

A Four-Stage Model for Management of Borderline Personality Disorder in People With Mental Retardation

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Successful treatment of borderline personality disorder (BPD) among individuals with mental retardation (MR) in residential settings is complicated by the feelings of helplessness, confusion, and hostility often generated among direct support staff responsible for treatment. Effective staff training and presentation of the treatment plan in a simple, proactive format increases staff understanding and competence and thus enhances successful treatment. In this paper, a four-stage format for behavioral and psychiatric intervention in people with BPD and MR in residential settings is presented. A case study illustrating the effective implementation of the model in a 48-year-old woman with MR and BPD, living in a community group home, is also presented.

Keywords: borderline personality disorder, developmental, intellectual disability, mental retardation, psychopathology

Borderline personality disorder (BPD) is characterized by the presence of a pattern of unstable interpersonal relationships, disturbances of self-image and affect, and marked impulsivity. BPD is often comorbid with mood disorders, substance related disorders, eating disorders, posttraumatic stress disorder, attention deficit-hyperactivity disorder, and other personality disorders. Estimated prevalence in the general population is 2%. Diagnosis of BPD is made in early adulthood and is more likely to occur in women than men.¹ Linehan⁵ suggests that the etiology of BPD represents a dysregulation of the neurological emotional regulating system, which results from an interaction between biological vulnerability of the developing individual and certain types of "invalidating environments" characterized by early pervasive trauma and abuse.

The functioning of the individual with BPD is characterized by displays of hostility, emotional dysfunction, mood lability, and aggression. Nugent⁸ suggests that BPD occurs in people with mental retardation (MR), at rates, perhaps, well above those in the general population. Reiss⁹ notes, that despite the fact that the consequences of personality disorders puts people with BPD at high risk for restrictive treatment and placement, there has been very little research on the presentation or prevalence of BPD in people with MR. Even single case reports are very rare. Moses⁷ also points to a dearth of research and case

reports but notes, anecdotally, that case reports but notes, anecdotally, that discussions with professional caretakers of people with MR about the behavioral characteristics of BPD often elicit descriptions of individuals that match the criteria. Some of the characteristics which are reported by staff and may be associated with BPD in people with MR include: excessive reaction to typical requests, verbal aggression that is personally disturbing to the victim, over attachment to some staff and devaluation of others, extreme changes of mood in disproportionate response to environmental events, verbal aggression that leads to physical aggression, and an apparent inability to see connections between behavior and consequences. Moses⁷ goes on to suggest that, despite the frequent existence of such characteristics, BPD goes largely unrecognized and untreated in people with MR. Mavromatis,⁶ in fact, suggests that BPD is among the most difficult diagnoses to make among people with MR. She points out that the major features of BPD, including self-injurious behavior, impulsivity, aggression, and affective lability commonly occur among individuals with MR and may mimic symptoms of BPD. Thus, it is essential to look for additional features of BPD including patterns of idealization and devaluation, splitting, manipulatives, subjective perceptions of victimization, chronic feelings of emptiness, stress related paranoia, and impulsive patterns of self destructive behavior other than self-mutilation.

Hurley and Sovner⁴ note that individuals with MR display a characteristic pattern of BPD symptoms which includes slightly atypical and sometimes idiosyncratic presentations of classic BPD patterns including: unstable and potentially volatile interpersonal relationships which are often characterized by overreaction toward and verbal abuse of caretakers, impulsivity as marked by global efforts at environmental disruption rather than the goal directed patterns seen in the non-disabled population, labile affect characterized by sudden shifts in feeling and expression of feeling, difficulties in controlling anger along with overblown reactions to stimuli, self-injurious behavior which is probably geared to gain attention rather than to commit suicide, identity disturbances which may present as confusion over sexual identity, anhedonia, as evidenced by chronic lack of enjoyment, and fear of abandonment as characterized by expression of unreasonable demands and excessive needs for attention from caretakers. Hurley and Sovner⁴ note that many of these symptoms are often mistaken, among people with MR, as signs of cognitive deficit, emotional immaturity, and neurodysregulation rather than as indications of a personality disorder.

