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Relational Engagement and Borderline Personality Disorder

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ABSTRACT

This paper explores Dialectical Behaviour Therapy (DBT) for clients with Borderline Personality Disorder (BPD) from a relational ethics perspective. Authors use Bergum and Dossetor's (2005) relational ethical theory as a framework for examining DBT. A key component of DBT is the focus on the relationship between the client and healthcare provider. Alignment with the framework is evident in the following: holistic approach to the client; engagement and validation of the client in treatment; and therapist reflection and accountability. Despite this alignment, there remains tension and contradiction in relation to DBT and clients with BPD. These include practices of therapist withholding or withdrawal and using aversive techniques. Unanswered ethical questions remain for health care. Implications for mental health practice are provided in conclusion.

Key Words: Ethics, relational engagement, borderline personality disorder, dialectical behaviour therapy, mental health.

Ethics in mental health care often focuses on issues such as enforced medication treatment and mental health legislation. Ethical evaluation of treatment ensures people are provided care based on sound and just principles and that treatment is congruent with professional codes of ethics. Dialectical Behaviour Therapy (DBT), an intense psychotherapy for people with Borderline Personality Disorder (BPD) is an intervention that could benefit from a broad examination of associated ethics. An avenue for ethical exploration of DBT, given its focus on relational engagement, is relational ethics, a post-modern ethical stance which considers relationship, emotion, and individual circumstance when making ethical decisions (Bergum & Dossetor, 2005).

Though no single therapy, including medication and psychotherapy successfully treats all aspects of BPD, DBT is the *treatment of choice* in treating the self-harm and suicidality accompanying the condition (Swift, 2009). In essence, DBT uses the relationship between the therapist and client to treat the disorder (Bateman, 2005). The primary intervention is the use of validation and emotional support to the client, while at the same time advocating change for life threatening behaviours (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). Traditional biomedical ethics tends to remove emotion from the decision-making process and gives less consideration to the personal and relational components of ethics (Bergum & Dossetor, 2005), which makes evaluation of relationship focussed DBT less effective. A relationally based ethical framework, such as Bergum and Dossetor's, provides a suitable mechanism for ethically evaluating DBT's relationally based therapy. This article will use Bergum and Dossetor's relational ethics theme or principle of relational engagement to ethically evaluate DBT treatment of people with BPD.

Borderline Personality Disorder

BPD is characterized in the Diagnostic and Statistics Manual of Mental Disorders as a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (American Psychiatric Association [APA], 2000, para.1). Prevalence of this disorder is relatively widespread with rates ranging from 0.5 – 5.9 % of the general United States population, 10% of community mental health clients and 15-25% of in-patient mental health patients diagnosed with the disorder (Leichsinring, Leibing, Kruse, New, & Leweke, 2011).

Mental health treatment of people who have BPD is not easy: traditionally people with BPD have been viewed as untreatable (Swift, 2009). The pervasive nature and the difficulties with interpersonal relationships and emotional lability make it difficult for clinicians to understand the disorder (Osborne & McComish, 2006). Treating people with BPD triggers uncomfortable feelings in clinicians, such as frustration, anger, and irritation (Bland, Tudor, & McNeil-Whitehouse, 2007). Considering the challenges of working with a group of patients who alternately idealize and devalue the people who are trying to help them, it is understandable that health care providers have difficulty in maintaining professional and compassionate care. Given the common emotional reactions mentioned, even more care must be taken by the mental health care provider to ensure competent, ethical care.

Dialectical Behaviour Therapy

DBT was developed by Marsha Linehan to treat people who live with BPD. The dialectical approach within DBT focusses on treating the whole person, rather than centering on a particular aspect of their disorder. The relationship is paramount and both the client and clinician will affect one another (Swales, Heard & Williams, 2000). Lynch et al. (2006) state there is a need for a dialectical approach as treatments oriented only to change invalidates those with BPD, leading to treatment failure and "a treatment focused only on acceptance invalidated the seriousness of the patients' suffering and the urgent need to produce change" (p. 461).

Another core foundation of DBT is using behavioral strategies. These strategies use reward and extinction either promoting positive behavior such as coping mechanisms, or reducing negative behaviors such as self-harm and suicidality. Therapist validation promotes positive coping mechanisms by the client, and therapist withdrawal is used to decrease dysfunctional behavior such as self-harm or poor relationship skills (Lynch et al., 2006). Analyzing challenging behavior such as self-harm and life endangering behavior such as substance use is done with a chain analysis, breaking down each step of the behavior to explore feelings, thoughts, and behaviors at each point where a different decision could have been made (Lynch et al., 2006). Behavioral chain analysis is aversive or punishing, as people with BPD typically dislike and will avoid detailed discussion of their self-harm or problematic behavior (Lynch et al., 2006).

Finally, DBT uses cognitive restructuring, helping people with BPD problem solve. These strategies focus on the links between behavior, emotion, and thought process recognizing though someone in distress may not feel emotionally able to manage the situation, but that appearing competent within the situation can actually promote feelings of competence (Lynch et al., 2006). In effect, cognitive restructuring uses a positive feedback loop to promote change. Another cognitive restructuring technique is examining thoughts logically, and reviewing the rationale and effectiveness of behaviors (Brown, 2006).

