# Recovering: A Process of Empowerment

Persons with borderline personality disorder constitute a vulnerable population not only because of the natural history of the disorder, but also because they are frequently stigmatized by persons entrusted with altering the course of the disorder. In this article, the predominant forms of treatment that have been available to persons with borderline personality disorder are reviewed, and it is concluded that they are, albeit unintentionally, oppressive. It is demonstrated how a critical examination of the concept of recovery opens the possibility for delivering care in a fundamentally different way. Grounded in the underlying assumptions of recovery and interpretive phenomenological research, a proposal that moves beyond recovery toward developing and disseminating a practical theory of recovering is presented. Key words: *borderline personality disorder, empowerment, recovery*

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THERE MAY BE no psychiatric diagnosis laden with more stereotypes and stigma than borderline personality disorder. People who live this label—the majority being female—live with not only chronic and life-threatening psychological distress but also prejudice. Collectively, and as individuals, persons with borderline personality disorder are referred to as not sick, manipulative, and noncompliant. In practice settings, persons with this label may find care difficult to obtain or intentionally limited. Consequently, women with borderline personality disorder constitute a vulnerable population not only because of the natural history of the disorder, but also because they are marginalized by persons entrusted with altering the course of the disorder.

There have been various treatment approaches developed to help persons with borderline personality disorder. In general, the outcomes of treatment have been moderate. The rate of suicide, premature termination from treatment, and ongoing dependence on the mental health care system are alarmingly high for persons with borderline

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personality disorder. The guarded prognosis for persons with borderline personality disorder has been attributed to the complicated nature of the disorder rather than the problematic assumptions underlying available treatment approaches.

In this article, the major forms of treatment for borderline personality disorder are reviewed, and it is concluded that they are, albeit unintentionally, oppressive. A critical examination of the concept of recovery reveals how care could be delivered in a fundamentally different way. Grounded in the underlying assumptions of recovery and interpretive phenomenological research, a discussion that moves beyond recovery and toward developing and disseminating a practical theory of recovering is presented.

## REVIEW OF TREATMENT FOR PERSONS WITH BORDERLINE PERSONALITY DISORDER

### Individual psychotherapy

Historically, one of two treatment options was offered to persons with borderline personality disorder: psychodynamically oriented psychotherapy and supportive psychotherapy. The former was assumed to be the treatment of choice.

Based on psychoanalytic principles, theorists such as Kernberg,[1] Masterson,[2] and Adler[3] developed approaches to reveal patients' intrapsychic conflicts with the goal of resolving them through insight. Kernberg and Masterson conceptualized borderline pathology as an intrapsychic conflict; Adler emphasized intrapsychic deficits. When applied to psychotherapy, the conflict model focuses on interpretation of independence–dependence conflicts; the deficit model emphasizes supportive responses to developmental delays. In either case, reliance on the theory of separation–individuation presupposes that therapists know what is wrong with persons who have borderline personality disorder. Success for the client is dependent on coming to understand oneself as having deficits because of maternal failures.

The other school of psychotherapy argues that persons with borderline personality disorder need support prior to and concurrent with intensive psychotherapy.[4–6] Therapists working in this tradition focus on the here and now with the goal of helping clients develop or use existing coping mechanisms. In supportive psychotherapy, exploration of early childhood experiences occurs only in the context of the impact on current events. Supportive psychotherapy is based on the assumption that persons with borderline personality cannot establish the transference necessary for psychodynamic psychotherapy and, thus, must be helped to manage their deficits.

### Group psychotherapy or counseling

Early reports of group therapy reflect the psychodynamic influence of the time. Grobman, for example, extracted findings from 4 years of group therapy with "a typical female patient diagnosed as having a borderline personality organization."[7(p300)] He concluded that although individual treatment was ineffective, group therapy helped the client remain in treatment, develop a therapeutic alliance, and work through primitive anxieties. Using social learning theory, Goodpastor et al[8] have suggested that active, directive techniques such as behavioral prescription, relaxation techniques, and cognitive self-control are particularly useful in helping group members manage aggression and enhance interpersonal skills

regulation. An evaluation of a problem-focused group for community mental health center clients[9] indicated that members identified and reached self-defined goals, reported decreased hostility and depression, and consistently perceived Yalom's curative factors of universality and existential factors to be helpful components of group therapy. In a follow-up study,[10] coding of eight videotaped sessions revealed that the most frequently used interventions—providing and seeking information—were indicative of a moderate to high degree of structure on the part of the group facilitators.

### Combined individual and group therapy

A recent treatment option available to persons with borderline personality disorder is dialectical behavior therapy (DBT).[11] In contrast to previous treatment approaches, DBT begins to clearly articulate the strengths and potential for growth of women diagnosed with borderline personality disorder.

