4-7-2021

Borderline Personality Disorder: Interventions for Adolescents and Caregivers

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BORDERLINE PERSONALITY DISORDER: INTERVENTIONS FOR ADOLESCENTS AND CAREGIVERS

AN EVIDENCE-BASED PRACTICE GUIDE FOR SOCIAL WORK PRACTITIONERS

WRITTEN BY

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4.7.21

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SOCIAL WORK

Introduction

Borderline personality disorder (BPD) encompasses a wide range of symptoms characterized by emotional dysregulation, including challenging interpersonal relationships, impulsivity, disturbances in cognition and identity, and is often accompanied by intentional self-injury and suicidal behaviors. Those living with BPD often struggle to develop and maintain healthy and appropriate relationships with their parents and loved ones. They exhibit behaviors such as intense and frequent mood swings, unstable or undefined sense of self, feelings of emptiness, impulsive and risky behavior, self-harm, and volatile interpersonal relationships (Courtney-Seidler et. al., 2013). In this guide, emphasis is placed on three aspects of intervention: (1) clinical interventions for adolescents who meet the criteria for BPD; (2) interventions clinicians can teach to parents/caretakers so they can better work with their child's diagnosis; and (3) due to the negative impact this can have on adolescents, clinical interventions for parents/caregivers diagnosed with or exhibiting common symptoms of BPD is also provided. Though "BPD is still considered a controversial diagnostic category for youth under the age of 18" (Miller et al., 2008), as many as 3% of teens living in the community meet the criteria for BPD (Bernstein et al., 1993). Zanarini et al. (2020) found three significant risk factors that may contribute to adolescents developing BPD.

The first is the severity of childhood neglect, specifically emotional neglect (though if present, physical and sexual abuse can also play a role). Second, heightened response to stressful or seemingly stressful situations can be a significant risk factor which may exhibit as severe mood states such inappropriate anger/rage and perpetual feelings of emptiness and depression (Zanarini et al., 2020). Third, adolescents that meet the diagnostic criteria for BPD tend to have lower childhood performance, struggle with academic expectations, athletic success, and making and maintaining prosocial friendships (Zanarini et al., 2020).

Introduction Continued

In terms of diagnosing BPD in adolescents, a study by Courtney-Seidler et. al. (2013) discusses the interview-based, diagnostic instrument, Childhood Interview for BPD (CI-BPD). CI-BPD is a semi structured interview that helps identify what symptoms are or are not present in the child being assessed. Early identification and intervention with at-risk youth is imperative in order to mitigate maladaptive patterns before unhealthy, habitual behaviors emerge (Courtney-Seidler et. al., 2013). Early intervention should be stressed and noted by clinicians who suspect a young person, as young as 12, may have a budding BPD. The hope is to interrupt behavior patterns before the emergence of a full-blown disorder.

The complexities of this diagnosis in adolescence warrants attention from clinicians in regard to aiding parents of children with BPD. Responding to youth in crisis, parents often struggle to develop and maintain a healthy, appropriate relationship with their child. Parents and caregivers often do not understand their child's behavior, reporting feeling burdened, helpless, and experiencing significant grief (Jørgensen, 2020). As clinicians working with caregivers of struggling adolescents, it is the helping professional's responsibility to widen their perspectives to include the family system and environment. In this way, a more holistic approach to care can potentially increase protective factors for the youth receiving treatment.

In addition, a brief section and accompanying intervention in this guide will include several studies that have examined parental behaviors and mental health issues as contributing factors to a child developing BPD and/or other challenging issues.

> Adolescents of parents with a diagnosis of BPD have also been found to be at risk of emotional, behavioral, psychosocial and somatic problems .... It was most concerning that 26% of children of mothers with BPD reported past suicidal ideation and/or plans, compared to less than 9% in comparison groups (Bartsch et. al., 2015, p. 114).

