邊緣型人格障礙治療概論

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BPD is treatable!

2 years = 40% Remission
6 years = 68% Remission
10 years = 85% Remission

(Zanarini, 2005, 2006)

Remission is defined as
“no longer meeting 5 of 9 criteria”

However, remission does not mean
“recovery” or having a good quality of life
Functional remission, defined as a Global Assessment of Functioning score greater than 70 sustained for 2 months.

Gunderson J et al, Arch Gen Psychiatry 2011; 68: 827–837
Advance in the Understanding of Borderline Personality Disorder

• The increasing recognition that the disorder has a far more benign course than previously thought;

• The emergence of a range of relatively effective psychosocial interventions that appear to accelerate the rate of improvement.

Fonagy P & Bateman A
Br J Psychiatry 2006; 188: 1-3
DSM-IV 如何診斷人格障礙(I)

A. 至少在下列兩項以上持續地偏離常模：
   (1) 認知
   (2) 情感表達
   (3) 人際關係
   (4) 衝動控制

B. 行為模式沒有彈性，且出現在許多個人情境或社交場合
DSM-IV 如何診斷人格障礙 (II)

C. 在個人社會、職業表現等方面造成臨床上顯著的挫折或損害
D. 從青春期末期或成年早期開始出現
E. 不是來自其它精神疾病
F. 不是來自酒精或藥物使用，或其它身體疾病
Personality Disorders in DSM

Cluster A: eccentric disorders
a pervasive pattern of abnormal cognition (eg., suspicious), self-expression (eg., odd speech), or relating to others (eg., seclusive).

Cluster B: dramatic disorders
a pervasive pattern of violating social norms (eg., criminal behavior), impulsivity, excessive emotionality, grandiosity, or "acting out“ (eg., tantrums, self-abusive behavior, angry outbursts)

Cluster C: anxious disorders
a pervasive pattern of abnormal fears involving social relationships, separation, and need for control.
DSM-III-R & DSM-IV BPD 診斷準則

1c. Fear of Abandonment
2c. Unstable, intense relationships
3b. Identity disturbance
4a. Impulsivity
5d. Suicidal or self-mutilating behaviors
6a. Affective instability
7b. Emptiness
8b. Inappropriate, intense anger
9d. Lapses in reality testing
Personality Disorder in DSM-5  

APA, Jan. 2011

To diagnose a personality disorder, the impairments must meet *all* of the following criteria:

A. A rating of **mild impairment or greater in self and interpersonal functioning** on the Levels of Personality Functioning.

B. Associated with a “*good match*” or “*very good match*” to a **personality disorder type** or with a rating of “*quite a bit like the trait*” or “*extremely like the trait*” on one or more personality **trait domains**.

C. **Relatively stable** across time and consistent across situations.
To diagnose a personality disorder, the impairments must meet all of the following criteria:

D. Not better understood as a norm within an individual’s dominant culture.
E. Not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).
人格功能等級(一)  Bender, 2010

自我Self

• 認同整合Identity integration: Experience of oneself as unique, with clear boundaries between self and others; coherent sense of time and personal history; stability and accuracy of self-appraisal and self-esteem; capacity for a range of emotional experience and its regulation.

• 自我導向Self-direction: Pursuit of meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to productively self-reflect.
人格功能等級(二)  
Bender, 2010

人際的Interpersonal

• 同理心Empathy: comprehension and appreciation of others’ experiences, tolerance of differing perspectives, understanding of social causality.

• 親密感Intimacy: Depth and duration of connection with others, desire and capacity for closeness, mutuality of regard reflected in interpersonal behavior.
Figure 1-2. Concepts of borderline disorders.

Borderline Personality Disorder

Psychodynamic theorists trace the origins of borderline personality disorder to disturbances in the parent-child relationship in the second and third years.

Borderline child is unable to integrate disparate experiences of parental love and hostility.

Borderline patients have unstable mood and self-image, are often inappropriately angry, and overreact to minor slights and disappointments.
DIB-R : Sectors of Psychopathology

▲ Dysphoric affect
▲ Disturbed cognition
▲ Impulsive behaviors
▲ Troubled relationships

Zanarini et al.
I. Affective Disturbance

• a range of intense dysphoric affects:
  aversive tension, including rage, sorrow, shame, panic, terror, and chronic feelings of emptiness and loneliness
  *multifaceted emotional pain

• tremendous mood reactivity:

Lieb K et al,
Lancet 2004; 364: 453-61
II. Disturbed Cognition

- troubling but non-psychotic problems, such as overvalued ideas of being bad, experiences of dissociation in terms of depersonalisation and derealisation, and non-delusional suspiciousness and ideas of reference;
- quasi-psychotic or psychotic-like symptoms — ie, transitory, circumscribed, and somewhat reality-based delusions and hallucinations;
- genuine or true delusions and hallucinations.