Gabriel³ points out that individuals with MR and BPD are volatile and difficult to support. They tend to test program structure and search for "loop-holes." They create environmental turmoil and chaos in order to fill their own inner "vacuums of loneliness." (p. 208) In residential settings, in fact, the occurrence of BPD is often best validated by noting the countertransference reactions of the caretaking staff. Caretakers are likely to express extreme frustration, confusion, and anger. People with BPD including those with MR, are "splitters" - they tend to engage in manipulative patterns of idealization and rejection, which cause disharmony and confusion among entire staffs. As a result of this splitting, it is common to note, as a characteristic of the disorder itself, that in any given group of staff, some members will vehemently dislike and others will passionately defend the affected individual.⁴

Among people with BPD and MR, the most effective treatments focus on psychopharmacological intervention, psychotherapy, and behavior management. Mavromatis⁶ notes that pharmacological intervention must be tailored to the individual and directed at target symptoms of mood lability, depression, and psychosis. She adds that

pharmacological intervention alone is rarely effective and must be combined with psychotherapeutic and behavioral strategies. The most successful psychotherapy with BPD patients focuses on limit setting, structure, consistency, and careful long-term structure of a healthy therapeutic relationship.^{4,6}

Linehan⁵ has developed a system of Dialectical Behavioral Therapy (DBT) that addresses the cognitive and behavioral aspects of BPD. This system focuses on cognitive behavioral training and restructuring to promote emotional and behavioral regulation. While geared toward individuals with intact cognitive capacities, many aspects of the DBT treatment program, particularly the strategies for coping, distracting and soothing, are adaptable for use with people with MR.

Behavior management further requires use of a structured behavior program that eliminates opportunities for destructive behaviors, and provides support along with enforcement of strict limits.⁴ Dana² has referred to such an approach as a plan for "errorless learning." Nugent⁸ lists some specific guidelines for behavioral support of the individual with BPD and MR, which includes maximizing consistency and structure, appropriate social interactions, supporting the individual to trust others, providing opportunities for closely supervised choices, teaching acceptable ways to communicate emotions, and making sure that staff addresses the splitting and manipulation by maintaining communication with each other.

Hurley and Sovner⁴ emphasize that staff cohesiveness is an essential aspect of treatment. In the residential setting, primary therapy is conducted by the care staff, who are generally nonprofessional direct caretakers. Uneducated and uncommitted support staff are vulnerable to intense and often disabling emotional reactions which, at best, leave them unequipped to provide the neutral consistency and commitment necessary to support effective treatment, and, at worst, cause them to become detrimental to achievement of therapeutic and programmatic goals.

In our experience, the primary focus of treatment of the person with BPD and MR is on development of staff resources to ensure the consistent and effective occurrence of practices most likely to enhance positive therapeutic outcome. A Four-Stage Model of crisis development has proven to be an extremely

effective tool for training in the use of therapeutic approaches and will be described, first in general, and then in the context of a case study. The programmatic approach and the inclusion of some simple principles drawn from DBT will also be outlined within the context of that model.

THE FOUR-STAGE FORMAT

In the model, behavioral fluctuations are conceptualized as occurring in four predictable stages. Each stage incorporates a set of behavioral manifestations of affective states along with goals for that stage and guidelines for interventions to achieve those goals. A general outline of the stages is presented in Table 1.

The model is envisioned and presented as a step-wise flow chart. It should be noted that this linear organization serves an important purpose in terms of training staff to understand the behavioral manifestations of BPD and to implement appropriate therapeutic procedures at appropriate times. However, it must also be understood that this organization is not meant to imply that BPD is anything less than a dynamic disorder, the phases of which cannot necessarily be discretely categorized into neat, step-wise packages. Individuals with BPD may, indeed, function primarily in one stage or may rapidly fluctuate between stages. Thus, the flow chart model should be recognized not as an attempt to categorize the affected individual so much as a means for outlining a parsimonious and effective treatment plan. The stages of the model are discussed in more depth below.

