in Psychiatric Treatment*, **10**: 378–388.
Bion, W. R. (1967) *Second Thoughts: Selected Papers on Psychoanalysis*. London: Karnac.
Birnbaum, R. (2004) Borderline, bipolar, or both? *Harvard Review of Psychiatry*, **12**: 146–148.
Bolton, S. and Gunderson, J. (1996) Distinguishing borderline personality disorder from bipolar disorder. *American Journal of Psychiatry*, **153**: 1202–1208.
Boscolo, L. and Bertrando, P. (1996) *Systemic Therapy with Individuals*. London: Karnac.
Bridges, N. (2005) *Moving Beyond the Comfort Zone in Psychotherapy*. New York: Jason Aronson.
Byng-Hall, J. (1995) Creating a secure family base: some implications of attachment theory for family therapy. *Family Process*, **34**: 45–58.
Carlyle, J. and Evans, C. (2005) Containing containers: attention to the 'innerface' and 'outerface' of groups in secure institutions. *Group Analysis*, **38**: 395–408.
Dallos, R. (2004) Attachment narrative therapy: integrating ideas from narrative and attachment theory in systemic family therapy with eating disorders. *Journal of Family Therapy*, **26**: 40–65.
Flaskas, C. (2005a) Psychoanalytic ideas and systemic family therapy: revisiting the question 'why bother?' *Australia New Zealand Journal of Family Therapy*, **26**: 125–134.
Flaskas, C. (2005b) Relating to knowledge: challenges to generating and using theory for practice in family therapy. *Journal of Family Therapy*, **27**: 185–201.
Gunderson, J. (2002) *Borderline Personality Disorder, a Clinical Guide*. Washington, DC: American Psychiatric Publishing.
Gunderson, J. (2004) Special report: Borderline personality disorder. New knowledge and new conceptions. *Psychiatric Times*, **21**: 41–42.
Hellerstein, D., Aviram, R. and Kotov, K. (2004) Beyond 'handholding': supportive therapy for patients with BPD and self-injurious behavior. *Psychiatric Times*, **21**: 58–64.
Herman, J. (1992) *Trauma and Recovery*. New York: Basic Books.
Hill, J., Fonagy, P., Safier, E. and Sargent, J. (2003) The ecology of attachment in the family. *Family Process*, **42**: 205–221.
Jenkins, H. (2006) Inside out, or outside in: meeting with couples. *Journal of Family Therapy*, **28**: 113–135.
Jenkins, H. and Asen, K. (1992) Family therapy without the family: a framework for systemic practice. *Journal of Family Therapy*, **14**: 1–14.
Larner, G. (2004) Family therapy and the politics of evidence. *Journal of Family Therapy*, **26**: 17–39.

Leibovich, M. (1981) Short-term psychotherapy for the borderline personality disorder. *Psychotherapy and Psychosomatics*, **35**: 257–264.
Linehan, M. (1993) *Cognitive Behavior Therapy for Borderline Personality Disorder*. New York: Guilford Press.
Linehan, M., Schmidt, H., Dimeff, L., Craft, J. C., Kanter, J. and Contois, K. (1999) Dialectical behavior therapy for patients with borderline personality disorder and substance abuse. *American Journal on Addictions*, **8**: 279–292.
Livesley, W. J. (2005a) Principles and strategies for treating personality disorder. *Canadian Journal of Psychiatry*, **50**: 442–450.
Livesley, W. J. (2005b) Progress in the treatment of borderline personality disorder. *Canadian Journal of Psychiatry*, **50**: 433–434.
MacKinnon, D. and Pies, R. (2006) Affective instability as rapid cycling: theoretical and clinical indications for borderline personality and bipolar spectrum disorders. *Bipolar Disorders*, **8**: 1–14.
McNamee, S. (2004) Promiscuity in the practice of family therapy. *Journal of Family Therapy*, **26**: 224–244.
Main, M. (1991) Metacognitive knowledge, metacognitive motitoring, and singular (coherent) vs. multiple (incoherent) model of attachment: findings and directions for further research. In C. M. Parkes, J. Stevenson-Hinde and P. Marris (eds) *Attachment Across the Life Cycle*. London: Routledge.
Miller, D. (1996) *Women Who Hurt Themselves: A Book of Hope and Understanding*. New York: Basic Books.
Palazzoli, M., Boscolo, L., Cecchin, G. and Prata, G. (1978) *Paradox and Counterparadox: A New Model in the Therapy of the Family in Schizophrenic Transaction*. New York: Jason Aronson.
Palazzoli, M., Boscolo, L., Cecchin, G. and Prata, G. (1980) The problem of the referring person. *Journal of Marital and Family Therapy*, **6**: 3–9.
Paris, J. (2005) Recent advances in the treatment of borderline personality disorder. *Canadian Journal of Psychiatry*, **50**: 435–441.
Pocock, D. (2006) Six things worth understanding about psychoanalytic psychotherapy. *Journal of Family Therapy*, **28**: 352–369.
Pointon, C. (2004) The future of trauma work. *Counseling and Psychotherapy Journal*, **15**: 10–13.
Rosenthal, M. Z. (2006) Dialectical behavior therapy for patients dually diagnosed with borderline personality disorder and substance use disorders. *Psychiatric Times*, **22**: 28–29.
Russell, P. (1975) The Theory of the Crunch. Unpublished manuscript.
Spinazzola, J., Blaustein, M. and van der Kolk, B. (2005) Posttraumatic stress disorder treatment outcome research: the study of unrepresentative samples? *Journal of Traumatic Stress*, **18**: 425–436.
Stern, D. (1998) *The Motherhood Constellation: A Unified View of Parent–Infant Psychotherapy*. London: Karnac.
Teicholz, J. G. and Kriegman, D. (eds) (1998) *Trauma, Repetition and Affect Regulation: The Work of Paul Russell*. New York: The Other Press.
Thomas, D. (1952) Do not go gentle into that good night. In D. Jones (ed.) (1971) *The Poems of Dylan Thomas*. New York: New Directions.

Tomm, K. (1984a) One perspective on the Milan systemic approach: Part I. *Journal of Marital and Family Therapy*, **10**: 113–125.
Tomm, K. (1984b) One perspective on the Milan systemic approach: Part II. *Journal of Marital and Family Therapy*, **10**: 253–271.
van der Kolk, B. (2005) Developmental trauma disorder. *Psychiatric Annals*, 401–408.
van der Kolk, B., McFarlane, A. and Weisath, L. (1996) *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society*. New York: Guilford Publications.
van der Kolk, B., Roth, S., Pelcovitx, D., Sunday, S. and Sinazzola, J. (2005) Disorders of extreme stress: the empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, **18**: 389–399.
Winnicott, D. W. (1947) Hate in the countertransference. In J. P. Brandell (1992) *Countertransference in Psychotherapy with Children and Adolescents*. Princeton, NJ: Jason Aronson.
Winnicott, D. W. (1965) *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press.