BORDERLINE PERSONALITY DISORDER

DSM-IV

301.83 Borderline personality disorder

"Borderline" has been used to identify clients who seem to fall on the border between the standard categories of neuroses or psychoses. The term has been refined to indicate a client with a pervasive pattern of instability of interpersonal relationships, self-image, affect, and control over impulses beginning in early adulthood, and includes such factors as feelings of abandonment, impulsivity, reactivity of mood, chronic feelings of emptiness, and problems with anger.

ETIOLOGICAL THEORIES

Psychodynamics

Unconscious processes that are believed to shape personality are set in motion by drives or instincts that are then influenced by conflicts among them as well as instinctual wishes and demands of reality. Defensive maneuvers are unconsciously developed to protect against anxiety arising from this conflict. This personality is seen as a painstaking but poorly constructed defense.

It is also seen as resulting from a fixation of libido at stages of psychosexual development associated with certain body parts. Although it is difficult to agree on how personality is formed, severe personality disorders are believed to begin early in childhood and milder forms are thought to be influenced by factors during later development.

Biological

Personality is believed to have a hereditary basis known as "temperament" and biological dispositions that affect mood and level of activity (e.g., cranky, placid, self-contained, outgoing, impulsive, cautious). There is little agreement about how this affects the development of personality disorders.

Family Dynamics

The child's social environment, particularly that within the family, is assumed to be the main force that shapes personality. The theory of object relations provides a basis for personality development and an explanation of the dynamics that manifest the borderline characteristics. The individual with borderline personality may be fixed in the rapprochement phase of development (18–25 months of age). In this phase, the child is experiencing increasing autonomy, while still requiring "emotional refueling" from the mothering figure. Because the mother feels threatened by the child's efforts at independence, she strives to keep the child dependent. Nurturing and emotional support become bargaining tools. They are withheld when the child exhibits independent behaviors and are used as rewards for clinging, dependent behaviors. This engenders a deep fear of abandonment in the child that persists into adulthood as the child continues to view objects (people) as parts—either good or bad. This is called "splitting," which is the primary dynamic of borderline personality.

Current studies suggest that borderline personality disorders are strongly associated with a history of physical or sexual abuse by family members, and incest may be a major reason for the disproportionate ratio (2:1) of female clients.

CLIENT ASSESSMENT DATA BASE

Ego Integrity

Markedly disturbed/distorted sense of self
Experiences ambivalence toward being independent; does not like to be alone (frantic attempts to avoid real or imagined abandonment)
Reports feelings of emptiness and boredom; depression, sadness
May conform to current companions, sharing beliefs and values based on imitation

Food/Fluid

Binge eating may be reported (impulsivity)

Neurosensory

Mental Status:
Behavior: May be erratic, impulsive, intense, clinging; may indulge in unpredictable/impulsive behaviors (e.g., irresponsible spending, reckless driving, gambling, substance abuse)
Mood: Marked reactivity of mood (e.g., intense episodes of anxiety, irritability, dysphoria)
Emotions: Intense emotions with rapid, unpredictable, strong mood swings; quick to anger (may be intense, inappropriate), lacks ability to control; may exhibit hostile attitude
Affect: May appear genuine but not necessarily be appropriate to the situation
Thought Processes: Displays overall poor reality base with difficulty making decisions; engages in concrete "all-or-nothing"/black-or-white thinking; lacks insight and does not learn from past experience; unable to form long-term goals or values
Magical thinking, difficulty in identifying the self; severely impaired self-concept
Lying and fabrication habitual, almost delusional
Self-centered, often to the point of narcissism, inordinantly hypersensitive, and inflexible; relationships may be transient, shallow, and/or demanding, with little flexibility and unstable interpersonal behavior; may use and exploit others; lacks empathy for others
Major defense mechanism used is projection (seeing in others those attitudes one fails to see in self)
May border on neuroses and psychoses, exhibiting transient psychotic symptoms when experiencing extreme stress; transient episodes of paranoid ideation or severe dissociative symptoms
May be associated with other personality disorders that have histrionic, narcissistic, schizotypal, or antisocial features

Safety

May reveal evidence of self-mutilative acts, usually nonlethal actions (e.g., cutting, burning)
History of recurrent suicidal behavior, gestures, threats