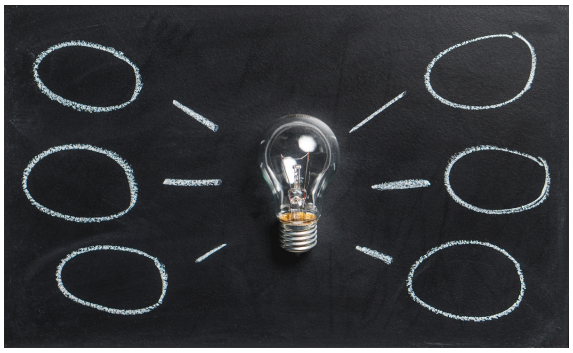
This is one of the primary reasons an introduction of interventions for parents diagnosed with BPD is also included. BPD is a challenging diagnosis in both adolescents and adults, often requiring therapeutic support throughout the teenager's life and into adulthood. Due to the persistent nature and complexities of borderline personality disorder, the use of evidence-based practices (EBP) is essential to provide the best possible and most effective care to the client.

The content in this guide is for mental health professionals, clinicians, and social workers engaging with adolescents and parents of adolescents diagnosed with BPD. Though the focus is adolescents ages 11-17, specifically addressing the parent/child dynamic, suggestions for working with children who have caregivers diagnosed with BPD is also provided.

Recommendation 1

MENTALIZATION-BASED THERAPY

Helping adolescents understand and interpret their emotions, beliefs, intentions and desires.



Freenstra (2017) and other researchers report there is a dearth of evidence-based treatments for adolescents with borderline personality disorder. Mentalization-based treatment (MBT) is one of the very few evidence-based psychotherapeutic approaches recommended for BPD. "The concept 'Mmentalization '" is defined as a developmentally acquired capacity to understand and interpret one's own and others' behavior as an expression of mental states such as feelings, thoughts, fantasies, beliefs, and desires" (Beck et. al. 2020, p. 595). With its roots in attachment theory and contemporary neuroscience, MBT is designed to help the client with interpersonal interactions in their day to day (Feenstra, et. al. 2017). In other words, MBT helps clients understand emotions, beliefs, intentions and desires. When in a state of high arousal/stress, mentalization often goes offline, compromising the client's ability to recognize the situation for what it is, and to respond appropriately and proportionately to the actual or perceived distress. This intervention is designed to help the client stabilize, or ideally, to increase their capacity for empathy (Choi-kain, Unruh, 2016).

Choi-kain and Unruh (2016) define the concept of prementalization (or the typical thought processes and outcomes of various states of arousal frequently associated with BPD) in conjunction with how therapists often fall prey to unhelpful responses. Table 1 located in the Appendix and reproduced from the work of Choi-kain and Unruh (2016), provides categorical descriptions of inappropriate states of mentalization.

It also includes examples of what active BPD states may look like, symptomatic/behavioral indicators, and clinician reactions that may actually enable a client to continue with unhelpful responses.

Ideally, when implementing MBT interventions, if extremes arise (poor mentalization), the therapist offers a divergent path of thought to follow. "The patient is invited to incorporate the missing vantage point into a more balanced perspective, which allows assessment of the patient's ability to broaden overly rigid, reactive, unrealistic, or emotionally vacant perspectives" (Choi-kain, Unruh, 2016, para. 13). The therapist is ever monitoring the client's emotional state, aiming to elicit enough arousal that different perspectives can be explored, but not too much arousal that mentalization collapses. If the therapist is too probing, too sympathetic, and pushes self-reflection, the client can be inadvertently escalated, triggering insecure or disorganized attachment processes (Choi-kain, Unruh, 2016). MBT's goal is to help clients understand more readily their own mental state underlying their actions and the mental state of others through the process of mentalization. By learning these skills in a safe environment that does not trigger maladaptive reactions, the client may increase their capacity to recognize their own internal landscape, as well as that of others, thus producing more positive interpersonal interactions.

Recommendation 2

DIALECTICAL-BASED THERAPY

Developing adaptive behaviors through a dialectical framework.