Based on a biosocial theory of the disorder, Linehan's approach[11] focused on the dialectics of the illness, namely emotional vulnerability versus invalidation, active passivity versus apparently competent person, and unremitting crises versus inhibited grief. Individual therapy proceeds through the stages of skill enhancement, reality tolerance training, and generalization/integration. Additional group sessions are held weekly to teach coping skills. Linehan and colleagues have conducted an array of outcome studies[12–14] demonstrating that DBT is successful in reducing inpatient hospitalization, parasuicidal episodes, attrition, anger, and interpersonal dysfunction. The data, however, have not revealed significant improvement in reports of depression, hopelessness, suicidal ideation, and general satisfaction.

### Hospital treatment

Two predominant approaches to hospitalization that have mirrored individual psychotherapy are long-term psychoanalytic and short-term supportive. Studies of long-term hospitalization have demonstrated improvement for some individuals.[15–18] Across studies, however, the findings consistently reveal that premorbid functioning and the amount of aftercare have a greater effect on outcome than does the length of hospitalization. In general, the practice of shorter hospital stays has become more common. Nehls[19] describes an innovative program for persons with borderline personality disorder in which predetermined, brief admissions to the hospital were to be initiated by the client. Clients valued the program for saving their lives and helping them break a cycle of addiction to the hospital. Despite the program's philosophy of client empowerment, the descriptions of how brief hospital treatment plans were implemented reveal the usual power differential between providers and consumers of care. When compared to the authoritarianism and dependency of the traditional approach to hospitalization, clinicians view the program as empowering. However, they note the illogical nature of empowering clients to make decisions about a treatment option that they believe to be harmful and the adversarial interactions about relinquishing power over hospital admissions.[20]

### Case management

In the past decade, case management services have expanded to include persons with

the diagnosis of borderline personality disorder. Nehls and Diamond have described case management as a necessary component of a systems approach to care for persons with severe borderline personality disorder.[21] Other authors[22,23] have suggested that persons with borderline personality disorder, in contrast to persons with schizophrenia, need clear limits about the nature of the case manager–client relationship.

To date, there is only one article[24] that documents from the perspective of persons with borderline personality disorder the experience of having a case manager. Clients value case managers for providing needed assistance with the mundane activities of daily living and for literally saving their lives. From the client's perspective, a partnership with a case manager was developed that yielded a sense of personal satisfaction and, in turn, decreased the client's perceived need for service. From the client's perspective, case management may have the potential to decrease—not increase—power struggles over service utilization. A study of case managers, however, has revealed that case managers monitor themselves in terms of expressing concern and setting boundaries.[25] By monitoring themselves, case managers seek to create distance rather than connections with clients. This practice, as noted by case managers themselves, impedes the case manager and consumer from working together toward the process of change.

## A NEW VISION OF CARING FOR PEOPLE WITH BORDERLINE PERSONALITY DISORDER

Clearly, there have been advances in mental health care for persons with borderline personality disorder. The range of treatment options has expanded, and the focus of care has shifted from residential treatment to community-based settings. Despite changes in form and setting, the assumptions from which treatment approaches emanate have remained relatively constant. The predominant view of people with borderline personality disorder is that they are immature victims in need of nurturance or are manipulative attention-seekers in need of limits. With few exceptions, treatment options are developed and provided by nonclients in an attempt to address these foibles.

A vision constructed by the consumer, of building a meaningful life while decreasing dependence on traditional mental health services, has yet to be embraced. This vision of mental health care is consistent with the concept of recovery. William Anthony has been instrumental in developing and operationalizing the concept of recovery for persons with serious mental illness.[26] He asserts that knowledge gained from models of psychiatric rehabilitation and community support systems provide the groundwork for a new vision for mental health systems—a vision based on the concept of recovery. Adopting a vision of recovery shifts the control embedded in caring practices to the person who is recovering. Recovery is viewed

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as a highly idiosyncratic process aimed at creating meaning.

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.[26(p15)]

Recovery may best be viewed as a way of relating to other human beings. It is not a new technology to be delivered by providers, but rather a re-establishment of the essence of helping relationships. Deegan[27] writes:

> The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings. . . . Those of us who have been diagnosed are not subjects to be acted upon. . . . We can become experts in our own journey of recovery.[(p92)]

In the field of mental health, recovery is becoming an increasingly popular term. Discussion of how to implement recovery-oriented mental health practice and policy is becoming commonplace. There is concern, however, that the underlying assumptions of recovery may be lost or diluted if recovery services are simply "tacked on" to what is currently offered or if what exists is simply renamed recovery. Curtis[28] cogently argues that to make a meaningful change in service delivery requires fundamentally doing differently that which is done every day. This charge—to deliver care in a fundamentally different way—challenges providers to examine assumptions about recovery[26,29] and their relevance to persons with borderline personality disorder.