Sexuality

May present a profound disturbance in gender identity
Sexual promiscuity
Possible history of incest/sexual abuse

Social Interactions

Significant impairment in social, marital, and occupational functioning
Interpersonal relationships unstable and intense, alternating between extremes of overidealization and devaluation
Frequently attempts to provoke guilt in others, making endless demands
History of recurrent physical fights

Teaching/Learning

More prevalent in females
Substance abuse (especially alcohol) may be reported
Higher incidence found in families with history of both chronic schizophrenia and major affective disorders

DIAGNOSTIC STUDIES

P-300: A change in brain electrical activity that occurs in most people about 300 milliseconds after they perceive a tone, light, or other signal indicating that they have to perform a task; may be abnormal, smaller than average, and slightly delayed.
CSF5-HIAA (5-hydroxyindoleacetic acid): Decreased in some clients.
Prolacting Response: Diminished response to serotonin-releaser fenfuramine.
Drug Screen: Identifies substance use.

NURSING PRIORITIES

1. Limit aggressive behavior; promote socially acceptable responses.
2. Encourage assertive behaviors to attain sense of control.
3. Assist client to learn healthy ways of controlling anxiety/developing positive self-concept.
4. Promote development of effective coping skills.
5. Help client learn alternate, constructive methods of interacting with others.

DISCHARGE GOALS

1. Impulsive behavior(s) recognized and controlled.
2. Establishes goals and asserts control over own life.
3. Problem-solving techniques used constructively to resolve conflicts.
4. Interacts with others in socially appropriate manner.
5. Client/family involved in behavioral therapy/support programs.
6. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS	VIOLENCE, risk for, directed at self or others/SELF-MUTILATION, risk for
Risk Factors May Include:	Use of projection as a major defense mechanism
	Pervasive problem with negative transference
	Feelings of guilt/need to “punish” self, distorted sense of self
	Inability to cope with increased psychological/physiological tension in a healthy manner
[Possible Indicators:]	Vulnerable self-esteem
	Easily agitated, angry when frustrated (may become assaultive)
	Provocative behavior: argumentative, dissatisfied, overreactive, hypersensitive; use of unprovoked anger, hostility toward others
	Choice of maladjusted ways of getting needs met (e.g., splitting, projection, provocation, depression)
	Self-mutilative acts; substance abuse
Desired Outcomes/Evaluation Criteria—	Verbalize understanding of why behavior occurs.

Client Will:	Recognize precipitating factors. Demonstrate self-control, using appropriate, assertive coping skills. Clarify feelings of negative transference and eliminate the use of projection.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Establish therapeutic nurse/client relationship. Maintain a firm, consistent approach.	Building rapport and trust is imperative, although difficult, for this client.
Determine negative transference feelings and clarify the actual source of anger, hostility.	Heightens self-awareness of these feelings to assist with resolution.
Help identify how much anger is "elicited" by significant other(s) and how much results from own unresolved feelings.	Becoming aware of the use of projection helps break this maladjusted pattern. **Note:** Feelings of anger and hostility, not depression, are more often the basis for destructive behaviors/suicidal acts.
Intervene immediately in a nondefensive manner when acting-out occurs. Set firm, consistent limits.	Intervention is critical to prevent dangerous situation for client or others. Therapeutic milieu helps client manage self and develop self-control. Environmental safety provides external control until internal control is regained.
Make an agreement or "no harm" contract to discuss angry or hurt feelings when they begin, instead of "internalizing" and displacing anger/hurt onto others and acting on the feelings.	Agreeing not to engage in violent behaviors involving self, others, or property promotes safety and enhances feelings of self-worth by having client assume control of own behavior. Helps client learn to work through feelings as they occur, to prevent intensification and promote resolution.
Encourage client to evaluate situations in which angry feelings develop. Discuss whether the amount of anger is appropriate to the actual event.	Needs to listen to recognize/assess inappropriate, unwarranted anger directed at others.
Explore what client expects from others, and self, in interpersonal relationships.	Helps client learn to define roles and recognize own responsibility in the situation.
Define expectations and rules of the situation clearly, and state what the client can/cannot do.	Structure reduces ambiguity and anxiety, providing sense of security and minimizing escalation of violent behavior.