Dialectical Behavior Therapy (DBT) is perhaps the most widely accepted, and most often utilized intervention for persons diagnosed with BPD. A branch of cognitive behavior therapy, DBT was developed by Dr. Marsha Linehan in the late 1980s, and was originally created for chronically suicidal adults often diagnosed with BPD. Fidelity to DBT principles require extensive training, time, and ongoing supervision. However, a number of studies have shown a significant drop in parasuicidal behaviors in both adult and adolescent clients undergoing DBT interventions (Hjalmarsson et. al. 2008, MacPherseon et. al, 2013).

> DBT incorporates aspects of behavioral science, dialectical philosophy, and Zen practice. Through a balance of change and acceptance techniques within a dialectical framework, DBT aims to extinguish maladaptive behaviors and shape and reinforce adaptive behaviors within a validating environment, with the goal of helping clients build a life worth living (MacPherson et. al., 2013, para. 3).

One treatment element of DBT consists of four modules: mindfulness; interpersonal effectiveness; distress tolerance; and emotional regulation (Grohol, 2016). Typically, DBT is offered in concurrent weekly individual and group therapy sessions. Within the framework of DBT, participating in mindfulness is non-judgmental observation and describing of what one notices, i.e., thoughts and emotions.

The interpersonal effectiveness module focuses on how the client can ask for what they need, assertively saying no while learning to cope with inevitable conflict in appropriate ways. This goes hand in hand with distress tolerance. Distress tolerance is the ability to accept oneself and the current situation non-judgmentally. This means the client can accept reality as it is, while also knowing they do not have to approve of their situation or circumstances (Grohol, 2016). This, along with emotional regulation are important, multifaceted skills to practice with adolescents. A few emotional regulation skills are identifying and labeling emotions, identifying obstacles that inhibit changing emotional states, acting in the opposite way one is impulsively inclined to act, and increasing events that are positive (Grohol, 2016). Due to the complexities and importance of adherence to DBT protocol, this section of the guide can only introduce a few basic elements, advocating for it as an effective evidence-based practice. Clinicians should seek certified training opportunities in order to implement DBT in its most empirically studied form.

Recommendation 3

COMMUNICATION STRATEGIES FOR CAREGIVERS

How to effectively address behavioral concerns.

Caregiver support and family treatment is an especially important aspect of treating adolescents with BPD since they often live at home as dependents. According to Jørgensen et. al. (2020) there is limited research regarding the burden experienced by caregivers and parents, but their study indicates a relationship between the severity of adolescent BPD and caregiver burden. One of the reasons BPD can strain interpersonal relationships, especially between parent/child, is because those living with BPD often feel invalidated by those closest to them. In turn, parents may misunderstand their child as being manipulative, uncaring, and lacking in empathy for others (Fleisher, 2017). The resulting behaviors induced by chronic burden can exacerbate maladaptive behaviors from the adolescent, creating a collusion cycle between caregiver and child. Adolescents with BPD are associated with hypersensitivity to parental criticism, perceived or actual. Whalen et. al. (2015) conducted one of the first studies examining this phenomenon.

> Specifically, [they found] adolescents with BPD symptoms may perceive their caregivers as more critical (even if their caregivers do not actually exhibit high levels of criticism) — a perception that may negatively influence their interactions with and behaviors toward these caregivers. As such, perceptions of caregiver criticism (regardless of caregiver's actual attitudes or behavior) may, over time, exacerbate relationship difficulties and maintain symptoms of BPD (para. 13).

This study exemplifies the importance of working with family members to assess how they are expressing emotions, how those expressed emotions may be perceived by the child, and implement alternative strategies of communication that can be received more positively by the adolescent. The balance clinicians are faced with is assessing if caregivers are actually invalidating (emotionally/physically neglectful, overly critical, punitive, mirror their child's maladaptive behaviors), or if it is how the child is perceiving their interactions with the caregiver. The latter is often negative, with the adolescent describing the parent/child relationship as full of conflict, uncaring, invalidating, unpredictable, over-involved, and/or indifferent (Stepp et. al., 2014).

If the BPD symptoms exhibited by adolescents are consistently met with warm, nurturing parenting, the symptoms may abate or remain at their current levels rather than increasing. In contrast, if parents react to the presentation of symptoms with increasingly negative or decreasingly positive parenting practices, disorder may be unavoidable (Stepp et. al., 2014, p. 374).