Lieb K et al, Lancet 2004; 364: 453-61
III. Impulsivity

• deliberately physically self-destructive: self-mutilation, suicidal communication, and suicide attempts

• more general forms of impulsivity: substance abuse, disordered eating, spending sprees, verbal outbursts, and reckless driving

Lieb K et al,
Lancet 2004; 364: 453-61
IV. Intense Unstable Relationships

• a profound fear of abandonment, which tends to manifest itself in desperate efforts to avoid being left.

• a tumultuous quality to close relationships, which are marked by frequent arguments, repeated breakups, and reliance on a series of maladaptive strategies that can both anger and frighten others.

Lieb K et al, Lancet 2004; 364: 453-61
Affective Dysregulation & Dissociative Experience

• Corticolimbic disconnection model of dissociation
  I. Affective dysregulation is hypothesized to be correlated with increased amygdala functioning
  II. Dissociation is linked to inhibited processing on the amygdala and dampened autonomic output.

  Sierra & Berrios
  Biological Psychiatry, 1998

• BPD group had a significantly higher startle response in the electromyogram

  Ebner-Priemer UW et al.,
  J Psychiatr Res. 2005 Jan-Feb
Enhanced Emotion-induced Amnesia in BPD

- BPD patients displayed enhanced retrograde & anterograde amnesia in response to presentation of negative stimuli, while positive stimuli elicited no episodic memory-modulating effects.
- These findings suggest that an amygdala hyper-responsiveness to negative stimuli may serve as a crucial aetiological contributor to emotion-induced cognitive dysfunction in BPD.

Hurlemann R et al., Psychol Med 2007 Jan 16;:1-11
BPD & Dissociation

• Chronic, complex dissociative symptoms and disorders are common in BPD.
• The ninth DSM-IV-TR criterion for BPD does not adequately describe the dissociative comorbidity in the disorder.

Ross CA
J Trauma Dissociation. 2007; 8(1):71-80
Some Symptoms Appear to Wane over Time

• affective instability, quasi-psychotic thought, serious identity disturbance, impulsive symptoms (e.g., substance abuse, promiscuity), self-mutilation, suicide attempts, stormy relationships, devaluing and manipulating others, and a demanding and entitled posture.
Some symptoms do not seem to respond or respond much more slowly to psychological treatment

- depression, feelings of helplessness, hopelessness, feelings of worthlessness, anger, chronic anxiety, loneliness, a sense of emptiness, odd thoughts, a propensity to become paranoid under stress, fears of abandonment, intolerance of being alone, and strong dependency issues
Course of Subsyndromal Phenomenology

▲Affective symptoms decrease the least
▲Impulsive symptoms decrease the most
▲Cognitive and interpersonal symptoms occupy an intermediate position

Zanarini et al.
Am J Psychiatry 2003; 160:274-283
Balance of Combined Treatment According to Type of Borderline Personality Disorder

<table>
<thead>
<tr>
<th>Borderline Personality Disorder Type</th>
<th>Pharmacotherapy</th>
<th>Psychotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 (Affective)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 (Impulsive)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 3 (Aggressive)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 4 (Dependent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 5 (Empty)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For each type of borderline personality disorder, a combination of psychotherapy and pharmacotherapy is indicated. Reliance on pharmacotherapy will be greater, particularly early in the course of treatment, for types 1–3, until affect regulation and impulse control have stabilized. Adapted with permission from American Psychiatric Publishing, Inc. (2).
A Longitudinal Perspective on Personality Disorder Symptomatology

INCREASING SYMPTOMS

- Axis I & II disorders
- Psychosocial stressors
- Biological stressors
- Alcohol/Illlicit drugs

Diagnostic Threshold

BPD Symptoms

DECREASING SYMPTOMS

- Psychotherapy
- Psychotropic medications
- Maturation

Sansone R & Sansone LA, Psychiatry 2008; 5: 53–57
Comorbidity (I)

Axis I disorders:

- major depression, 41–83%
- dysthymia, 12–39%
- bipolarity, 10–20%
- substance misuse, 64–66%
- post-traumatic stress disorder, 46–56%
- social phobia, 23–47% for obsessive-compulsive disorder, 16–25%
- panic disorder, 31–48%
- any eating disorder, 29–53%

