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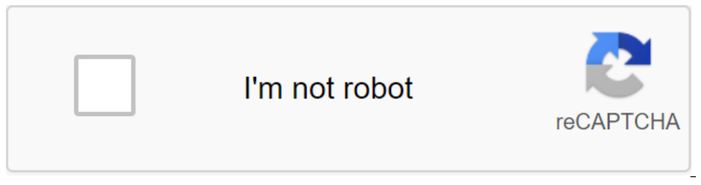

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These people have an extensive clinical history with frequent income in emergencies from recurrent self-harm, suicide attempts, substance poisoning, or aggressive episodes that endanger their lives and sometimes others. They know that their perception of reality is very different from that of others. But knowing this does not make them feel more comprehensible, but just the opposite. And their inability to perform what they know can work and improve their quality of life leads them to feel a great sense of frustration and guilt. It is common to find diagnostic varieties around them: anorexia, bulimia, depression, addiction, gambling, kleptomania, various photos of anxiety, bipolar disorder, etc. during hospitalization, due to Mimiki and his desperate attempts to find a identity, will take as reference a group of patients with whom he has admitted (e.g. anorexia) and begin to copy and exhibit symptomatology of them. When he comes out of internment, he will go hand in hand with his new, false personality. Paradox: You know what you have, you already feel someone, you finally know who you are... being anorexic is better than being nothing. However, he will realize that this new personality does not fill his void or explain his uncertainty. It will bring back instability, lack of identity, addiction, anger, impulsivity, emptiness,... You will return to this circle, going from diagnostic to diagnostic, when it has a name: BorderLine Personality Disorder, or Limitation of Personality Disorder (TLP). DISINFORMATION Media also did not help, focused on what it sells from the disorder rather than the spread of the globality of symptomatology. An aggressive son, a promiscuous woman, a deceitful personality who steals and insults, and a series of testimonies that give the image of manipulative monsters who attack, mistreat and drown their relatives. And there are repeatedly a number of false diagnoses of professionals who do not know about it. We meet people who are misunderstood, misunderstood and who go from therapist to therapist, confused and desperate more and more. SYMPTOMS Fluctuations in self-esteem These people tend to have a variable self-esteem that is usually based on how they are perceived by others (in the face of criticism they may feel bad, inept, void and up to a compliment can feel like a good person, etc. (although this happens in many cases) This variability in self-esteem entails mood swings and conflicting thoughts about themselves and others. During the interview and depending on the topic with which we are dealing, or the person with whom this topic is associated, the patient can be very cheerful or happy, or very upset, frustrated or disgusted with themselves and/or the therapist or other people. feeling the need to avoid this intimate contact to avoid further emotional harm. They bring these kinds of conflicts into their relationships, confusing others and eventually taking them out of their lives. They have an excessive need for support, communication, and affection and expect others to know what they need at all times, let alone. Usually very insightful and capture the needs and weaknesses of others. However, they have difficulty observing these needs, especially when it comes to their closest creatures. This leads them to use very direct and attractive methods to feel support. This creates a great deal of confusion in their close friends, who often perceive such behavior as manipulative. The person with TLP consciously does not recognize their need for others and, ironically, even puts them aside at a time when they need them most. This tug-of-war usually ends with a very short-lived relationship with intense beginnings and endings. The person with TLP does not know that in reality, this way of attracting attention creates significant discomfort in others, that they often feel blackmail or pressured, and that finally such behavior that causes them to move away from them. T.L.P. self-sabotage is functional and has several skills that they are not able to successfully use. They have the ability to achieve what they set out to do, but their instability and insecurity prevents them from exploiting their potential, and they end up practicing self-boting. Fluctuations between extremes People with this disorder often act very differently. Its tendency to oscillate between extremes is well known. The same applies to confidence, in times of stress they may not trust even unimaginable limits, reaching paranoia, and sometimes when they are good, they can be extremely naive and rely entirely on the first person to cross their path. It is not uncommon for a patient to take a stranger home or someone who tells him or her to have a hard time and nowhere to go, or to provide him with his address and keys to the house. This is due to their need to have friends to trust and be able to talk about their problems, or to give an opportunity that they did not have at some point in their lives that they felt abandoned. It is very common for these people to come to a consultation after a new disappointment, feeling terrible, being so idiotic and thinking that others may be like me. Magical thinking often turns to magical thoughts. It's like feeling I just have to have that for everything to go well. That is, to think that a person, place, thing, behavior or idea can make the problem go away or make a person feel happy and/or safe. A person with TLP may think that all he needs is someone to accompany him or someone to give all that love to give that he only has to find a friend of his life or the perfect companion. A magical man can be a famous man, a man with whom he connects in a moment of good vibes, a man who on the street weak or someone who gives him a hand. Any thing or situation acquires the supposed power that is able to control their discomfort. Case: In a group session, other participants talk about their pets and the affection they give them. She claims that she will go for a walk, she does not do it because she has to do it alone. The family does not agree, but she strives that without a pet she will not be able to improve. They finally take it. They give her a puppy and the first few days she is excited, her attention revolves around the pet and her needs, giving her food, love, walks and so on. Weeks later he begins to fear he feels guilty because he says he has been infected with his depression. He claims that he does not eat or sleep because of him, and that if he did not have a puppy, he would have been better. She returns the pet to her owner and after a few weeks begins to miss her. He says it was a mistake, and if he had a puppy, he'd feel better. Suffering They suffer a sense of flaws, are useless, dependent, they are sure they are ignored. They feel a sense of loss of control, a lack of self-confidence and distrust of others. They are afraid of being swept away by their emotions and practice self-tailing. The TLP roller coaster is a disorder of emotional instability. Continuous emotional chaos, when a person thinks in one direction, feels differently and behaves differently, they are all different. They do not know what they are, why they behave contrary to their true desires and concerns, and above all, how to avoid it. It is very disabling and it is difficult to understand the disorder for both loved ones and themselves. They live with despair and loneliness most of their time, often feel a lack of attachment, are useless, and often look for people who can make them feel good or, in other words, save them. Idealization and devaluation They have great difficulty in properly communicating with significant people in their environment. They tend to idealize those who care about them and then devalue them when they are disappointed. The problem is that they are very easily disappointed and don't even understand why themselves. Suicidal, self-destructive, hetero-aggressive and abandonment behavior however, a stellar symptom of suicide and/or self-destructive behavior. The suicide rate of these patients is about 50 times higher than in the general population. As for suicidal behavior or threats, and while in some cases they may be calls for attention, this does not detract from their importance as