Determine prior suicidal gestures/attempts. Evaluate seriousness of suicidal expressions/ideation. Use scale of 1–10 and prioritize according to seriousness of threat, availability of means, timing of previous attempts, current age.

It is important to take suicidal threats seriously, listening carefully to underlying messages and providing a safe environment to prevent client from following through on plan, especially when scale is in upper range. **Note:** Risk of suicide completion is highest during first few years after initial presentation, declining as client ages.

Provide close supervision, as indicated.

Allows for early recognition of escalating behavior and timely intervention.

Note substance use/withdrawal. (Refer to Ch. 6, for specific plan of care, as appropriate.)

Substance use, especially alcohol, increases likelihood of suicide 6-fold.

Provide care for client's wounds, if self-mutilation occurs, in a matter-of-fact manner. Do not offer sympathy or provide additional attention.

Additional attention and sympathy can provide positive reinforcement for the maladaptive behavior and may encourage its repetition. A matter-of-fact attitude can convey empathy/concern.

Collaborative

Have client participate in group therapy sessions with feedback given by peers.

Group setting aids in promoting diffusion of anger; provides insight as to how negative, aggressive behaviors affect others, making feedback easier to digest.

Support substance withdrawal. Refer to support group (e.g., Alcohol/Narcotics Anonymous).

Provides assistance to enable client to maintain abstinence.

Administer medication as indicated, e.g., carbamazepine (Tegretol), tranylcypromine (Parnate).

May reduce frequency of impulsive/self-destructive acts while other therapeutic interventions are initiated.

NURSING DIAGNOSIS **ANXIETY [severe to panic]**

May Be Related to:

Unconscious conflicts (experience of extreme stress)

Perceived threat to self-concept; unmet needs

Possibly Evidenced by:

Easy frustration and feelings of hurt

Abuse of alcohol/other drugs

Transient psychotic symptoms (disorganized thinking; misinterpretation of environment, interference with ability to think clearly and logically)

Performing self-mutilating acts

Desired Outcomes/Evaluation Criteria—
Client Will:

Verbalize awareness of feelings of anxiety and healthy ways to deal with them.

Recognize warning signs of increasing anxiety and validate perceptions before drawing conclusions.

Develop and implement effective methods for decreasing anxiety.

Report anxiety reduced to manageable level.

Use resources effectively.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Maintain open communication and provide consistency of care.	Provides for accurate information and reduces anxiety.
Assess escalating anxiety and observe client contact with reality (e.g., presence/development of resultant inability to think clearly).	Underlying feelings of worthlessness, inadequacy, powerlessness can lead to increasing anxiety with psychotic symptoms, delusions/hallucinations, disorganized thinking, confusion, altered communication patterns. (Refer to CP: Delusional Disorder.)
Note rapid changes in behavior (e.g., from cooperative to angry, demanding, argumentative).	Need for immediate gratification can lead to frustration and changes in behavior, which may indicate loss of touch with reality.
Monitor for substance use; note physical symptoms of abuse (e.g., slurred speech, mood swings, dilated/constricted pupils, abnormal vital signs, needle marks).	May cloud symptomatology, potentiate erratic behavior, and interfere with progress, requiring therapeutic intervention.
Provide information in brief, clear, calm manner. happening help client maintain contact with reality.	Specific instructions and expectations about what is
Maintain calm, quiet, nonstimulating environment.	Auditory and visual stimulation may increase labile affect and potential for acting-out.
Correct misinterpretations of environment as expressed by the client.	Confronting misperceptions honestly, with a caring and accepting attitude, provides a therapeutic orientation to reality and preserves client's feelings of dignity and self-worth.
Encourage client to identify events that precipitate stress/anxious feelings (e.g., real or anticipated anxiety about relationships with others).	Helps to establish a cause-effect relationship, enhancing awareness and promoting change.
Explore how client has dealt with these feelings, including times when substances were taken to relive tension, anxiety.	Provides an understanding of the relationship between anxiety and drug use.