STAGE 1: OPTIMAL FUNCTION

During "Optimal Function," the individual is engaged in typical activities of daily life. Mood is relatively stable and there is an absence of disruptive or destructive behavior. The individual exhibits interactional behavior that is mostly prosocial and adaptive. The goal at this stage is to help people maintain optimal behavioral functioning and emotional regulation. Intervention in Stage 1 is educative and preventative. A treatment intensive schedule of reinforcement for adaptive behavior is emphasized. During this stage, coping skills that are soothing and distracting are taught and practiced. The individual is also guided to develop structured schedules and daily plans, and to self manage successful navigation of the activities of daily living.

STAGE 2: ANTECEDENTS/PRECURSORS

During Stage 2, characteristic behavior patterns that have been identified as antecedent to more severe forms of acting out begin to emerge. These are often idiosyncratic to the individual, behavioral in nature, and may include changes in mood, affect, facial expression, body language, voice tone, and attitude. During this stage, the individual is cued to initiate previously developed schedules and routines for coping, soothing, and distracting. PRN medications may also be utilized at this stage in conjunction with other coping strategies. The goal of intervention is to return to Stage 1 and avoid movement to Stage 3. Successful return to Stage 1 is reinforced as effective coping.

STAGE 3: CRISIS

In Stage 3, the individual engages in a characteristic pattern of disruptive or destructive behavior. Behavior during this stage may become intense, dramatic, disruptive, and often dangerous. Typical acting out behaviors may include tantrums, aggression, environmental destruction, vocal expressions of rage, and self-mutilation. During this stage, the individual may be unresponsive to directions or guidance and attempts to intervene by any type of reasoning or negotiation may become counterproductive. Previously constructed plans for preservation of physical safety are implemented. The individual is monitored closely but with minimal interaction until signs of resolution (signaling readiness to move to Stage 4) emerge.

STAGE 4: RESOLUTION

The final stage, "Resolution," is likely to gradually precipitate a return to "Optimal Function." During this stage, the individual begins to exhibit signs of calming and may, in fact, appear exhausted from the intense affective and behavioral exertion associated with the episode of dyscontrol. Goals and interventions during this stage focus on continued de-escalation and reinstatement of structure and stability via implementation of the strategies for coping,

TABLE 1. GENERAL OVERVIEW OF THE FOUR-STAGE FORMAT

| STAGE 1 | STAGE 2 | STAGE 3 | STAGE 4 |
|--|--|--|--|
| OPTIMAL FUNCTION | ANTECEDENTS/ PRECURSORS | CRISIS | RESOLUTION |
| Behavior: Individual is engaged in typical daily activities | Behavior: Individual engages in behavior signaling impending instability | Behavior: Individual is acting out | Behavior: Individual is calm / exhausted |
| Goal: Maintain function at this stage | Goal: Return to Stage 1 | Goal: Maintain physical safety of all involved, and move to Stage 4 | Goal: Gradual return to Stage 1 |
| Interventions: Teach and reinforce appropriate behavior Maintain structure Teach and practice skills for coping, soothing, and distracting | Interventions: Initiate procedures for coping, soothing, and distracting Maintain structure | Interventions: Initiate safety procedures Observe for signs of resolution | Interventions: Reinstate structure Validate feelings Initiate procedures for coping, distracting, and soothing |

soothing, and distracting. While signs of Resolution may indicate the beginning of a return to "Optimal Function," it is not at all unusual for individuals to enter the Resolution stage only to re-escalate to Crisis behavior that precipitates a return to Stage 3. In fact, this appears to be a rather common pattern, highlighting the requirement to clearly identify and address the behaviors that do effectively indicate Resolution. Once Resolution is definitively achieved, a brief processing and validation of feelings may be indicated, but should be immediately followed by the creation and implementation of a plan to engage in activities to promote a return to Stage 1. Focus during this stage should remain on the present and the future with a strong emphasis on "moving on."