Lieb K et al, Lancet 2004; 364: 453-61
Comorbidity (II)

Axis II disorders:

avoidant personality disorder, 43–47%,
dependent personality disorder, 16–51%,
paranoid personality disorders, 14–30%

Lieb K et al,
Lancet 2004; 364: 453-61
Borderline syndrome

I. close to neurotic border: a search for a lost symbiotic union, anaclitic depression

II. as-if type: marked weakness of identity, effort to please & ingratiate

III. core process: dichotomous swing, feelings of loneliness & depression

IV. close to psychotic border: given up attempts at developing relationships, overtly reacts negatively, angry toward others

Grinker et al. 1968
### BPD 之分類（二）

<table>
<thead>
<tr>
<th>Interpersonal Context</th>
<th>Phenomenology</th>
<th>Others’ responses</th>
<th>Clinical implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Held/idealizing</td>
<td>Empty, dysfunctional, symptomatic</td>
<td>Sympathetic</td>
<td>Collaborative; interpretations; patient needs expressive, involving therapies</td>
</tr>
<tr>
<td>Threatened/Devaluing</td>
<td>Angry, self-destructive pleas for help</td>
<td>Scared, guilty, angry</td>
<td>Confrontations; patient needs social supports, behavioral change</td>
</tr>
<tr>
<td>Alone</td>
<td>Terrified, dissociated, paranoid, substance-abusing, promiscuous</td>
<td>Rescue, avoid</td>
<td>Words unimportant; patient needs containment, medications</td>
</tr>
</tbody>
</table>

Adapted from Gunderson 1984
Mind, Brain, & Personality Disorder

Trauma & BPD (I)

persecuting object \hspace{1cm} \rightarrow \hspace{1cm} \text{victimized self}

Hypervigilant Anxiety
HPA Hyperreactivity
Mind, Brain, & Personality Disorder

Trauma & BPD (II)

victimized self → persecuting object

Failure to mentalization → terrorized state →
Incapacity to think & reflect
Hypervigilant Anxiety Accusations

Gabbard G.O., 2004
BPD的生物社會學說 (Biosocial Theory)

I. 情緒失調 (Emotional dysregulation)
II. 不認可的環境 (Invalidating environment)

Marsha M. Linehan，1993
BPD的生物社會學說 (Biosocial Theory)

不認可的環境（一）：

a. the expression of private experiences is not validated; instead, it is often punished, and/or trivialized.

b. Invalidation has two primary characteristics. First, it tells the individual that she/he is wrong in both her/his description and her/his analyses of her own experiences, ..... Second, it attributes her/his experiences to socially unacceptable characteristics or personality traits.

Marsha M. Linehan, 1993
BPD的生物社會學說 (Biosocial Theory)

不認可的環境（二）：
84%的邊緣型人格障礙病人回溯報告，曾在十八歲前被雙親忽略 (biparental neglect) 或遭受情緒虐待 (emotional abuse)，且比起對照組報告有較多的照顧者，無論性別，不認可病人的想法及感受、無法提供他們所需要的保護、忽略對病人的身體照顧、情緒疏離、及提供不一致 (inconsistent) 的照料。

女性邊緣型人格障礙病人報告曾被同性照顧者忽視且被異性照顧者虐待者，其被一位非照顧者性虐待的危險比例較高。

BPD的生物社會學說 (Biosocial Theory)

不認可的環境（三）：

一、無法認可自己的情緒表達，也因此就沒有機會學習到如何標定或處理各種情緒反應。
二、過度簡化處理各種生活問題的難易度。
三、學習到必須要表達極度的情緒或呈現極端的問題才能得到有助益的回應。
四、在這種環境中的人無法學會，何時可以信任自己的情緒反應或照顧者的認知表達，來做為個人經驗或生活情境的有效詮釋。

Marsha M. Linehan，1993
BPD的生物社會學說 (Biosocial Theory)

不認可的環境（四）：
一、虐待本身對於邊緣型人格障礙的形成既非充分也非必要的條件，反而是一些造成虐待事件的前置 (predisposing)因素和親子互動的脈絡(contextual)特徵才是這個疾病真正發展的媒介因素。

Fonagy P, Bateman A
J Personal Disord. 2008; 22:4-21

二、遭受虐待後父母的反應方式，例如，相信病人的說法、保護病人、和不顯露出盛怒，有助於較快速的復原；反過來說，缺乏情緒反應、低支持度、不足夠的認可則可能加重受虐經驗的影響。