**Assumption: recovery is possible**

Care for persons with borderline personality disorder is not currently grounded in the most basic and necessary assumption of recovery, that is, that recovery is possible. For persons with borderline personality disorder, the lack of hope is ever present. In a study[30] of what it is like to be someone who lives with the diagnosis of borderline personality disorder, a women conveys her experiences with mental health providers.

> People who study pathology tend to, you know, like, judge people by their limitations and not their possibilities. By diagnosing you as borderline they're telling you you are hopeless. We have nothing; we have very few medications, and there's really not much psychoanalysis. No, they don't offer alternatives. They just kind of like diagnose you and [say] now get lost. And one doctor might even say, "Well, there's a good chance you will take your life—there's nothing I can do about it; nobody can stop you. I hope you don't. Good luck." You know. And, um get lost.

Revealed in this quotation is a perception that persons with borderline personality disorder are untreatable and undeserving of care. A practice of not providing care stands in contrast to the care measures of health care workers who continue to maintain a presence with patients regardless of their prognosis or personal characteristics.

To implement a vision of recovery, an assumption that women with borderline personality disorder can be helped to build meaningful lives must be embraced. To demonstrate to clients that recovery is possible, clinicians must maintain a hopeful presence in clients' lives. Hope can be communicated through language and by continually offering choices and options.

### Assumption: recovery is a nonlinear process

Historically, providers have assumed that clients will progress in a gradual and sequential fashion. To facilitate recovering, it must be understood that establishing a hierarchy of treatment goals can be counterproductive. In the words of Crowley, recovering practices should employ a "just start anywhere" approach.[29(p15)] For persons with borderline personality disorder, a condition of treatment may dictate that self-destructive behavior cease. This rigid guideline fails to acknowledge that recovery is a self-defined process that cannot be facilitated by defining successes or failures in absolute and prespecified terms. In contrast, there must be flexible entry into and out of programs.

### Assumption: recovery is self-defined

Recovery must be understood as a personal experience best defined by the individual. Currently, clients rely on mental health professionals in part because clients have not been encouraged to view themselves as capable. In a study of case management services,[24] a woman with borderline personality disorder describes the paternalistic view of "therapists":

> No one asks me what I want. I don't have a voice. They tell me you can't use the hospital, you have to do this, you can't do that. No one asks me for my opinion. I might as well not be there because they think they have all the answers.

Professionals must come to understand that "disabled persons are not passive recipients of rehabilitation services. Rather, they experience themselves as 'recovering' a new sense of self and of purpose within and beyond the limits of the disability."[31(p11)] Providers must become accustomed to the fact that a consumer's formula for recovery is likely to be as varied as that chosen by a community member who does not have a serious and persistent mental illness. Consequently, the use of traditional mental health services may or may not be included in recovering plans. A consumer recently commented that recovery meant seeing herself like everyone else, that is, someone who had the ability to purchase an item that was new—not from Goodwill; someone who "didn't have to live with everyone else's bad taste." This example highlights how often clients receive services that are reimbursable but are not necessarily what is needed for building a meaningful life.

### Assumption: recovery requires a partnership

Recovery-oriented care assumes that clients and providers will work together toward client-defined goals. Despite ongoing rhetoric about patient-centered or consumer-oriented care, decisions about what and how services are delivered continue to be controlled by providers and administrators. Partnerships cannot be attained by simply inviting consumers to the table and presenting them with treatment plans. This is not recovery-oriented care.

To begin the practice of forming partnerships, there must be a radical change in the balance of power and control. For example, recovery partners or teams could be formed. A team could be composed of the consumer as the recovery manager and others

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as consulting members. Team members chosen by the client, with assistance if necessary, may include but would not be limited to housing specialists, job coaches, psychiatrists, counselors, family, significant others, clergy, and recovering consumers. A consulting member of the recovery team could be available to serve as the assistant manager to the client. Initially this may be a provider of care; however, over time the choice of an assistant manager could rest with the consumer, as could the option of changing the membership of the recovery team. The redirection of power clarifies the basis of the recovery plan—it is the consumer who directs the process and outcome of recovery.