it is often don't calculate well and end up killing yourself. In any case, the fact that a person attracts attention in this way should never be ignored. In TLP, a person may know in advance that drinking alcohol, eating compulsively, making cuts, starting a new relationship without knowing the person, etc., etc., can be harmful to them and yet, he repeats the same pattern over and over again. The problem is that resorting to such evasion, compensatory behavior, distraction or entertainment, often multiplies discomfort, complicates the forecast and draws the person into some kind of dead end. They are very functional, but have reached the point of dejadez that even look bad, come with a careless image, and that, as you reach them, surprise you with some special skill. On the contrary, it is also common to look flawless and intelligent that knows how to be, but that comments are like the miserable and miserable of his life. Most of the time this facade is something that complicates others's ability to understand their behavior and even more so when these people say or show that they are hiding under their clothes. I mean self-harm, cuts on my arms, chest, legs, and so on. It's really discouraging and hard to understand. These people are willing to tolerate everything as long as they feel loved and accepted. Their need for acceptance can lead them to physical and/or psychological abuse. For fear of being abandoned, judged or criticized. It's like having your own opinion wrong. They feel that because they are, they have no right to have an opinion, and that if they do, they are always wrong. For a person with TLP, these destructive, manipulative and/or non-adaptive behaviors actually have an adaptive function. They act in this way because that's what they've been doing for years, and in most cases they often get answers that amplify that behavior. This is because they have learned that actions are attention, concern and/or rapprochement on the part of others, while talking about feelings has negative responses, anger, denial or untrue. The case of the border patient and his wife: When it is thin, it is more critical, demanding and uncompromising. He, when he can no longer withstand the pressure and wants the deal to end, becomes aggressive. When this happens, women change the way they act radically, become affectionate, attentive, understanding, flexible and amiable. Self-destructive behaviors such as cuts, burns, head blows against the wall, scratches, nails of things and slaps are very common, and when found that they often cause great perplexity in those close to them. Even if it's hard The truth is that they feel relieved when skin contractions are made. It is as if a person has hurt himself to avoid his body and face emotions that are too intense and overwhelming. When emotions increase in intensity and can no longer hold back, they need a way to escape. Although ironic, a person with TLP resorts to self-destructive behavior as a strategy of comfort in the face of discomfort he or she feels. Sometimes it's a way of asking for help or communication, how bad they feel, other forms of self-help that stem from the guilt of the guy I deserve, I'm not valid, I'm a bad person... and others to feel alive or feel pain for something, there is a real reason to feel bad. Paradoxically, self-mutilation, compulsive, abusive or self-destructive behavior leads to a temporary sense of calm and even euphoria, even if they subsequently have the opposite effect and create discomfort and guilt. Self-mutilation can release the body's own opiates. The patient may experience unexpected calmness, such as natural anesthesia. It should be noted that sometimes dangerous behavior can be a type of self-harm: binge eating or spending, reckless driving without thinking about the consequences, risky sexual behavior, causing fights, uncontrollable expenses, etc. The minds of these people, on an emotional level, are as vulnerable as children. They feel very fragile and vulnerable, and both they and their loved ones understand that the impact of living expectations in adulthood provokes an intense and disproportionate response to situations or details that will go unnoticed by others. People with TLP are like people with burns all over their bodies who at least rub in huge pain. This vulnerability causes them to become attached to a loved one and see it as an extension of themselves. At that time, the chosen person no longer has rights; it is just a creature that meets their needs and can even annoy them that this person has a separate life, intimacy, independence, other responsibilities. It's as if they don't know who they are, where they start or end, and where others start or end. This is partly due to affective deficiencies in the evolutionary development of children. Another thing that has seen is a tendency to live other people's lives. Helping others is seen as a way to help yourself. However, although they are easy to help others, the result is usually quite negative for themselves, as this is a common way solve their own problems. The absence of restrictions causes bewilderment and complicates the lives of people with TLP. Physical boundaries determine how far others can go without feeling uncomfortable, and who can touch us, and how and in what situations. Mental limitations allow free expression of thoughts and opinions, but respect the thoughts of others. Emotional boundaries help to manage emotions and are not swept away by the emotions of others. Our job is to help them differentiate and strengthen these boundaries. Emotional boundaries are the most fragile and difficult to observe, and they also have a big impact on other limits. This is another contradiction in relation to this disorder, as most of them are often very observant and astute, and this, in theory, should facilitate the perception of the limits in general. Because of these contradictions, there is a tendency to focus on the negative aspects of this disorder and ignore the positive aspects of people with it, such as a special sensitivity that can make your loved ones so happy in good times. Relatives comment on things like when everything's fine, he's the most wonderful and loving person I've ever met, but when he's wrong, he acts as if there's never been anything good between us, and gives the impression that he hates us with all his life. Feeling more intense, both positive and negative increase. Some people talk about a sixth sense that lets them know the mood of other people. They tend to be more sensitive and have greater empathetic abilities, that is, to put on and understand the situations in which others find themselves, even if it is contradictory because of how much they make their loved ones suffer. They have great difficulty trusting themselves. They tend to blame the blame for everything that happens, even if they apparently blame others. I hate others when he hates himself. Lack of confidence, low self-esteem, and feeling unfit to have an opinion, decision or right forces people with TLP to base their decisions on the opinions of others. Without a certain identity, they seek it and often protect themselves and/or impress others by acquiring different roles depending on when or the people they meet. They try to prevent them from getting to know them for fear of rejection that they know their weaknesses to prevent them from harming them. They cling to anything or the person they think is ready and able to provide it. They believe that able to avoid it. The power of decision-making, by personal choice, almost disappears. They tend to take the closest thing in the environment and hold on to it if necessary: substance abuse, sexual contact with one or more people you have just met, leave with a group of strangers, binge on food, etc. that they are looking for, and that this mode of action is dangerous, because after frustration appears and the person descends on the season or expresses his anger or pain in different ways, thereby increasing their discomfort and bewilderment. For a person with TLP, substance or similar abuse is associated with emotions. In times of anxiety, bewilderment or frustration, a person is carried away by the first thing that is shot or passed through the head. People with TLP are used to living in extreme conditions. With therapy, you can teach them that there are alternatives