

Single Session Treatment of a Borderline Personality Disorder

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Introduction

Much has been written about brief or short-term therapy from a variety of theoretical perspectives (Basch, 1992; Bloom, 1992; Budman & Gurman, 1988; Cade & O'Hanlon, 1993; Crits-Cristoph & Barber, 1991; Fisch, Weakland, & Segal, 1982; Garfield, 1989; Gustafson, 1986; Langley, 1994; Lankton & Erickson, 1994; O'Hanlon & Davis, 1989; Preston, Varzos, & Liebert, 1995; Sifneos, 1987, 1992; Walter & Peller, 1992; Wells & Gianneti, 1990). Does it work? Does it work better than long-term therapy? Is it the best alternative? Or, is it only a manifestation of the zeitgeist of contemporary times and the managed care treatment model?

These discussions are generally not dispassionate interchanges, but are usually emotionally loaded by the philosophical, financial, theoretical, or conceptual rationale for the short-term therapy. If one does brief or short-term therapy out of a conviction that it is an important option in developing adequate treatment plans, there is less heat. If, however, the therapy is foreshortened because it is forced by the "evil empire" of the managed care companies, there is often great anger.

The short-term debate is exacerbated when the treatment conceptualization includes a diagnosis of personality disorder. Among the diagnostic grouping within the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*; American

Psychiatric Association, 1994), no diagnosis seems to raise the therapist's emotions as much as that of the borderline personality disorder. For many, the term "borderline" has become an accusation and epithet. It evokes images of non-compliance, unbridled anger, a stormy therapeutic alliance, self-injurious behavior, and dichotomous thinking and actions (Beck, Freeman, & Associates, 1990; Layden, Newman, Freeman, & Morse, 1993; Linehan, 1994). All of the upset, however, fails to note that, as with any diagnosis, the patient can have a mild, moderate, or severe form of that disorder. The mild form of the borderline disorder may be more amenable to treatment than the severe forms of Axis I disorders. The combination of short term therapy and borderline personality disorder is a volatile mix.

The issue, we believe, is not how many sessions a therapist has to work with a patient, but rather, what one does with the sessions. From our perspective, short-term therapy must be easily available and accessible, structured for the patient, active, directive, cooperative, problem-focused, solution-oriented, and psychoeducational. It is not an issue of time spent, but the goals of the therapy, and the strategies or goals and the consequent interventions used to meet those goals. The mild and moderate forms of a disorder would be treated differently than the more severe manifestation of that disorder. Given a choice, therapy would best be dictated by the needs of the patient, not of the therapist or the payment system. This is not always the case.

The following session attempted to demonstrate what could be done in the shortest possible therapy, a single session with a borderline personality disordered patient.

The context for this session was a workshop led by the first author (AF) on the cognitive behavioral treatment of personality disorders. The workshop organizer invited a patient in his practice to be interviewed as part of that workshop. The patient agreed and was interviewed for 45 minutes in front of a group of practicing therapists. Prior to the interview, the workshop leader met with the patient. Subsequent to the interview, a brief time was used when both the workshop leader and the patient responded to questions from the group. After that, the patient was debriefed by her therapist to assure that there were no problems or issues stemming from the session.

The annotations to the session (interspersed throughout the transcript in italic typeface) will highlight the workshop leader/therapist's development of hypotheses and the treatment conceptualization, as well as the strategies that led to the implementation of that conceptual model through the use of specific therapeutic techniques.

Patient Data

The patient's name, the name of her therapist, and other identifying data have been changed to maintain privacy and confidentiality. While there is a

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