This is why teaching skills that help parents validate their child may be a beneficial, psychoeducational, intervention. Parents must build awareness around the language and tone they use, understanding what constitutes criticism regarding what their child is or is not doing to their satisfaction.

Recommendation 4

APPROPRIATE CAREGIVER RESPONSES

Parenting strategies for emotionally dysregulated adolescents.

As a continuation of Recommendation 3, unhelpful responses from caregivers can include either dismissing or punishing a child based on their expressed emotions, and parental reactions such as rejection, can lead the adolescent to feel invalidated (Bennet et. al., 2019). An invalidating environment is characterized more broadly by Cheavens et. al., (2005) noting "pervasive criticizing, minimizing, trivializing, punishing, erratically reinforcing communication of internal experiences (e.g., thoughts and emotions), and over-simplifying the ease of problem-solving" (p. 258). Teaching parents how to respond appropriately to negative or strong emotions characteristic of BPD, is the second intervention to help adolescents with emotional regulation.

An important component of emotion socialization is the caregiver's response to children's affective expression. Invalidating responses such as criticism convey the notion that emotions are "intolerable, unacceptable or overwhelming. Consequently, emotional arousal is likely to be amplified" and the adolescent's ability to use positive coping skills to regulate their emotions will be hindered (Bennett et. al., 2019, p. 210). So, what then, are the alternatives? Hammond (2018) has fifteen suggestions for parenting a child diagnosed with or showing signs and symptoms of BPD. A summary of suggested parenting tips are as follows:

1. Focusing on logic is not always helpful. Instead, focus on the emotion and convey an understanding of the child's emotional need. Adolescents with BPD are not necessarily trying to control a situation when they throw tantrums, rather they are desperate for another person to feel as deeply as they do about a problem.
2. Self-harming behaviors and suicidal ideation should be taken seriously and treated by a professional. Logically explaining why these behaviors are not good is irrelevant. Instead try to understand what emotional trauma is contributing to these behaviors. Similar action should be taken with addictive behaviors such as drugs, alcohol, sex and sexting, food, etc.
3. Parents should do their best to ensure their affect matches their emotional claims. Adolescents with BPD are sensitive to the emotions of others, often absorbing and displaying the emotion to a greater degree when the parent is, for example, frustrated, but denying how they feel.
4. Remember BPD is associated with intense fear of abandonment; physical and emotional. This means not ignoring the child, trying to spend one-on-one time with them, and always displaying empathy. Part of this is showing unconditional love to help the child feel supported and securely attached. Hammond (2018) recommends asking the adolescent if they feel supported and loved, rather than only asking the parents if they feel they are doing this. Remember the perspective of the child with budding BPD is what matters most.

Shifting parenting styles to a more loving, warm approach will not mean the behaviors and symptoms of BPD will automatically go away. However, by creating a safer environment, the behaviors resulting from the adolescents' reactions may lessen in severity.

Recommendation 5

FAMILY-BASED INTERVENTIONS FOR PARENTS DIAGNOSED WITH BPD

How caregivers with BPD impact their children and loved ones.

At times, our primary client may be an adolescent with BPD. At other times we are addressing the emotional and mental health concerns of a child with a parent who has either been diagnosed or is displaying characteristics of BPD. In either case, a holistic approach to improving family dynamics should be considered. Children who have a parent with BPD are at risk for more adverse childhood experiences, such as disruptive and unstable households, parental drug or alcohol abuse, parental suicide or suicide attempts, and are also more likely to experience excessive worry, anxiety and fear of uncertainty, and fear of abandonment (Bartsch et. al., 2015). One approach is to help parents with their own "behavior awareness, improving attachment behaviors and emotional regulation strategies, [as these] may be important intervention targets" (Eyden et. al., 2018, p. 85). Fossati and Somma (2018) have compiled a helpful list of family interventions based on EBP to assist not only the parent with BPD, but also the family members living with and being cared for by said parent. The authors have grouped the interventions into four major headings:

(a) family empowerment in the context of an evidence-based treatment of the BPD person; (b) psychoeducation interventions for family members of BPD persons; (c) multicomponent family interventions based on skills training as add-on components of the BPD person's treatment or standalone interventions; (d) mentalization-based multicomponent interventions as add-on components of the BPD person's treatment or stand-alone interventions (p. 4).