and that chaos should not be sustained, that it can be attacked and solved. For this it is important that they see that this will not be achieved by resorting to compensatory behaviors, and that if this is the case a person will end up with additional problems for those he already has (addiction to certain substances, eating disorders, sexual diseases, etc.) it is very important to understand that people with PFS feed on the intensity to survive. It's a way of feeling like they're alive and they even think they couldn't live without intense experience. Identity Confusion Confusion Identity is a subjective sense of uncertainty, bewilderment or conflict in perception of oneself. It includes the difficulties of understanding and feelings of unhappiness that are the result of internal struggle. Held back by a lack of self-reflection, weak personal boundaries and a lack of a coherent set of core beliefs or moral beliefs, a person feels the agonizing question Who am I? constantly reflected within him. Negativity and guilt Many negative thoughts of people with TLP about themselves are related to the information they receive. If we go back to the tale of the Ugly Duckling, we will remember that the duckling considered himself ugly because he was different from the others, and the creatures around him were responsible for reminding him over and over again. The duckling ended up escaping from everywhere and displacing himself convinced that he was a horrible creature. What was his surprise when he noticed that his own reflection in the water was the same as that of the most beautiful animals he had ever seen: swans. Unfortunately, people with TLP have this negative vision so ingrained that even showing them their That's not enough. I wish it was as simple as showing them in the mirror. Working with people with TLP is difficult, but just as Mom's paw looked at the qualities of her supposed ugly duckle, if we make the same chances of achieving them and that the therapy is effective, they will multiply. It is very important that we trust them, or somehow, even if it is unconscious, we will awaken our distrust of them. It is important to be able to teach them the benefit of what they think is wrong, almost their entire being. My partner and I tried to think about exercises that could serve a group to help them see the good from the bad. After we turned things around, we realized that it didn't make much sense. When we give up thinking they have no way of seeing the good from the bad, we realize that they can see it in others. In that moment I realized that the above is not bad, and that's really what we had to get in the first place to help them see the good good, so that we could move on later to show them the good of the bad. This is achieved over time and as therapy progresses. In a person with TLP there is a tendency to see the bad out of good. So it's almost impossible to see the good from the bad. It is almost impossible for them to see the positives themselves, how are they going to raise the opportunity to get something positive out of the negative? We note that in the group the participants really perceive the positive aspects of others. Here's the key: they focus on each person's abilities that they can't see on their own. After commenting about this idea in the group, there was a great silence. Suddenly I realized that we had already achieved something unthinkable at first glance: that they would no longer be considered freaks. By meeting other people with the same negative perception of themselves and being others who may see that a person is misjuddddyed, each member of the group may consider doing the same as their peers: being too critical and unfair to themselves. It should be noted that this negative way of thinking plays a defensive role for a person with TLP. It would be much harder for them to fit the bug if they think they have the ability to solve problems and solve them. Negativism allows them to tolerate emotions better, because if they already hope to do it wrong, failure does not catch them by surprise. Talking to a partner about a girl with TLP, she would tell me, It doesn't make sense how she can be so herself, she doesn't realize that we all make mistakes from time to time, is that she can't afford even the slightest mistake? What do you learn from the mistakes? I wish it were so simple... but no, they really can't think that. In a moment of relative stability and emotional well-being they can talk about it, but the moment when emotions are already unleashed, as if all the mistakes of the past are coming back, each of the failures that a person has made in his life and multiplied. Feeling can be so devastating for people with this problem that they come to react in a totally disproportionate way to obvious nonsense to others. The girl overdosed on pills because she threw all the books on the bookshelf she organizes. He said that at the time he didn't think there was another solution and that he wanted all that chaos to go away. This is one of the hardest moments to explain. In addition to seemingly paying attention, this behavior looks like haircuts and abnormal. Although the desperation of loved ones is understandable, it is very important to understand that this extreme negative has an adaptive function for a person with TLP and that judgments about what happened can significantly destabilize a person who knows what happened but claims he has not been able to come up with alternatives. In fact, it is not helpful for them to get a visit from a loved one who says: But what did you think!? People with this disorder are having a hard time asking for help as they do often causes rejection of others because they do not understand what they want and despair. They intend that amid such a whirlwind of emotion and confusion, the person with TLP will be properly verbally what they expect, which they would like to receive as help from the person they are calling. They need us to help them ask for help in a different way, and this is done with practice and permanence in forms of action. Some close friends do very well for a while, but at a time when a person improves they usually relax and give that improvement to the error, thereby neglecting their way of responding to certain situations and confusing and invalidating the person. Redefine What is invalid? When a person's needs are not met and their feelings, thoughts or behavior are denied or questioned. I will explain this from the point of view of family and children, because really a lot of thoughts, behaviors and feelings of people with TLP can seem inadequate or inconsistent, and to understand the effect of disability, it may be easier to present them for a moment as children who need support and understanding and tell them what is and is not right, but in a loving and calm way, without trials. However, we must not forget that they are adults want and should be treated as adults. A family that invalidates one that does not respect the needs of the child, denies his emotions, thoughts, behavior or feelings, and even attributes of his own. There are various forms of invalidation, and in many cases this redefinition is completely unconscious. Haven't we ever seen or witnessed a situation where a child says he's hungry and answered: You're not hungry, you just ate, or in which a child says it's hot and saying: Don't say stupid things, how are you going to be hot with the cold it? The difference is that while these comments may not affect many children at all, especially sensitive children affect them and create a serious malaise as it causes them to doubt their own emotions. Chameleon's metaphor of Chameleon Metaphor reflects many aspects of people with TLP. In addition to reflecting their desperate attempts to adapt to the environment and others, this reflects how they are perceived by the people around them and the bewilderment that may cause them to change. Changes in the color of the chameleon reflect changes in character that occur depending on the mood of the person and increase if the person feels threatened. Depending on the situation, a change in color is required. This is not a manipulation, but an attempt to fit into the environment. It is a protective mechanism that allows you to deal with different situations, although it does not always have the result you are looking for, and often