Have client keep an “anger journal” describing when anger occurs, how it is handled, and outcome of situation.	When reviewed periodically with primary nurse⁄therapist, therapeutic writing can provide insight into development of feelings, effectiveness of response and create opportunity to develop new coping strategies.
Assist in learning to identify early warning signs that anxiety is escalating and request intervention before it becomes overwhelming.	Promotes development of internal control.
Ask client to describe events⁄feelings preceding cutting or hurting self. Explore ways to relieve anxiety without self-damaging acts. (Refer to ND: Violence, risk for, directed at self or others⁄Self-Mutilation, risk for.)	Provides knowledge for adapting new effective coping skills and breaking the pattern of self-destructive acts.
Identify constructive ways of releasing tension (e.g., jogging, talking with nurse⁄therapist, use of relaxation⁄imagery techniques), involvement in outdoor education programs (e.g., hiking, wall⁄rock climbing, caving).	Client needs to learn constructive methods of coping to replace the maladjusted behaviors that have been used. Note: Exercise does not need to be aerobic or intensive to achieve therapeutic effect.
Discuss fears involving interactions with parents, spouse, children, or significant other(s).	Knowledge of specific fear may provide insight into problem areas.
Encourage client to develop a relationship with more than 1 person.	Helps client to achieve object constancy. (Client may feel abandoned when therapist leaves and have a feeling that the person ceases to exist.)
	Dependency can be avoided, and client can begin to develop independent activities in this atmosphere.

Collaborative

Administer medications as indicated:	
Antipsychotics, e.g., haloperidol (Haldol), thiothixine (Navane), thioridazine (Mellaril);	May help reduce anxiety, hostility, ideas of reference, illusions, increasing receptiveness to other therapeutic approaches.
Antidepressants.	A number of agents have been used with varying success to help alleviate symptoms of severe depression.

NURSING DIAGNOSIS	**SELF ESTEEM, chronic low/PERSONAL IDENTITY disturbance**
May Be Related to:	Lack of positive feedback; unmet dependency needs
	Retarded ego development/fixation at an earlier level of development
Possibly Evidenced by:	Difficulty identifying self or defining self-boundaries; feelings of depersonalization, derealization
	Extreme mood changes; lack of tolerance of rejection or being alone

	Unhappiness with self, striking out at others
	Performance of ritualistic, self-damaging acts, such as "cutting veins and watching the blood flow to cleanse the soul"; belief in need to punish self
Desired Outcomes/Evaluation Criteria—	Verbalize a sense of worthwhileness.
Client Will:	Demonstrate increased self-worth/respect with reduction in frequency of punishing/mutilative behaviors.
	Use "I" self-image to promote good interpersonal relationships.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Encourage client to describe and verbalize feelings about self.	Aids in assessing in which areas negative feelings are most intense.
Provide safe, supportive environment to discuss issues of abuse/incest and ownership of behaviors. (Refer to CP: Problems Related to Abuse or Neglect.)	Studies suggest a high percentage of these clients may be victims of physical/sexual abuse, which is a significant factor in the development of the disorder. Failure to address these issues potentiates continued problems with relationships and self-destructive acts.
Explore client's need to punish self. When did this begin, and what events precipitated these acts?	May help to establish a cause-effect relationship for feelings of low self-esteem.
Discuss what stressors usually bring on anger/depression. Explore ways to deal with feelings before they become overwhelming.	Information can be used to learn and implement effective methods to prevent onset of depression, destructive acts.
Note attitude of superiority, arrogant behaviors, exaggerated sense of self, resentment, and anger.	Indicative of attempt to compensate for feelings of worthlessness, inadequacy, and powerlessness.
Note personality traits such as extreme shyness, chaotic impulsiveness, chronic irascibility, antisocial tendencies, refusal of treatment for substance abuse.	Research suggests these traits are associated with poor outcomes. Recognition of this provides opportunity to deal with these issues, possibly influencing therapeutic efforts in a positive manner to improve individual response.
Encourage client to verbalize feelings of insecurity and need for constant reassurance from others.	Provides insight into sources of insecurities which affect image of self as worthwhile individual.
Discuss feelings of worthlessness and how these feelings relate to need for acceptance by others.	Gives client the message that life cannot be spent trying to meet others' expectations.