USING THE MODEL TO DEVELOP TREATMENT PLANS AND TRAIN STAFF

As noted, when developing treatment plans and training staff, the model is envisioned as a flow chart. Each section of the chart represents a stage in the process of the manifestation of the

disorder. Each stage is marked by a characteristic behavioral pattern that is unique to the individual along with goals for increasing effective function during that particular stage. The emphasis of treatment is on providing interventions that enhance the goals of each stage. Goals and interventions are determined with the assumption that certain interventions will be effective only when applied at appropriate stages. The Four-Stage Model, then, prescribes, with some exactitude, when and how staff must intervene to promote optimum treatment throughout the process of the disorder.

At Stage 1, the goal is to provide the individual with conditions that will optimize and enhance maximum adaptive function. It is strongly emphasized that Stage 1 is defined by implementation of systems of positive behavioral support and is where most of the treatment effort is exerted. This often appears counterintuitive to staff who have come to expect to exert the greatest amount of energy on intervention during crisis stages. It is important to dispel this belief during training since failure to provide appropriate

preventative interventions in Stage 1 is likely to lead to escalation through further decompensatory stages.

At Stage 2, the goal becomes to recognize and address antecedents so that Stage 3 behaviors are avoided. Stage 2 is also presented as a time for treatment intensive intervention. It is emphasized that during Stage 2, initial staff reaction might be to avoid addressing the emerging precursors that signal possible onset of crisis behavior. Again, staff are taught that this response is detrimental to treatment goals and that recognition of antecedents and precursors must be addressed with appropriate, preplanned interventions. In both Stages 1 and 2, coping, soothing, and distracting strategies are emphasized along with limit setting and environmental structure.

In Stage 3, the individual is experiencing severe emotional and behavioral dyscontrol and may be functionally unable to comply with requests or respond to interventions. The goal is to maintain maximum physical safety of all involved while observing closely for signs of resolution. It is actually during this stage that staff are trained to discontinue attempts at active intervention except for those which promote physical safety (i.e., removing other individuals from the area, placing mats on the floor, observing from a safe distance, etc.).

Finally, as the individual begins to calm down in Stage 4, he or she is closely monitored and supported with strategies for promoting de-escalation and a gradual return to Stage 2.

If PRN medications have been prescribed to address severe agitation, they are best administered during Stage 2. Medication may also be an effective intervention as signs of Stage 4-Resolution begin to emerge. Once Stage 3 is initiated, however, it may be unsafe to interact with the individual to administer oral medication. In keeping with the representation of this stage as the period of least interaction and intervention from staff, we do not attempt to administer medication during Stage 3.

This model serves a number of important purposes. It categorizes and demystifies the fluctuations of mood and behavior associated with BPD, enabling staff to predict changes and plan and implement appropriate interventions at appropriate times. The overall treatment plan is summarized and conceptualized in a simple, action-oriented format. The structure necessary to achieve effective treatment of BPD is enhanced by the use of the model and potential for staff

consistency is optimized. The model also supports a proactive approach to behavior management based on identification and prevention of stimuli antecedent to more severe acting out behaviors. In support of the presentation of this model as a proactive approach, it should also be noted that all interventions and contingencies (including any use of PRN medication), all prescribed strategies for soothing and de-escalation, and all provisions for environmental safety during the crisis stage must be well developed and learned by all treatment providers in advance. It is further noted that early intensive staff training, clinical and administrative support, and continuous review and adjustment of program contingencies are understood as the most essential factors for successful treatment outcome.