Previous sections of this paper provided a brief overview of DBT, with a summary of only some of the techniques and strategies for working with people who have BPD. As mentioned, DBT functions by looking at people holistically and using relationship to drive the process. The therapist externally validates the client helping decrease hopelessness and models desired functional behavior, with the therapist demonstrating what healthy self-validation looks like (Brown, 2006). Self-disclosure is used by the health care provider to establish the relationship with the client exploring healthy coping and to promote change (Swales et al., 2000). As outlined in this paper, it is evident that DBT is a relationship-based treatment for people who have BPD using behavioural strategies and cognitive therapy to promote change.

Relational Ethical Theory

As outlined in Bergum and Dossetor's book, *Relational Ethical Theory* (2005), this philosophy looks at areas of ethical dissonance in healthcare through the lens of individual relationships. In fact, they write that "relationship is key to ethical action" (p. 197). This theory recommends that understanding is found by immersing oneself in the situation, rather than using external rules to determine right and wrong. Principles such as beneficence, autonomy, or codes of ethics are not discarded, rather these principles require analysis within the context; application of the principles cannot occur without examining the uniqueness of each situation. Relational ethics are "founded on empathy and education, rather than on knowledge and principles" (Bergum & Dossetor, 2005, p. 213).

Relational Engagement

Healthcare is not simply technology and physical interventions. Bergum and Dossetor (2005) view engagement within healthcare as "ethically necessary" (p.xxii). Relational engagement consists of purposeful reaching out and connection with another human being and may mean sharing in suffering (Bergum & Dossetor, 2005). Bergum and Dossetor propose that health care relationships are reciprocal. Though the health care professional gives and is responsible for providing care, relational theory views being with a patient as rewarding and offering much in return.

Bergum and Dossetor (2005) write about knowing the uniqueness and wholeness of the person in care, if health care providers are engaged relationally. Certainly, it is easy to label people in care by their diagnosis or by their behaviour. It allows us opportunity to focus treatment on what is causing the person difficulty. However, labels can lead to distancing and objectification of the person who is living with the issue (Bergum & Dossetor, 2005). As health care providers, when we isolate and stigmatize people by their labels, humanness and opportunity for connection is lost.

Bergum and Dossetor (2005) refer to the need for appropriate vulnerability when engaging relationally with people. Not only does vulnerability require the health care provider's participation relationally, but it also entails examining power imbalances, personal motivations and reactions (Bergum & Dossetor, 2005). This vulnerability requires health care provider reflection upon why certain uncomfortable emotions present themselves when caring for others, and how these emotions impact relationships and ethical interactions (Bergum & Dossetor, 2005). There is recognition that health care providers are not all powerful and that they should assume responsibility for their actions or inactions. Relational engagement requires us to be fully present, and to reflect fully on those uncomfortable situations that we would rather ignore.

Applying Relational Engagement to Dialectical Behaviour Therapy

DBT strategies include validation, consultation teams, holistic approach, behavioural strategies, and cognitive restructuring. This section will examine these techniques through a relational ethical lens.

Linehan (1993) writes of clinicians needing engagement with clients as equals, recognizing that both the client and clinician require support. DBT also recommends therapists attend to clients and validate them on several different levels, ranging from simply staying awake to radical genuineness (Linehan, 1993). This validation is meant to build confidence, but also at the level of radical genuineness, confirms the "inherent capacity of the client to improve and overcome her difficulties, while at the same time retaining an empathic understanding of the level of the difficulties" (Swales et al., 2000, p.15). Validation also recognizes that there is truth and wisdom within the behaviour (Swales et al., 2000). The principles of validation are well aligned with Bergum and Dossetor's theme of relational engagement including the importance of relationship building, looking beyond labels, and considering the uniqueness of each person.

The health care provider is held accountable and is required to adhere to the same set of principles as the person who is in treatment (Linehan, 1993). This is achieved through consultation teams. Therapists meet with other health care providers, examining whether DBT principles are met including engaging and validating the client, focussing on what the client wants to achieve, and ensuring health care providers are not judging or speaking derogatorily about patients (Linehan, 1993; Lynch et al., 2006). In effect, consultation teams provide DBT to the therapist (Linehan, 1993). Given that engaging with people who have BPD is challenging due to their alternate idealization and devaluing of treatment providers, those working in this area of mental health need as much support as the people they are treating. This is not entirely compatible with Bergum and Dossetor's (2005) theory of relational engagement, as they note that stress and burn out results from disengagement and decreasing interaction, rather than interacting. However, Bergum and Dossetor (2005) also refer to the health care provider receiving support from other external sources, in order to maintain capacity for giving. Within the DBT framework, the treatment team meets this need. Relational engagement also includes examining rationales and meanings behind emotional reactions, which is consistent with the consultation team's role in providing accountability of the health care provider. Recognition of the vulnerability of both therapist and client is seen in both DBT therapy and within Bergum and Dossetor's ethical framework.