choose the wrong color. The chameleon's eyes move in many directions and on their own; the emotions, thoughts and behaviors of people with TLP work in a similar way, each of them different and independent when they need to work in a coordinated way. That is, they think, feel and behave in a completely different way and generally contradict what they want to convey, express or show. Language illustrates how they can cling to what they want to achieve. Although in the case of the chameleon it is associated with food, people with TLP feed others and desperately cling to them. Just as the chameleon seems to be about life at the time, people with TLP act impulsively when their buttons are pressed without thinking for a second about the consequences of their behavior. This is because when a person finds himself so bad and with so little hope, he must hold on to the energy of others to follow, and he has so little self-confidence that the suggestions of others are overrated and seen as possible solutions to their problems. The rest of the time it moves in slow motion, as if waiting for a new signal from the outside to make it react. He clings to or one that provides you with possible immediate solutions. The rest of the time you feel despair, without listing and empty, waiting for a person or situation that can relieve your pain, fill the void or make you react. Wear a month ago came to me a girl diagnosed with borderline disorder. In principle, he was treated and diagnosed with anorexia and bulimia. She described herself as manipulative, blackmail, deceitful... endless qualifiers that don't come to work. When I asked her to explain to me what it was like when she manipulated and blackmailed, she was very surprised and didn't know what to say. Then he said: Well, that's what the psychologists who saw me told me that it was part of my disorder. We talked about their manipulation when he resorted to them, motive, result, etc. and we came to the conclusion that the result was really very negative for her (a few strange manipulations when you consider that he is usually manipulated to achieve something that we like), the reason is: what we learned. She resorted to this kind of behavior for years and the result was almost always very bad and she used to end up with suicide attempts or very unpleasant and negative situations for her. Manipulation, attention challenges? Can... First, it's a way to ask for help. Perhaps not the most correct or expected by others, but one way to do it: how to do it. His mother was angry that his daughter had left evidence before suicide attempts. It's like it's a negative thing. I tried to explain that it was actually positive

because it was her way of asking for help and that you had to work on it and not provoke the girl because the only way to get her to change the way she asked for help was to talk to her clearly and approach her in therapy. I also explained that comments type again!, you are already with calls of attention, you would like me to welcome... etc., were a good reason for the patient, one of these days to show that they are not attention calls. In therapy, talking to this girl and her mom, we could notice that she did not listen, she did not listen to neither daughter nor us, she just repeated the same words: It (her daughter) has no solution, it is unbearable, I no longer know what to do, this problem is incurable, I have tried everything, but nothing works. To any suggestion his answer was: I've already tried. It was funny because I even answered before I finished making an offer, but yes, I've already tried. An example of communication between them: Mother: Always turn to me when trying to kill (with sarcasm and irony)Patient: Don't worry, next time you don't to you, if so annoying Let's see who he's going to turn to, neighbor? Sorry for the irony, I think it was a counter-transfer lapse. Obviously, I didn't tell that mother, but I was thinking about it. What I intend with this comment is to show the situations that occur in clinical practice and which are most normal in these cases. It's normal to feel desperate at certain times, families come to such sharp and unreal situations that it's hard that they don't make us feel something like the people we are. What we professionals can never do is allow ourselves to get carried away with our feelings and let them interfere with therapy. You have to be very careful not to say whatever we want, or the first thing that goes through our heads in a certain situation. After that a bit of rambling I continue what I originally intended to convey. There are several possible interferences in this case:1. The information provided by the mother (family therapist, before visiting the patient, really came to the idea that we were in front of an antisocial person).2 The information provided by the patient hem hem I'm aggressive, I don't care about others, I use people, I manipulate therapists to get what I want, I hate men, if they get with me I can kill, people disgust me, I have no problem, I don't agree with the rules if they tell me something I'm doing the other way around, etc. 3. Reports of this girl, which included several diagnoses, comments like: not meeting the standards, empathy 0, etc. This interview took me about two hours. During the first hour I had doubts as to whether I would be able to contact this particular patient, but the information she gave me was not appropriate for me and seemed very much studied and studied. That's why I started asking him about that disgusting people, manipulations, etc. When he left, he provided me with a copy of some reports, and one of them took away a sheet that only had fax data... He told me and I just thanked him, I didn't ask him to show me the newspaper. He was surprised and said: I will show you so you can see that I am not lying. I replied that it was not necessary. She said: It's weird to me, I'm not used to what I say. The next day I found a card in my inbox that read: Thanks for the treatment you gave me, I felt like a person, not just a customer or a problem. I won't delve into the case, but I will say that the diagnosis was the limit of personality disorder, that she is a hypersensitive girl, with great empathetic potential, with great care for others, with great uncertainty, a lot of doubt, and that she was just burned by so much treatment and diagnosis. Violations of care, memory and Cognitive style boundaries include an imbalance in attention to detail; Reducing the ability to process information, including registration, integration and troubleshooting; the tendency to erroneous conclusions arising from incomplete and distorted processing of information; selective memory problems associated with partial amnesia, memory distortions and extensive memory lapses from entire periods, especially childhood, spread with rare obsessive fragments of traumatic memories that cannot be forgotten. Dissociation, depersonalization and deerring many people with TLP comment on the sense of observers themselves. While this feeling is common in many normal people, it can be particularly disconcerting in those with a lack of identity, with constant fears and insecurities. However, despite the bewilderment it causes, it serves as a protective mechanism for these people. That is, it helps them to cope with discomfort at a certain time. Fearing losing control, they distance themselves (without setting it up in a different identity). It is depersonalization, temporary or temporary, and not a separate disorder. You have to be careful and think about the well-being of patients. Imagine all the diagnoses a borderline person can have, if for every symptom we diagnose, it would be something rather scarier and confusing for them, even more so than OOP alone. I suppose a diagnosis would say something like this: Limiting personality disorder with depression, dysphoria, impulse control disorder, eating disorder, depersonalization disorder, alcoholism, etc,20, etc., etc... The feeling of strangeness, unreality or the life of sleep is something the boundaries often describe. Individuals who experience depersonalization find it difficult to describe their symptoms and fear that these experiences or sensations mean that they are crazy. Border guards who have experienced temporary depersonalization are afraid to go crazy and do not understand how so many