Treatment planning and staff training using the model has proven to be a vital component in improvement of behavioral and affective function in a number of individuals with BPD and MR. Training focuses on five major components:

- An overview of the general etiology and clinical characteristics of BPD.
- A presentation of the etiological factors and clinical manifestations particular to the individual being addressed.
- A presentation of the treatment plan as outlined in the Four-Stage Model.
- An explicit commitment from management and staff to ensure available resources and support treatment goals.
- Provision of ongoing training, support, and review of progress toward treatment goals throughout the duration of the treatment plan.

CASE REPORT

Ms. Q was a 48-year-old woman with cerebral palsy and mild MR who was admitted to a community group home run by a private, non-profit agency following discharge from a psychiatric hospital. At the time of discharge from the hospital, Ms. Q met eight of the nine diagnostic criteria for BPD. Ms. Q also exhibited symptoms of major depressive disorder.

Ms. Q had been admitted to the hospital five times in the previous ten years for depression and self-destructive behaviors. History included a childhood marked by familial dysfunction, severe abuse, and loss. During adulthood, she had a history of institutionalization, instability, episodes of depression, alcohol abuse, hallucinations,

suicidal ideation, disturbances of sleep and appetite, and anhedonia. Throughout her adult life, Ms. Q had been at a series of hospitals and psychiatric institutions. Prior to her latest hospitalization, Ms. Q had lived in a staffed apartment. This placement was lost following a period of escalating oppositional behavior including severe temper outbursts, aggression to others, and severe self-injurious behavior.

Ms. Q made a good initial adjustment to her placement at the home. Within two months, Ms. Q began to exhibit increasing agitation and behavioral outbursts, which appeared very similar to those described throughout her history. These escalated in intensity and frequency and were marked by severe self-injurious biting of arms and hands, screaming, crying, throwing self from wheelchair to floor, aggression to others (hitting and biting), and demands to be medicated, restrained, and hospitalized. These episodes were very intense and lasted from one to four hours. Episodes were often triggered by an unmet demand, particularly for coffee, medication, or to be hospitalized. Coffee appeared to be an important symbol that had historically been a trigger for manipulation and outbursts. There was a very strong attention-seeking element and these episodes appeared largely volitional at the antecedent stage, with progressive loss of control as the episode escalated in intensity and severity. It was noted that Ms. Q was able to regain and maintain control of herself when appropriately motivated to do so. It was also noted that Ms. Q appeared to avoid resolution of the episodes by re-escalating as a solution to the initial problem was approached.

At the time of initial evaluation, Ms. Q was treated with the following pharmacotherapy: Effexor, Risperdal, Tegretol, and trazodone. There were also PRN's for trazodone as well as for Ativan to address severe agitation. At initiation of treatment, PRN medications were generally used as an intervention of last resort. Ms. Q frequently engaged in severe tantrums triggered by unmet demands for these medications. A pattern developed whereby such tantrums were finally resolved, hours later, when Ms. Q finally received the medication.

Based on Ms. Q's expressed and observed need for external structure, a behavior program was developed which included a self-monitoring checklist system for completing daily activities and following rules (i.e., no hurting self or others, no screaming, no throwing self to floor). This

program included opportunities to earn bonus privileges for completing responsibilities, following rules, and demonstrating appropriate coping skills. Coffee intake was restricted to three cups of half caffeine per day, although extra cups could be "earned" by maintaining adaptive behavior. It should be noted that prior attempts to allow increased coffee intake were followed by severe behavioral decompensation.

A number of cognitive-behavioral interventions based on Linehan's⁵ DBT were also incorporated in Ms. Q's behavioral treatment plan. Ms. Q was taught to plan a series of coping strategies based on personal interests. These included counting, meditating, napping, praying, watching uplifting movies, telephoning individuals for support, and engaging in other types of soothing and distracting activities. With staff cueing, Ms. Q was taught to initiate these strategies when antecedents to acting out behaviors occurred. These strategies were learned and practiced during times of high adaptive function/low stress and implemented during periods of affective and behavioral distress. Ms. Q was also instructed to create a daily plan of activities that kept her busy and distracted from negative rumination throughout the day (particularly during periods of time identified as "high risk" times). When Ms. Q expressed or exhibited antecedents, she received close guidance to verbally rehearse and then initiate completion of the steps in this plan. The plan was designed to occupy Ms. Q for one to two hours at a time. A sample plan included steps such as:

1. I am going to have a snack I enjoy,
2. then I am going to work in the garden for 20 minutes,
3. then I am going to take a nap, and
4. when I get up from my nap, I will set the table for dinner.