Everson MD, Hunter WM, Runyun DK
Am J Orthopsychiatry 1989; 59:197-207
BPD的生物社會學說 (Biosocial Theory)

不認可的環境（五）：

邊緣型人格障礙病人學會的是：

一、不認可自己的經驗，
二、更轉而不斷地向周遭尋求線索以告訴自己如何思考、感覺、與行動。

Marsha M. Linehan，1993
## Table 3. Familial Aggregation of Borderline Personality Disorder

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Risk Ratio&lt;sup&gt;a&lt;/sup&gt;</th>
<th>P Value</th>
<th>ρ&lt;sup&gt;b&lt;/sup&gt;</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimate (95% CI)</td>
<td></td>
<td>Estimate (95% CI)</td>
<td></td>
</tr>
<tr>
<td>Proband-relative pairs</td>
<td>2.9 (1.5-5.5)</td>
<td>&lt;.001</td>
<td>0.28 (0.11-0.44)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>All pairs&lt;sup&gt;c&lt;/sup&gt;</td>
<td>3.9 (1.7-9.0)</td>
<td>&lt;.001</td>
<td>0.37 (0.11-0.64)</td>
<td>.006</td>
</tr>
</tbody>
</table>

Abbreviation: CI, confidence interval.

<sup>a</sup>For proband-relative pairs: risk of borderline personality disorder (BPD) diagnosis in relative of proband with BPD (by both DSM-IV and Revised Diagnostic Interview for Borderlines [DIB-R] criteria) vs risk of diagnosis in relative of proband without BPD (by DSM-IV plus DIB-R criteria), using entire sample weighted by inverse probability of selection; for all pairs, risk of BPD in a relative of a family member with BPD vs risk of BPD in a relative of a family member without BPD diagnosis.

<sup>b</sup>Tetrachoric correlation coefficient.

<sup>c</sup>Pairs of first-degree relatives (excludes mother-father pairs).
# Family Study of BPD & Its Sectors of Psychopathology

## Table 4. Familial Aggregation of Sectors of Borderline Personality Disorder Psychopathology

<table>
<thead>
<tr>
<th>Sector</th>
<th>Proband-Relative Pairs</th>
<th>All Pairs of Family Membersa</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimate (95% CI)</td>
<td>Estimate (95% CI)</td>
</tr>
<tr>
<td></td>
<td>P Value</td>
<td>P Value</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-IV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affective</td>
<td>0.13 (0.04-0.22)</td>
<td>0.18 (0.08-0.27)</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>0.22 (0.12-0.32)</td>
<td>0.20 (0.11-0.30)</td>
</tr>
<tr>
<td>Behavioral</td>
<td>0.09 (0.01-0.17)</td>
<td>0.09 (0.02-0.15)</td>
</tr>
<tr>
<td>Cognitive</td>
<td>0.13 (0.03-0.23)</td>
<td>0.07 (0.00-0.15)</td>
</tr>
<tr>
<td></td>
<td>.004</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>.&lt;.001</td>
<td></td>
</tr>
<tr>
<td>DIB-R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affective</td>
<td>0.19 (0.09-0.29)</td>
<td>0.21 (0.13-0.29)</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>0.30 (0.23-0.37)</td>
<td>0.27 (0.17-0.36)</td>
</tr>
<tr>
<td>Behavioral</td>
<td>0.14 (0.08-0.22)</td>
<td>0.13 (0.05-0.21)</td>
</tr>
<tr>
<td>Cognitive</td>
<td>0.17 (0.09-0.26)</td>
<td>0.18 (0.10-0.26)</td>
</tr>
<tr>
<td></td>
<td>.&lt;.001</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>.&lt;.001</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; DIB-R, Revised Diagnostic Interview for Borderlines.

a Pairs of first-degree relatives (excludes mother-father pairs).

b Pearson product moment correlation coefficient.