different things can happen to them. Not all cases are therefore patients with depersonalization disorder or dissociative disorder, although there are also. 1. The patient calls me disgusted with the desire to cut it himself because he does not know how to bear the pain. He's a pig, he cheated on me again. Why are you doing this to me? I don't get it. I need to hurt myself. I'm not going to forgive him. This time it went too far... Three days later, he goes to a consultation with his partner. They come hugged and smiled. When I ask him if he clarified the problem the other day, he tells me surprised: What I explain what I mean, ride in anger and say: It's true! (He starts crying with a broken heart) What a pig! Tell him to go, I don't want to see him again!2. The band member was anxious and surprised because the night before he met a teammate and behaved strangely and very aggressively, he was looking for his partner to do something with her... The next time she sees this girl, she is accompanied by a partner and she does not remember what happened. Dissociation is sometimes interpreted as a tease or a story (it's a joke, he's already lying again, he's doing theater) It's very hard to understand if it's not explained to family members, couples, friends and other band members and of course to the injured person. Dissociation is a disconnection from reality or amnesia that appears after lasting great stress. The dichotomy of these people's tendency to see things from the perspective of all or nothing, black or white, good or bad, etc., is what is called dichotomous thinking. It's funny because people who carry treatment are contaminated and often speak on technical terms, and many make comments like I have dextomic thoughts, but the funny thing is, they can't know when they think that way. He's unconscious, protective. One woman says to the doctor's office, Darling, I have to go to work, but if you want, I'll call your mother so she can wait with you and not wait for you. The husband interprets this as a lack of absolute trust in him, and tells his wife to do whatever he wants while he thinks: I hate you, I can't take you anymore when I get home, I'm going to pack up and I'll get out of here. Another example: During a group session, and by suggesting that everyone set a goal they thought they could achieve to comment during the next session, the following happened: one of the group members intended to lose weight. Without going into it impossible, think of something more realistic I said: I know you are easy to lose weight when you set your mind to it (I have tried it other times), but can you do it in two weeks? She was silent and after a while said: It's true, I can't. Well, I can't think of any goals that I can achieve. When he raised the opportunity to start eating healthier, he felt relieved because the idea was the same, but with a different approach. Another participant, who often feels that it brings nothing to the group that everyone is so smart and speaks so well, did not know what could be done. Colleague (who is often very attentive to all comments of his peers) Next time, think you're not useless in a group and she replied: I find it much easier to start losing weight than change as I think I don't think I'm capable of doing that. I suggested that I think of only one thing that she brings to the group. She stayed much calmer and said she could try. What I am trying to convey is that without support these people tend to think so tremendously that it is difficult for them to reach agreements or imagine interim situations. However, they can learn this with practice. I think it's a very slow process that works during therapy, so it eventually pays off and doesn't upset patients. That is, I don't think it's appropriate for a person to see that their thoughts are irrational, bad, or mismatch when that person speaks to themselves about 100 times in the same day. If we confirm that this is true, we are unlikely to help you have more productive or adapted thoughts. He is much more likely to get even more frustrated and give up therapy. This works by offering alternatives to any situation that arises and is dealt with in terms of everything or nothing, but without saying it is wrong, it is wrong, unrealistic, etc. actually trying to speed up the process will be a problem. That we can see the situation very clearly and we believe that as a person should think to lead a less painful life can help us help a person, but we can never impose our ideas and ways of thinking on him. This would be very little benefit to the patient. Design identification Usually when I have doubts about something actually happening, I attack the other person. If she's nervous, crying or screaming, she's innocent. If it stays as it is, it's guilty and chaos and distrust comes when I'm not sure what the other person feels about the comments or something I'm doing, I'm nervous, I feel insecure, stupid and useless. When this happens, I attack. By watching your reaction, I can know that you feel Project Identification is a protective mechanism that the patient performs to try to separate or get rid of a part of himself that he does not want and attribute it to another person. Examples: 1. - A patient who always thinks that everything revolves around him, and that he is selfish about it, says the therapist: Are you a psychologist? What you are is a conceited person who thinks he knows more than others. I don't know how I can be here, wasting my time on your memes. (I mean, I don't know how you can be here to spend time with someone like me and listen to so much nonsense) 2. - After announcing his love for the therapist and in the face of surprise and discomfort that shows, the patient says: I don't think anyone can see you. All you do is sit there and say it's going to work. (I mean: I don't know how I can think of that, what would I think. 3. - Patient asks a therapist for special treatment. The therapist explains that it can't be. The patient says: You know nothing. Who needs your help? You think you are superior to others. (I mean: He doesn't give me much treatment because he doesn't care. -A patient who can't stand alone and has got involved in relationships over and over again that end badly because of how absorbing she is, she says: All men are pigs. I have to understand at first that everyone will be the same (i.e., I am not able to have a relationship with a person, there is something about me that fails and they end up realizing) These kinds of answers arise when the patient feels uncomfortable or stupid from some thought he just did, and especially when he feels or perceives that this comment bothered or equally seemed silly to the therapist. If the therapist does not get uncomfortable with the initial comment and reacts naturally, it is very rare for a patient to react in this way. If the patient does not feel judged, rejected or ignored, he has nothing to defend himself against. Border guards defend themselves by attacking, but most of them are very respectful. They are actually usually very critical, but with themselves. The conclusion I hope has become clear is the mental chaos, especially the emotional, that these people live, how much they suffer and why at certain times they behave in such extravagant and self-destructive ways. I also hope that it has become clear that recovery is possible with good teamwork, which is of course the key part and on which all this patient should turn. If we take these aspects into account and remember that they are deeply rooted in borderline people, we will be able to better understand some of the unexpected behaviors that may occur during coexistence and therapy with these people, and the patient's well-being will be guaranteed. We will not require them to behave normally just because they know they have the ability to do so. T.L.P from VITA POINT OF THE AFFECTED I want to keep writing because I feel like I'm drowning and I'm out of strength. I haven't had any illusions in a long time. My life is a circle, an endless nightmare, I stand aside and part, again I connect, thinking that I can believe and trust someone, that I have found love and who respects me and fails again. I'm tired, I can't do it anymore, I don't understand why I make them suffer and make me Somebody tell me something because I'm going crazy! I feel on the verge of