## IMPLEMENTING THE VISION: DEVELOPING A PRACTICAL THEORY OF RECOVERING

The concept of recovery is not new to the helping professions. In the fields of physical disabilities and substance abuse, it has been part of providers' day-to-day language and practice for some time. For mental health providers, recovery as a philosophy and practice of care is in its infancy. Some regions in the United States, including California, Maine, Massachusetts, Nebraska, New Hampshire, New York, Ohio, Oregon, Rhode Island, South Carolina, Vermont, Washington, and Wisconsin, have attempted to integrate or adopt recovery as a guiding vision of mental care. On the one hand, the movement to implement recovery-oriented care is to be encouraged. On the other hand, implementation of a vision of recovery grounded in the assumptions of hope, respect, and partnerships requires further reflection, research, and education.

Perhaps the first step required to successfully advance an agenda for recovery is to reflect on the fact that, in the United States, recovery is not the philosophy on which mental health care is based. The assumptions of recovery advanced by previous authors have not been translated into day-to-day practices. To continue to profess that recovery-oriented care already exists impedes its development and widespread dissemination. An alternative and needed position is to reflect on the inconsistencies between what is professed and what is experienced and practiced.

Assuming that the concept of recovery does become the foundation of current and future mental health care, one must ask how will recovery or, more aptly, recovering be measured? Recovering does not fit neatly into a traditional science paradigm; it is both elusive and fundamental. Nonetheless, traditional and alternative approaches to understanding recovering should be pursued.

In the state of Wisconsin, a Blue Ribbon Commission has argued that the foundation of a successful mental health system is its ability to help persons with mental disorders realize outcomes that matter to them. The Commission, of which 20% are family or consumer representatives, coined the term "energizing outcomes" to refer to gains that demonstrate the development of new meaning and purpose in one's life. Specifically, the categories of outcomes are consumer satisfaction, empowerment and self-esteem, access to care, personal safety, awareness, and equal opportunity.[29] Focusing on these variables does shift the focus of outcome research from symptom relief and service utilization to the day-to-day meaning of living with severe mental illness. However, the categories or variables of interest continue to be defined by someone other than the person who is recovering.

If recovering is to be understood as consumer-based, then an alternative to positivist

and postpositivist approaches is needed. Interpretive phenomenological research approaches, unlike traditional scientific methods, decenter the researcher by studying phenomena from the perspective of those who live it. The goal of interpretive phenomenology is to interpret the meaning of everyday experience within a particular culture. In this approach to knowledge generation, the unit of analysis becomes how modalities are delivered, not the modalities themselves. In other words, the goal is to identify common meanings of recovering from the perspective of clients, providers, and family members, among others. This approach allows for the development of a practical theory of recovering, one that is grounded in the lived experience of participants. Because practical knowledge emphasizes knowing how, rather than knowing that, it can be used to fundamentally change how current and future care is delivered.

In addition to reflection and research, educational reform is needed to advance a recovery-oriented mental health care system. For example, absent from current conversations about people with borderline personality disorder is language that addresses strengths, possibilities, and choices. Attempts to develop programs based on new language (eg, client empowerment) have failed to be experienced by clients or providers as empowering.[19,20] Thus, we must widely train clinical service providers, administrators, policy makers, and mental health consumers in a new language of mental health care.

From a hermeneutic viewpoint, humans are understood as living in the world through language. Changes or shifts in language can change how humans think and dwell in the world. A shift toward recovery-oriented care may need to begin with frank discussions of power and control. When empowerment, for example, is viewed as a redistribution of unequal amounts of power, the world of consumers and providers remains separate. An alternate view of empowerment and recovery is to accept that all people engage in processes of recovery. In other words:

> Too often staff attitudes reflect the implicit supposition that there is the "world of the abnormal" and the "world of the normal." The task facing the staff is to somehow get the people in the "abnormal world" to fit into the "normal world." . . . Such an attitude places staff in a very safe position in which they can maintain the illusion that they are not disabled. . . . Such an environment is oppressive to those disabled persons who are struggling with their own recovery.[31(p18)]

To fundamentally change providers' views of persons with mental illness seems extremely difficult. Stigma toward persons with borderline personality disorder, for example, has been widespread, and patriarchal practices are apparent. By refocusing our attention toward what it means to be human, providers and receivers of care may begin to see their similarities. By attending to the interpretation of narratives in both practice[32] and education,[33] new modalities may not emerge, but new ways of being with one another will become evident.

The concept of recovery could prove to be an antidote for the pessimistic and paternalistic stance toward persons with borderline personality disorder. In order for this hope to become a reality, assumptions underlying recovery must be carefully examined as they reveal themselves in practice, education, and research. Moreover, as we enter the new millennium, it is timely for nurse researchers, clinicians, and teachers to move beyond embracing a vision of recovery toward identifying the practices of recovering as lived.

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