Movement back to Stage 1 following successful completion of the plan was reinforced as "effective coping."

TABLE 2. FOUR-STAGE FORMAT INDIVIDUALIZED FOR MS. Q

| STAGE 1 | STAGE 2 | STAGE 3 | STAGE 4 |
|---|---|---|--|
| OPTIMAL FUNCTION | ANTECEDENTS/PRECURSORS | CRISIS | RESOLUTION |
| Behavior: <ul style="list-style-type: none"> • Happy • Engaged in activities • Good sense of humor | Behavior <ul style="list-style-type: none"> • Loss of humor • Poor eye contact • Drooping head • Withdrawal • Statements such as: <i>I need meds.</i> <i>I want to go to the hospital.</i> <i>I feel messed up.</i> | Behavior: <ul style="list-style-type: none"> • Screaming • Self abuse • On floor • Aggression • Severe dyscontrol | Behavior: <ul style="list-style-type: none"> • A few moments of quiet • Appears calm/tired |
| Goal: <ul style="list-style-type: none"> • Stay at Stage 1 | Goal: <ul style="list-style-type: none"> • Move back to Stage 1/ avoid Stage 3 | Goal: <ul style="list-style-type: none"> • Move to Stage 4 | Goal: <ul style="list-style-type: none"> • Gradual return to Stage 1 |
| Interventions: <ul style="list-style-type: none"> • Practice coping skills • Practice relaxation • Focus on here and now • Future orientation • Assist to use journal to record feelings • Use empathetic listening to validate feelings • Keep busy • Be productive • Talk • Laugh • Have fun • Make the plan • Avoid <i>splitting</i> | Interventions: <ul style="list-style-type: none"> • Start coping strategies • Give medication if appropriate • Make calls for support (RN, management, psychologist, etc.) • Move to safe area (bedroom) • Make the plan • Bonus check if no move to Stage 3 | Interventions: <ul style="list-style-type: none"> • Back off • Stay out of space • Monitor from a short distance • Keep safe with minimal interacting • Stay casual • Stay busy with other people • Do not try to reason or engage in conversation • Call for support • Watch for signs of resolution | Interventions: <ul style="list-style-type: none"> • Engage in conversation • Validate feelings/ concerns • Give simple directives (i.e., Please sit up) • If screaming or aggression starts: Back to STAGE 3 interventions • If cooperative: <i>Start coping strategies</i> <i>Give medication</i> <i>Make the plan</i> <i>Resume behavior program (checklist)</i> |

The treatment plan was formatted in the Four-Stage Model and specific behavioral states, goals, and interventions were described. All staff were asked to learn the stages and refer to the model throughout all daily activities. (see Table 2) In addition to the milieu behavioral therapy, Ms. Q also engaged in weekly individual psychotherapy sessions during which the elements of the behavior management strategy were reinforced by the therapist. Individual psychotherapy, however, was discontinued when it was identified as a predictable setting event for tantrums.

Minor modifications were made to the medication schedule. The dosage of Tegretol was increased slightly in response to minimally therapeutic blood levels. The dosage of Effexor was also adjusted to address continuing symptoms of depression. Most importantly, Ms. Q was informed that when she felt the need for a PRN medication, she would be guided to engage in two of her coping strategies (usually counting or praying - both calming activities to Ms. Q). Then, if she still wanted the medication, it would be received. The rationale for this change was to encourage Ms. Q