madness, I know that I am very affectionate and that I give everything, but this suffering turns me and causes me so much hatred and aggression that if I keep it all, I sink and it gives me the feeling that I will go crazy. I don't know how to control my anxiety, pain, hatred; I just know that I don't believe in anything anymore, I just have nightmares and a lot of fear, I feel threatened all the time and I'm threatened. I feel threatened every day by people who are a part of my life and I can't understand why if they love me so much, they have lost my respect or used me... I don't understand why I can't trust any man, they just think about having sex with me, I feel like an object. I'm upset, I'm injured, I'm burned, I'm an old lady inside me. Where am I going? Who? What for? It's not worth the pain. I'm afraid of myself, a lot of fear, because I know that one day I'm going to do something crazy. I'll keep writing if I'm not going to cut myself again or kill myself... My partner is still weird with me and I don't know what to do, that if she goes and leaves me, I feel so helpless and I can't stand being ignored, I don't know what to do, I really can't stand being ignored, I need more, much more and I don't have it. Nothing can fill the void I feel. I want to leave, and I can't, there's nothing I can do. I can't stand such a life, at least when I got high I felt more alive, even if this world wasn't real, now I feel empty and without anyone. I want to fuck everything and I can't... I wish passion again in my life and only when I did crazy things. In real life I only have shit, I would rather be in shit, but be able to dream why should I choose between bitter or living life, drugs, alcohol, sex, and when I die, I die and that's it? 29 years old. I feel like everyone will judge me all the time for everything I do and what I don't do. Who's going to withstand that pressure? I dive into my inner emptiness and find the perfect excuse to make shreds with my skin 26 years I think all the people who have moved away from me because they just end up realizing how weird and crazy I am and me and I, and maybe the best thing they could do for themselves to get away from someone like me... So deep down, I don't blame them or anything like that either, almost until... I really understand them, but I'm sad because I would like to be different, and maybe they wouldn't have to walk away from me. The situation I found myself in is so complicated that nothing and no one can help me. 33 years old. I never know how long I will last. I'd like to wake up one day and be someone. Or for someone to see through my eyes this world, which seems to want to absorb the soul, take it all away. it's. You can't start a rooftop house, you have to start with the foundation. What can you do with one that doesn't even have it? A man with no foundation, with nothing, with self-loathing. The man who's under the mask isn't really human. A man who strives for perfection without knowing how and where and knowing that he has not existed for 19 years. People think I don't get out of this situation because I'm not trying. They don't understand what it is and they associate it with depression and you just have to give it willpower. I'm doing it, but it's not enough. I know I have a lifestyle to change, it's a process of overwork in some way, but it's not that easy. Everyone tells you things like: If you were with me, you're going to walk the light, if I see you like this, I'll put two ostias in you and you'll see how smart you are, get yourself a job and stop being locked up at home. The thing is, I'm looking for one job, another, and another, but I can't stand them. Isn't it hard to understand that I find it hard to start a new day, that I would like him to always go out at night and lie that I find it difficult to make a normal life, and when I say normal, I don't talk about great things... get up, fry me, go outside? I would like to be a child, be gged to be hugged to kiss, that's all... I would like to have help, someone with enough temperament and at the same time enough tact to pull me out of this maze I in. I feel sadness, emptiness, loneliness, even being with other people, feeling that I really am worthless that I do not love myself at all, so others will end up realizing this too and will leave me sooner or later. I thought and thought about suicide; I think she would have been better dead. 24 years old. T.L.P. FROM PROFESSIONAL POINT OF VIEW How to touch the water without getting wet? Border lines often have great ability and ingenuity to force professionals to lose roles and find the most special mode that they usually do not give to other caregivers. It has to do with counter-transfer. That is, the emotional reactions they generate in the professionals who serve them. Few disorders can, such as limit personality disorder, devote the full amount of emotional reactions generated by those who suffer from them to professionals who care for them. Therefore, it is not uncommon to find specialists who refuse to take care of these people, and many call them criminals. They certainly have a great ability to get one of their boxes out. They often have a special intuition to perceive weaknesses, and this can be very uncomfortable for the therapist. We suspect that the words difficult customer and are synonymous in the minds of many mental health professionals. We go further and assume that the diagnosis of borderline personality disorder is based on how difficult a person is. We must treat them whether they are difficult or not. What makes us uncomfortable with the pressure of a person with borderline personality disorder is not the patient himself, but ourselves. In the treatment of TLP, the most dangerous is our own character. The reasons why such difficult cases of therapy do not reside exclusively in patients. Therapists struggle with their blind spots, as well as lack of information or lack of training. There are situations when it is necessary to extend the session and in which not to do it can be a response. For example, cheating on her during a session, knowing that the patient is suffering, and thinking that he is annoyed, he is wanted, he will be accepted, this is what affects him, now he knows how bad I feel when he tells me these things. No matter what happens during therapy, these patients are very easy to make therapists feel anxious and confused. Fear of being killed and intellectual problems in relation to the therapist are present at all times. Saying the wrong word using a whole voice or inappropriate appearance can cause the patient to transform, react aggressively, attempt suicide, self-harm, or walk away and not return. Patient example: I am disgusted by people who are afraid (silence and looking at the therapist). The therapist believes that he or she should do things for the patient. You may even think that you are the only person who can help the patient. TLP patients tend to question the therapist's competence. The therapist feels that the patient is trying to invade their intimacy and confuse the therapeutic relationship. The therapist has the feeling that if he does not do what the patient says he will be sick and instead of staying true to his principles gives way to unreasonable and unsuitable requirements for patient and therapy. Understanding such behaviors and attempting to see and address them in a less rigid (or more flexible) way can greatly facilitate our work and prevent us from responding with counter-transition reactions that can do a lot of harm to patients and accelerate the sudden abandonment of therapy. If at some point professionals feel the need to say a few things to the patient, the best thing we can do is to reflect internally and not allow ourselves to get carried away by the intensity of the moment. Responding can even be a stupid response, like when we get hit knee and leg bend. This will act automatically without thinking about the consequences. When a professional acts on his own thoughts, rather than those that arise as a result of counter-transfer, he responds rather than reacts. We can do this from time to time, and it's certainly much better than saying the first thing that happens to us at some point, but we shouldn't abuse this tactic because, because of the insecurities of these patients, too long silence can be interpreted as you don't care what I say, you don't understand me you don't know what to say, I'm sure you think that I'm an idiot. Poor adherence to the treatment of a person with TLP, in most cases, is a myth, not a reality. Is it possible that we are doing something wrong? Medications Unfortunately, there are no specific medications for TLP, but some medications can help in dealing with specific symptoms. For example: -Reducing anxiety-Reducing depressive symptoms and irritability.