BPD parents who display a pattern of under- andover involvement in their child's care may lack the tools for effective parenting. They may benefit from "parent skills training and mentalization-based treatment [which] could help prevent the intergenerational transmission of insecure attachment patterns and self-regulation problems" (Eyden et. al., 2018, p. 103). Because family systems play a significant role in maintaining or moderating the severity of symptoms, providing both the BPD parent and family members with information about the disorder, along with psychoeducation is important. Family-based interventions include offering support group opportunities, DBT-Family Skills Training (DBT-FST), and MBT family interventions, which may be helpful for reducing the strain of challenging relationships, as well as disrupting and lessening family crises (Fossati & Somma, 2018). Family-based interventions impact not only the person with BPD, but also loved ones that are impacted by this diagnosis. Many questions remain regarding family-based interventions such as length and frequency of treatment, determining which intervention works best for unique family situations, and considering multiple variables such as severity of symptoms and life phase of the person with BPD (Fossati & Somma, 2018). However, these are also encouraging questions that both indicate and promote the need for further research.

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APPENDIX

TABLE 1. **Clues for detecting prementalization states**

Description	Example	Relevant features of BPD	Clinician reactions
Psychic equivalence			
Concrete, rigid thought processes paired with unrealistic certainty, making person's position impenetrable to new information and immovable despite inaccuracy *Internal imagination of what happens is equivalent to perception of external reality, without doubt or sense there may be other views or possibilities*	Patient does not receive a return call from a psychiatrist; believing that the psychiatrist is angry with her, she shows up at her next appointment and angrily states, "I know you hate me," leaving the psychiatrist completely perplexed *Action (not returning call) is equated with mental state (anger) and worry about psychiatrist's anger is equated with reality, which prompts angry confrontation with absolute certainty of interpretation of events*	Paranoia, black and white thinking, frantic efforts to avoid abandonment/ rejection sensitivity, grandiosity, idealization and devaluation	Confusion, frustration, lack of curiosity paired with defensive increase in therapist's sense of certainty and authority
Pretend mode			
Disconnected, complex, and pseudo-psychological thought processes that have no basis in actual experience or external reality *In contrast to psychic equivalence, there is a complete decoupling of internal and external realities, of what is thought and felt and what is conveyed; referred to as pseudomentalization*	Patient attends treatment dutifully and can talk the talk, appearing to be a "good patient" in sessions, but engages in a secret double life of self-destructiveness and increasing dysfunction *Patient's reality of psychic and behavior dysfunction is walled off and disconnected from what he says to the therapist and does in treatment; this can result in years of intensive, seemingly meaningful therapy without change*	Dissociation, self-harm and suicidality, splitting, secretive or "dishonest" behavior, emptiness, identity diffusion	Boredom; feelings of disconnection or exclusion; feelings of being on autopilot; tendency to try harder or do more work making sense of confused, disconnected material patient brings to session
Teleological mode			
Belief that mental states are only real if they are expressed in actions that are contingent with patient's needs and wishes; different from but overlapping with psychic equivalence in the sense that actions are equated with mental states that match the patient's wishes, giving him or her a sense of being in control of the actions of others	Patient demands proof that a therapist is dedicated by requesting special treatment, such as double sessions and rides home; when therapist refuses, patient self-harms to communicate distress and elicit rescuing by the therapist *Boundary crossings become an index of caring and self-harm an index of pain, which function to control or provoke predictable responses in therapist*	Self-harm, suicidality, "manipulative" behavior, promiscuity, frantic efforts to avoid abandonment	Feeling compelled to act or respond to patient in behavioral ways (boundary crossings, hospitalization and medication when in crisis) to make patient feel cared for or important; frustration; futility in ability to satisfy patient

BPD, borderline personality disorder.

Clues for detecting prementalization states (Choi-kain and Unruh, 2016).