Gunderson JG et al, Arch Gen Psychiatry 2011; 68:753-762
BPD 病人的行为模式

a. emotional vulnerability
b. self-invalidation
c. unrelenting crises
d. inhibiting grieving
e. active passivity
f. apparent competence

Marsha M. Linehan，1993
BPD病人的辯證行為治療模式

增進行為技能：

a. core mindfulness
b. distress tolerance
c. emotion regulation
d. interpersonal effectiveness

Marsha M. Linehan，1993
## Readiness for Psychotherapy

<table>
<thead>
<tr>
<th>Patient</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sees problem in self</td>
<td>Trained in skill that facilitate change</td>
</tr>
<tr>
<td>Seeks change in self</td>
<td>Agrees with patient’s goals</td>
</tr>
<tr>
<td>Patient (or others) in principle can assume primary responsibility for patient’s safety</td>
<td>Can contain patient’s emotions but does not assure patient’s safety</td>
</tr>
</tbody>
</table>

Gunderson, 2001
Level of care

IV. Hospital
III. Residential/partial hospital: 4-6 weeks
II. Intensive outpatient: 6-36 weeks
I. Outpatient: > 1 year

Gunderson, 2001
Management of BPD
a review of psychotherapeutic approaches

• Major approaches:
  I. Psychodynamic, e.g., TFT
  II. Cognitive-behavioral, e.g., DBT
  III. Supportive.

• All approaches aim at the amelioration of both the symptom-aspects that dominate the clinical picture at the outset, and the personality difficulties that remain apparent after the symptoms have been alleviated.

Stone MH
World Psychiatry 2006 Feb;5(1):15-20
Management of BPD  
a review of psychotherapeutic approaches

• Hierarchical approach: as to their level of seriousness
  I. suicidal and self-mutilative behaviors.
  II. any threats to interrupt therapy prematurely.
  III. in order of seriousness: non-suicidal symptoms such as (mild to moderate) depression, substance abuse, panic and other anxiety manifestations, or dissociation.

Stone MH  
World Psychiatry 2006 Feb;5(1):15-20
Management of BPD
a review of psychotherapeutic approaches

• Psychopharmacological treatment will often be used adjunctively to help control any target symptoms, which usually fall into such categories as cognitive-perceptual, affect dysregulation, or impulsive/behavioral dyscontrol.

• Therapists must then be alert to any signs of withholding, dishonesty, or antisocial tendencies, since these have an adverse effect on prognosis.

Stone MH
World Psychiatry 2006 Feb;5(1):15-20
Management of BPD
a review of psychotherapeutic approaches

• When all these disruptive influences are (to the extent possible) dealt with, therapists will next take up milder symptoms such as social anxiety or lability of mood.
• Throughout this initial process, the personality-disorder attributes of BPD will become more apparent, and will usually emerge with greater clarity, once the serious symptoms have been dealt with.

Stone MH
World Psychiatry 2006 Feb;5(1):15-20
Management of BPD
a review of psychotherapeutic approaches

• The management issues will gradually be supplanted with the overlapping and enduring personality issues: inappropriate anger, abrasiveness, manipulativeness, demandingness, jealousy, "all-or-none" thinking and the extreme attitudes (idealization/devaluation) that accompany such thinking, masochistic traits, etc.

Stone MH
World Psychiatry 2006 Feb;5(1):15-20
Management of BPD
a review of psychotherapeutic approaches

• Under ideal circumstances, the borderline patient will have graduated toward a higher level of function, where (acute) management issues have been adequately dealt with or have receded into the background.

• Psychotherapy, individual and group, becomes the dominant intervention, with such goals as psychic integration, skills training, and the fostering of long-range ambitions relating to friendships, partner choice, and work.
Stage of Treatment

Pre-Treatment: Commitment and Agreement
Stage 1: Severe Behavioral Dyscontrol  Stability and Behavioral control
Stage 2: Quiet Desperation  Non-anguished Emotional Experiencing
Stage 3: Problems in Living/Non-complicated Disorders  Ordinary Happiness/Unhappiness
Stage 4: Incompleteness  Freedom and Capacity for Joy

Korslund, 2010
Some Comparison

- General psychiatric management was as effective as dialectical behavior therapy on all outcomes at the end of 1 year of treatment, at the 2-year follow-up, which is a more robust test of any treatment.

Some Comparison

- Transference-focused psychotherapy, Dialectical behavior therapy, Generalist treatment, supportive psychotherapy
- Outcomes across the three treatments were “generally equivalent.”

Some Comparison

- Good clinical care and cognitive analytic therapy were equally effective, with significant improvements across a range of clinical outcome measures.

Chanen AM, Jackson HJ, McCutcheon LK, et al: Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial
Br J Psychiatry 2008; 193:477–484
Some Comparison

- Mentalization-based treatment with structured clinical management and found that both were effective treatments and that structured clinical management was superior in the initial months at reducing self-harm.