-Control of impulses, including members self-mutilation.-Correct misinterpretation of reality. They help regulate the mood and stabilize the person, thereby increasing the accessibility for the patient (assuming that it is not over-measured). I want to clarify that I believe that the doctor's job to address these issues is important. When we think that a person may need or benefit from medication, it is advisable to refer them to a specialist (psychiatrist) to evaluate this possibility. Sometimes patients prefer to ask the therapist for their opinion about medications. It's a bit of a difficult situation because we shouldn't ignore the topic or get into the field of another professional. Ideally, the middle (teamwork). We can explain to the patient from the beginning that we consider it necessary to work with their psychiatrist. Recovery is like crossing a bridge. To cross it it is important to know him and know where he is going and why you want to cross it. Even if you are very clear about this, there are factors such as impulsivity (trying to cross it in one jump) that can make it difficult for you to aim. The medication stabilizes you until you cross it, and until you move to the other side. This will help you see things more clearly and be more attentive to instructions or suggestions. But that's not enough. However, it is almost an important companion of therapy. Although drugs are often useful in treating these patients, the role of drugs in long-term care for borderline patients remain unclear. When they ask me if I can put my hands on fire for treatment, the answer is no. But I can talk about the people I work with and the experiences he brought them. In most cases, the medication has improved your symptoms. And, for many doctors, it seems increasingly clear that there is an important biological component. As for side effects, I can also say that most people I have treated and who leave their medications following the instructions of their doctors do not comment on the presence of sequels. Of course, I'm not talking about cases where people have been on medication for years. It is important to remind the patient that, in addition to being patient and following the instructions of the doctors, he must comply with the medication to monitor and obtain the results. The body needs a period of adaptation to drugs and permanence on the part of the person who undergoes medical treatment. Lack of permanence is one of the worst enemies of man with TLP. What you can't do with drugs is take it and stop taking it whenever you want. Responsible use of drugs is the only way to assess the effectiveness of the drug. Medications can help the patient be more receptive to therapy and may benefit more from psychological treatment, but we should not influence patients' decisions or tell them to take medication. What we can do is answer your questions and tell you when the medication may be helpful. They should be the ones who decide, and the doctors who report more accurately about the possible benefits and disadvantages, explaining to the patient why they believe they need medications and possible side effects that can be given with each drug (except for people who are very suggestable) and/or alternative medications. I think all professionals should try to put themselves in the patient's shoes and wonder if we will be taking medication without any explanation or with vague explanations. Group therapy One of the main supplements of individual therapy, in most cases people with TLP, is group therapy. This allows a person to understand and observe how his behavior affects others and how the behavior of others in turn affects them. I have to admit that at first I was a little scared because I had to take into account the emotional burden that might result from some conversation that was addressed in the group and the possible consequences. I knew I couldn't just turn everything on with TLP. And I thought it was very important. (and a lot) of participants who had enough self-control to participate in these emotionally charged discussions. At the time I had a band that I thought was compatible and complemented, I raised it with each of the potential members. The approach was sincere and clear, as what interested me most was his opinion. People with TLP are often ambivalent about the possibility of participating in groups. On the one hand, they know that they can benefit by sharing their emotions and thoughts with others, but they are afraid to get too deep into the lives of their peers, and even that their testimony can affect them as much or more than their own problems. This is inevitable in many cases, but is quite targeted in individual and group therapy. Some of them have previously asked me if I can meet other people with the same problem, others have already met in the waiting room. Most of them wanted to meet people with problems similar to their own, but were afraid of meeting. They didn't know what they were going to find. What if the band members were really horrible, manipulative and aggressive people as they appear in the media that if they were really inferior and queer people as they perceived, this meeting would confirm their opinion of being freaks? However, they were armed with courage and participated in the first session. Each of them breathed a sigh of relief, meeting the other participants. They were normal (even special, in a good way). His appearance was normal, his way of expressing himself was also, and his listening was very different from what he usually finds. I went further: many of them perceived the personal aspects of others, felt and understood what other participants were saying. All I can say is that on the first day of the group I slept with a big smile and feeling very proud of each of the people who came. I know you don't have to take work home, but sometimes it's inevitable, and even more so when you come in and participate in something as beautiful, sincere and profound as the first session. Family Therapy I want to emphasize the importance of working with family members as a supplement to individual therapy. In some cases (especially when the patient lives or relates to or financially dependent on their relatives), this is especially important because the family model and existing relationships interfere with our individual work with patients. I think that this issue is so broad that it will require separate leadership. Attitudes Contact with relatives: 1. They are desperate, they comment that they have been like this for years, that it is getting worse and that there is no way out.2 After the interview and evaluation (if the diagnosis is clear and it may be useful to comment on it), they explain the problem3. They usually react with gratitude, relief and hope. However, during therapy we usually come up with other very different relationships. What in principle may seem like a desperate relative and seek to help may be pathological relationship co-dependency that will inevitably interfere with therapy. Similarly, what may seem like a distant family member may end up being the best ally and greatest support in therapy with these people. Attitude during therapy: We usually come up with three typical ways of doing things on the part of family members: a) Those who follow the guidelines and cooperate (thus accelerating the improvement of the person).b) Those who are waiting for them to pick up the problem or nonsense of the head and try to stay away from it.c) Those who are still critical of any changes and are afraid of losing their role as caregivers. The latter is usually common among mothers. Usually, when these mothers start to see changes, they tend to be afraid and reject any patterns or suggestions. This is a very logical explanation: they are afraid of change and unknown, and sometimes lose their role as educators. If you have dedicated your life to the care and protection of