Identify situations in which client pushed others away. Help client to look at reality of behavior in context of this situation.	Pattern of relationships has often been one of approach-avoidance conflicts characterized by intense feelings, crises, and stormy episodes. Fearing engulfment, client pushes others away, then, fearing abandonment, tries to draw them back in. Awareness of this pattern of behavior and underlying dynamics provides opportunity for change.
Identify positive, realistic behaviors the client possesses.	Helps client begin to look at possibility of making desired changes to meet needs in a more satisfying way.
Give feedback regarding nonverbal behaviors.	Increases awareness of the possibility of double messages that client may be giving.
Encourage increased sense of responsibility for own behaviors.	Use of projection has enabled client to blame others for own problems/consequences of behavior.
Define sexual identity and what areas create confusion, fears.	Helps client assess possible learning needs or which direction to take in alleviating anxiety.
Assess knowledge of human sexuality and supply needed information.	Provides information appropriate to learning needs.

NURSING DIAGNOSIS	**POWERLESSNESS**
May Be Related to:	Lifestyle of helplessness; need for control (history of abuse/incest as a child)
Possibly Evidenced by:	Becoming enraged and hurt
	Manipulative behavior; self-centered and hypersensitive attitude
	Provoking guilt in others; making endless demands; using and exploiting others
	Ambivalence toward being independent; alternating clinging and distancing behaviors
Desired Outcomes/Evaluation Criteria—Client Will:	Express sense of control over present situation and future outcome.
	Develop a sense of being in charge of own life.
	Interact with others without abusing or violating their rights.
	Make choices related to and be involved in care.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Develop alliance with the client and assist to overcome fear of closeness and intimacy.	This individual is generally frightened by close relationships; an alliance demonstrates that it is possible to trust. **Note:** Evidence indicates incest/physical abuse in childhood are strongly associated with a poor outcome and high rates of suicide/violent crime.
Identify behaviors used to gain control of others (e.g., manipulation, attempts to influence, intimidate).	Increases awareness of modes of interaction that are used to get own way and feel in control of the situation.
Explore areas of life in which client is feeling inadequate or having no control.	Provides insight into feelings that are necessary for learning adaptive behaviors.
Encourage verbalization of how feelings of anger, hurt, and loss of control relate to desire to strike out at others.	Enhances understanding of how the use of projection has become a pervasive pattern.
Confront inconsistencies in statements; discuss what needs these statements serve.	Reinforces that lying and manipulation are maladaptive and lead to feelings of low self-esteem.
Recognize client manipulations and respond differently.	Redirection stops the manipulation, allowing for straight, congruent communication.
Provide opportunities to learn how to get needs met in an acceptable, truthful way.	Promotes inner strength and adaptive functioning.
Ask client to discuss feelings about someone in life who seems self-centered. Compare behaviors.	By comparing behaviors, client may understand how others perceive self-centeredness and the feelings about these behaviors.
Help client learn to listen to others and consider their feelings by putting self in their place.	Promotes feelings of empathy for others.
Encourage client to participate in developing treatment plan.	Aids in promoting a sense of control over life and helps client assume greater responsibility for own life.
Role-play desired behaviors (e.g., appropriate anger, admitting mistakes, shared humor).	Avoiding angry confrontations, maintaining sense of humor help client learn new ways of control.

NURSING DIAGNOSIS	COPING, INDIVIDUAL, ineffective
May Be Related to:	Use of maladjusted defense mechanisms (e.g., projection, denial, externalizing)
	Chronic feelings of emptiness, boredom
	Repetitive use of ineffective coping strategies

Possibly Evidenced by:	Inability to cope, problem-solve, or ask for assistance Not learning from previous experiences Inappropriate use of defense mechanisms (e.g., projection, manipulation) Relief of anxiety through destructive acts (sexual promiscuity, impulsive spending, gambling, substance abuse)
Desired Outcomes/Evaluation Criteria—Client Will:	Identify ineffective coping behaviors and consequences. Verbalize awareness of own coping abilities. Meet psychologic needs as evidenced by appropriate expression of feelings, identification of options, and effective use of resources. Verbalize feelings congruent with behavior.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Ask client to describe present coping patterns and their consequences.	Recognizing which defenses are maladjusted, ineffective, and destructive provides opportunity to effect change.
Have client identify problems and perceptions of their cause.	Exposes problem areas in thinking process and possible cognitive distortions.
Promote development of effective ways to deal with stress, anger, frustration.	Client will need help in learning new behaviors, e.g., appropriate expression of anger, "I-messages."
Develop with client/have client sign a behavioral contract to include minimum standards of acceptable behaviors, management of anger.	Fosters collaborative relationship between client and nurse that can be generalized to others as progress is made. Encourages client to assume control of own behavior and, as specified outcomes are achieved, enhances sense of self-worth and encourages repetition of successful behaviors.
Discuss ways of dismissing feelings of boredom and assist client to understand that these feelings can be controlled.	Client needs to get in touch with own feelings and own/be responsible for them before they can be resolved.
Be aware of attempts to split staff. Avoid manipulative games and be consistent in dealing with the client.	Staff-splitting can be a major problem. Client may behave in one way (quiet/cooperative) with some staff and in another way (angry/demanding) with others.