Bateman A, Fonagy P: Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder
Am J Psychiatry 2009; 166:1355–1364
The message is becoming clear – most people with borderline personality disorder need specialist treatment that is primarily structured and organized around their core symptoms.

Bateman AW
Am J Psychiatry 2012; 169:560-3
Treating BPD in Clinical Practice

1) Provide a structured manual that supports the therapist and provides recommendations for common clinical problems;

2) Encourage increased activity, proactivity, and self-agency for the patients;

3) focus on emotion processing, particularly on creating robust connections between acts and feelings;

Bateman AW
Am J Psychiatry 2012; 169:560-3
Treating BPD in Clinical Practice

4) Increase cognitive coherence in relation to subjective experience in the early phase of treatment by including a model of pathology that is carefully explained to the patient;

5) Encourage an active stance by the therapist, which invariably includes an explicit intent to validate & demonstrate empathy & generate a strong attachment relationship to create a foundation of alliance.

Bateman AW
Am J Psychiatry 2012; 169:560-3
The Role of Primary Caretaker

• Auxiliary ego boundary
• Holding environment:
  I. A construction scaffolding that supports the infant’s developing ego boundaries.
  II. It provides an initial regulatory environment in which an infant can begin to “hatch” and develop a progressive sense of “me-ness” with which to differentiate itself from the rest of the world.
The Therapeutic Boundary (I)

• The **therapist’s guidelines** become familiar landmarks that enable the patient to develop his or her own ability to contain distressing affects.

• The **physical setting** of therapy

• The patient may **play and experiment** with those perceptions that lie in a twilight zone between fantasy and reality.
The Therapeutic Boundary (II)

• Learn to deal with frightening internal states, translated word and gesture to a symbolic way.
• Break the therapeutic framework by acting out these illusions
• The therapist has to focus on initial interventions at the level of the boundary rather than on the content of the fantasy.
MOTHER AND INFANT LOOKING INTO EACH OTHER'S EYES

www.dreamstime.com/mother-and-infant-looking-...
Frances Tustin (1981) and Gail Yariv (1989) have pointed out the importance of stability, continuity, and a predictable rhythmicity in the relationship with the primary object for the development of a clear separation of self and other, or inside and outside.

Gabbard & Lester, 1995
邊緣型人格障礙病人治療指引

• 心理治療是邊緣型人格障礙病人最主要的治療模式，而以症狀為目標（symptom-targeted）的藥物治療則扮演輔助的角色。

• 邊緣型人格障礙病人的心理治療模式至少要注意到危機處理、安全維護、治療架構、疾病衛教、由治療團隊提供協調式治療等成份。

美國精神醫學會，2001
實務(一)

壹、治療室中的互動：
  一、治療師的準備
    1、放下、捨得
    2、「情緒調理機」
  二、特定基本技能：護持(holding)
    涵容(containment)

三、學習過程
  1、文獻探討
  2、實務經驗
  3、督導、個案研討
實務(二)

貳、治療模式：
  一、連結(engagement)
    1、處理試探行為(surviving testing behavior)
    2、維持界限(keeping boundary)
    3、治療配合度(treatment adhesion)
    4、自傷行為(deliberate self-harm behavior)
實務(三)

貳、治療模式：

二、發展諮商與心理治療(Developmental Counseling and Psychotherapy)

1、感覺動作/本質的
2、具體運思/情境的
3、形式運思/省思的
4、辯證/系統的
實務(四)

貳、治療模式：

三、人工頭腦學（Cybernetics）：
＊回饋（Feedback）
＊迴路（Feedback circuit）
＊型態配對（Pattern matching）：
　　歸納：八卦→四象→兩儀（陰→陽/好→壞）

四、整合、折衷（Integrative、Eclectic）取向：
實務(五)

支持—表達動力(Supportive-Expressive Dynamic) 心理治療

詮釋 Interpretation
觀察 Observation
面質 Confrontation
澄清 Clarification
鼓勵 Encourage to elaborate
肯定 Affirmation
同理 Empathy
建議—獎勵 Advice-praise
實務(六)

Dialectic Behavior Therapy，DBT模式
Marsha M. Linehan，1993

一、個別心理治療
二、社交技巧訓練團體
   Social Skill Training Group
三、督導/諮商團體
   Supervision/Consultation Group
   Interpersonal Group，IPG模式
John G. Gunderson，2001

Psychodynamic-Interpersonal-Existential模式
Jou et al，2001
實務(七)

貳、治療模式:

六、支持系統

1、心理治療
2、親友
3、社區支持團體
謝謝聆聽，
敬請指教！