TABLE 3. MEAN FREQUENCY/DAY OF EPISODES AT BASELINE AND AT POST TREATMENT INTERVALS OF ONE, TWO, SIX, AND TEN MONTHS

| | BASELINE (3 MONTHS PRIOR TO TREATMENT) | ONE MONTH FOLLOWING TREATMENT | TWO MONTHS FOLLOWING TREATMENT | SIX MONTHS FOLLOWING TREATMENT | TEN MONTHS FOLLOWING TREATMENT |
|-----------------------|---|--|---|---|---|
| All Episodes | 0.34/day | 0.39/day | 0.45/day | 0.23/day | 0.13/day |
| Major Episodes | 0.19/day | 0.10/day | 0.06/day | 0.10/day | 0.03/day |
| Minor Episodes | 0.15/day | 0.29/day | 0.39/day | 0.13/day | 0.10/day |

to regulate her emotional and behavioral well being without resorting to manipulative and self-destructive tantrums.

Staff training incorporated an overview of the etiological and clinical characteristics of BPD and presentation of the treatment plan in the four-stage format. The challenge of the treatment plan was explicitly emphasized and staff was asked to commit themselves to consistent implementation of the plan for a period of at least six months. The management team also met with the direct support staff and committed themselves to providing the resources necessary to enhance optimal treatment outcome.

Treatment outcome was assessed by measuring the number of acting out episodes before and after the staff education and the introduction of the four-stage treatment plan. Acting out episodes were defined as "major" (marked by tantrums including throwing self to floor and self-injurious behavior--lasting one hour or more) or "minor" (marked by mildly disruptive behavior such as crying or screaming with a regain of control in less than an hour). The baseline period represents a period of three months prior to initiation of the Four-Stage Format. Mean frequency of episodes per day is presented for the baseline period, and for each of months One, Two, Six, and Ten following initiation of treatment. Results are reported in Table 3.

Dramatic and relatively rapid improvement in behavioral function was noted following the initiation of the treatment plan and the Four-Stage Model. Overall, the number of episodes remained relatively stable for the first two months

following initiation of the treatment plan. However, the continuous divergence between frequency of major and minor episodes suggested that Ms. Q was effectively regulating behavioral and emotional control at the Antecedent stage and avoiding escalation to the Crisis stage. By the end of the third month of treatment, both major and minor episodes were markedly decreased. It should also be noted that use of PRN medication did not increase despite liberalization of the criteria for administration but, rather decreased in frequency of administration as behavior and mood improved.

Although Ms. Q continues to report a chronic, low-level depression and related difficulties, she is currently experiencing an improved quality of life. She is making friends and increasing her schedule of vocational and recreational activities. Ms. Q has also begun to develop an expanded future orientation. She is more willing to focus on "the moment" and to make plans for the future rather than engage in rumination about her unhappy past experiences. Ms. Q has begun to demonstrate some simple signs of empathy and an increasing ability to pull herself back to adaptive functioning, with minimal staff intervention, when she begins to experience some of the antecedents which previously tended to set the stage for larger scale acting out.

The essential programmatic issues in Ms. Q's treatment have been:

1. Explicit education of staff and management on the nature of BPD.
2. Publicly stated commitment by staff and management to program consistency.

3. Development of a structured self-management program with clear but simple goals and expectations for the affected individual.
4. Incorporation of the DBT principles and practices to teach skills for coping, distracting, and soothing.
5. Presentation of the treatment program in the Four-Stage Model.
6. Collaborative work with treating psychiatrist regarding hospitalization and pharmacotherapy.

CONCLUSION

BPD is an intensely difficult disorder to treat. Staff in residential programs are often particularly frustrated and challenged by the hostile, angry, and destructive behavior exhibited by the affected individual. Individuals with BPD are not likely to improve unless staff confusion is lessened and commitment and consistency enhanced. The Four-Stage Model of behavior management for people with MR and BPD provides a simple vehicle for educating staff, identifying goals, and prescribing interventions with a focus on development of proactive, action oriented procedures to promote self-regulation and behavioral improvement in individuals with MR and BPD.

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