Confront manipulative and other maladaptive behaviors.	Consistent confrontation removes the reward and reinforces need for the client to adopt new behavior and to stop directing anger at others. Consistency in approach provides a stable environment and reinforces sense of trust.
Give feedback on how effectively client is handling situations and discuss suggestions for improvement.	May need assistance and guidance in modifying behaviors that are not working.
Give positive feedback when client demonstrates use of appropriate, constructive behaviors.	Reinforces use of positive techniques, enhances self-esteem.
Evaluate antisocial behaviors and resulting problems. (Refer to CP: Antisocial Personality.)	Destructive behaviors may lead to legal involvements and other problems in which client needs to learn new behaviors.
Encourage client to discuss issues related to family. Involve family in therapeutic process when possible.	High incidence of incest/physical abuse is associated with the diagnosis of borderline personality disorder. Additionally, clients whose families accept and support them demonstrate more positive outcomes.

Collaborative

Involve entire team in planning and evaluating care.	When team is committed to a single approach and information is shared by all, issues of splitting and countertransference can be minimized.

NURSING DIAGNOSIS	**SOCIAL ISOLATION**
May Be Related to:	Immature interests; unaccepted social behavior
	Inadequate personal resources
	Inability to engage in satisfying personal relationships
Possibly Evidenced by:	Alternating clinging and distancing behaviors
	Difficulty meeting expectations of others
	Experiencing feelings of difference from others
	Expressed interests inappropriate to developmental age
	Exhibiting behavior unaccepted by dominant cultural group (including sexual promiscuity)
Desired Outcomes/Evaluation Criteria—	Identify causes and actions to correct isolation.
Client Will:	Verbalize willingness to be involved with others.
	Participate in activities at level of desire.
	Express increased sense of self-worth.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Determine presence of factors contributing to sense/choice of isolation.	Identification of individual factors allows for developing appropriate plan of care/interventions.
Differentiate isolation from solitude and aloneness.	The latter are acceptable or by choice, and this differentiation helps client identify which is applicable to self so steps to deal with problem can be taken.
Let client know the nurse will not abandon her or him.	Client is often fearful that the therapist will become angry or discouraged and give up.
Ask client to identify significant other(s) with whom she or he can talk. If there is no one, ascertain how this came about.	Aids in seeing a pattern of interaction that is ineffectual.
Examine guilt feelings involving significant other(s). Discuss how these feelings occurred.	May have unrealistic guilt feelings that need resolution before work on the relationship can begin.
Discuss/define fears about being alone. Develop a schedule to "practice" being alone a few minutes each day, gradually increasing the time.	Provides knowledge for developing adaptive coping skills and desensitizes person to feelings of anxiety.
Identify how fears, anxieties have affected quality and depth of interpersonal relationships.	Reinforces a sense that projection does indeed cripple relationships.
Develop a plan of action with client (e.g., look at available resources, support risk-taking behaviors).	Structure of a plan with support of a trusted person helps client try out new behaviors.
Discuss ways to identify and confront inappropriate behaviors. Talk about how others may respond to these behaviors, and suggest ways client can deal with them. Use role-play to practice new skills.	When plan is agreed on, client is involved and willing to look at behaviors that create problems in relationships. Provides a beginning to develop more appropriate ways to interact with others.
Encourage client to identify positive, realistic behaviors currently being used.	As client recognizes that there are already some positive behaviors to build on, self-confidence is enhanced, and client may be willing to take more risks.
Collaborative	
Encourage involvement in classes/group therapy (e.g., assertiveness, vocational, sex education), psychotherapy.	Provides opportunity to learn social skills, enhance sense of self-esteem, and promote appropriate social involvement.