Certainly, DBT is focussed on seeing the person with BPD holistically, similar to the concepts of relational engagement. However, this holistic approach is not based upon unconditional acceptance of the client. Rather it recognizes that though the client often has a traumatic and challenging life it is only the client who can change present behaviour. There is a difficult and distinct tension within health care provider engagement acknowledging the difficulties and challenges with having BPD, while helping the client to change. In fact, within her work on DBT, Linehan (1993) states that clinicians following a DBT philosophy must assume that people living with BPD are doing the best they can and live lives filled with intolerable suffering and anguish, but they also need to do better and improve. These assumptions are dialectical in nature; they contradict, but are both equally true. Some might not see this as holistic, categorizing the entire group of people with BPD as suffering but also not doing enough to change this suffering, which could indeed be seen as stereotyping. However, considering the criteria of BPD include suicidality, poor sense of self, and unstable mood (APA, 2000), there is suffering in living with BPD, just as there is suffering with chronic physical disease. Given the alternative to spending more effort in changing maladaptive coping mechanisms is to continue in misery, it appears clients with BPD need to work at moving beyond the suffering.

Behavioural strategies are used extensively within DBT. The positive reinforcing techniques of validating, listening to experiences, and being present align with Bergum and Dossetor's framework and theme of relational engagement. However, the idea of withholding and using therapist withdrawal to decrease a person's self-harming behaviour does not fit within Bergum and Dossetor's ethical philosophy as they refer to "not listening to each other" as being an area of potential abuse (2005, p. 104). Using therapist withdrawal is the opposite of relational engagement. If the health care provider is using the relationship to motivate or deter patients from action, is it truly ethical relationship engagement? Or is the DBT approach simply defining what we already do? Is it possible that health care providers (and indeed human beings in general) unconsciously reinforce approved actions with positive gestures, facial expressions, and language and punish unwanted actions by disapproving looks, terse tone, and less time spent with those challenging patients through the normal course of practice? If this is the case, then perhaps DBT is simply formalizing human reaction and using it to promote coping behaviour by people with BPD.

Furthermore, the use of chain analysis in DBT is used "as a punisher for engaging in target behaviors [such as self-harm]" (Lynch et al., 2006, p.469). Though Bergum and Dossetor do not refer to punishment within their book, the use of punishment certainly does not fit with a relational ethic or in fact, a professional health care provider ethic. Behavioural strategies in general, are simply about changing tangible, visible actions, and do not delve into rationales or emotions. If simply looking at observable behaviour, relational ethics does not apply. However, this behavioural technique is used in conjunction with the cognitive strategies and with a dialectical stance, so should not be viewed as simple

behaviour modification. Still the use of withdrawal and possible punishment cannot be reconciled with a relational ethical stance.

Finally, cognitive restructuring techniques are used extensively within DBT to teach people with BPD more functional actions and ways of living (Brown, 2006). These techniques, as mentioned earlier, include encouraging clients to act in an opposite way to their feeling, or to consider rationally whether a particular thought pattern is based on reality or based on an emotional reaction. These techniques require the health care provider be present and aware of what is happening for the person, but relational engagement is not necessary for this particular strategy to work. In fact, asking someone to behave opposite to how they feel may be invalidating. Yet, within DBT treatment therapists ask their clients to act the opposite of their feelings. However, as with all DBT strategies, cognitive restructuring is conducted with ongoing validation and support of the care provider. Within DBT, the validation and acceptance strategies are used to counteract the distress and discomfort that can occur for people with BPD with using change strategies (Lynch et al., 2006).

Implications for Mental Health Practice

DBT strategies are used within mental health settings to treat people who live with BPD. The use of validation strategies and focus on individualized care for people who live with BPD is congruent with ethical relational practice and those working with this group would benefit from using these strategies in practice. However, when using DBT care must be taken by health care providers to ensure the strategies are used ethically. If not, recognizing the dialectical nature of the treatment with the delicate balance of pushing for change while validating the difficult lived experience of the client, the clinician could easily stray too far into the behavioural component of DBT. This can lead to mechanistic, unethical, and punishing behavioural approaches. DBT consultation teams assist clinicians' reflection and examination of actions and reactions to facilitate a therapeutic approach. These consultation teams could be helpful regardless of the therapy or practice area. Having a formalized process where a group of peers supports and challenges practice could help health care providers develop ethical practice in a variety of settings, whether in mental health or other areas of health care.

Conclusion

Given the rates of BPD in the population, those working in healthcare will most certainly encounter people with this diagnosis. People who live with BPD deserve effective, ethical care for their disorder and those who work with this population need to consider how to best treat this challenging group.

DBT is recognized as an effective treatment for the self-harm and suicidality associated with BPD (Swift, 2009). The therapy sees people holistically, promotes therapist reflection and accountability, and is based upon engagement and validation of the person in treatment. However, it also leverages the relationship between health care provider and client to promote change and uses aversive measures to deter self-harming behaviours. The treatment certainly focusses on relational engagement, but viewing it through Bergum and Dossetor's relational framework, there are ethical questions remaining. These questions include therapist techniques of withdrawal and using aversive measures with clients. These particular DBT strategies would benefit from further ethical exploration and analysis.

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