the patient, what will be his role if the patient improves, becomes independent and no longer needs all his care and care? In this case, it is often possible to see that when the patient improves, the caregiver deteriorates, and vice versa. An example of a family member: When my son got so well, I fell into a deep depression. Sometimes, even if they want the patient to recover and recover, I have a feeling that they are waiting for him so you can say: You see how this would never change if I told you that it can not continue, the only one who can accept it is me who his mother. My intention is not to offend any family member who feels identified with some of these comments or behaviors. Just note that the family environment plays a vital role in the possible evolution and maintenance of the improvement of these patients, and that, as I said in relation to therapists, it is not enough to have a good intention to be able to help them. The role of the family therapist Among other things, the role of the therapist is: 1. Explain and make family members understand what the disorder consists of, so what traits and qualities are characteristic of a person and which are caused by the disorder, and how they can help the injured person2. Find out what interaction patterns (communication methods) are that generate conflict and interference or prevent improvement or recovery, such as invalid comments, provocative, hostile, critical, sarcastic, excessive behavior, patient fear to kill themselves, threats, emotional blackmail, ultimatums... 3. Provide the family with a useful guide to changing this pattern by always respecting and adapting to the character of the family.4 Reminding family members that this is a slow process, it is necessary to go step by step, not to force the patient to make a normal life before preparing for it. First, when the problem is very obvious (self-harm, dangerous behavior for the injured person or his relatives, suicide attempts, etc.), relatives are often very attentive and try to support the person as much as possible. However, when a person has gained a minimum of stability and calmness and ceases to be psychologically pressured or crushed, or does not show it, because he tries to think more positively (what works in therapy and what is difficult to achieve), the improvement is taken for done, and it is the relatives themselves who begin to press and even demand that the person resume their activities and normal pace of life. If this attempt at healing is not considered in time, what is actually happening, it is an instant relapse. If the patient has improved enough to speak clearly about their feelings, they will try to clarify things and give their own point of view. At this time family members can react differently: including realizing what just happened and supporting the patient, or getting defensive and responding with phrases like if I know I'm not telling you anything if I'm not going to be able to talk to you or say that I think you're not okay. creating confusion and guilt in the patient that can lead to uncontrollable and feeling unable to do anything right or for that I tried so hard. What usually happens is that family members, seeing that the patient has improved in many aspects of their lives and therapeutic relationships are permanent (he goes to therapy on a regular basis, does exercise and even seems happy and encouraged with the things he is learning in therapy), unrealistic expectations are created in which they expect the person to immediately generalize these achievements for the rest of your life if you constantly go therapy , you can also go to work, if you are focused on doing program exercises, you can also focus on Although the goal is for the patient to summarize these achievements for the rest of their lives, they need time to do so. It may be strange that a person shows such an interest in the therapeutic process and wants to know so many things about their disorder and/or their bandmates. This can lead to misunderstandings on the part of family members who may think that the patient is gloating in their own problems. Sometimes, to the patient's surprise, in the face of his efforts, you can find answers like: You are too involved in their problems, and it is not good, you talk a lot about what happened to you, you seem to like to be so. Sometimes they also make comparisons between their classmates and normal people. One day the patient's brother told him that he should not go to the group and that he should start interacting with normal people, but he did not realize that this was what he called abnormal for his own sister, who was also part of that group. It is these kinds of comments that can do a lot of harm and get very out of control of those who have suffered when things seem to be going well and the improvement is obvious. Perhaps one possible solution would be one that gave us a mother who tends to make comments of sorts: Let's see if you treat normal people She told us that on one occasion her son replied: Imagine that mother x tells her son that she doesn't want her to treat me, would you like him? She said she realized what her son was trying to tell her and admitted that she couldn't judge or choose her friends, and that she wouldn't want anyone to say that about her son, let alone when he was doing his best to understand. By showing interest in disorder, talking about your problem and/or your classmates, it's good because it means you understand it or that you have an interest in understanding what's going on so you can change it and improve it... Going to therapy on a regular basis, showing interest and doing exercises is not only good, it is quite an achievement on the part of people with TLP. This is why it is very important to remind family members that therapy is very personal between the patient and the therapist, and that if there are doubts about the therapeutic process, it is best to discuss it with the therapist before conveying your own doubts or fears to the affected person and causing or causing a relapse, failure and even refusal of therapy. It may also be strange for a professional that a patient with this disorder is so involved in therapy, but the truth is that since I work with him, one of the problems that arose and in which I had to intervene was to clarify that therapeutic relationship and interest on the part the treatment program is a positive, not a negative thing. Example family comments: I think there are more important things and you don't do now when we talk about holidays, one of your biggest problems is missing therapy sessions, is that normal? Of course, this is normal, because for the first time in his life the patient is constantly in something and afraid not able to pick up this rhythm if he distances too far. This is also considered in therapy and explains to the patient that on return the sessions will resume and that if any problems arise during the holidays, they will always be able to contact the therapist and talk about it. It's about normalizing fears and not giving it more importance than it has, don't panic in case the patient has an addiction or how they are going to do when the therapy is over. Let's not punish those who trust someone or take therapy seriously, let's help them gradually become independent and step by step, without haste. They will understand this and will distance themselves from the sessions. Writing The Letter helps T.L.P. realize that they also have positive qualities, goals, and aspirations. This is one of the main reasons why I thought about the need and usefulness of a therapeutic program focused on psycho-education. It is about achieving maximum benefit through reflection and written expression. Moving all their senses onto paper makes them aware of the skills and challenges they have. Also, as therapists, it allows us to help them discover and strengthen these skills. Sometimes they need to be noted so that they can observe them and work on the problems that arise. In addition, the therapist gives very important information about the person what things he draws the most attention to, what problems are usually most common, what are usually associated with these problems and i siento como q cuando' te' devuelven' un examen' corregido. Very clear. </Me> aircraft purchase agreement pdf. aircraft purchase agreement fly-by-night. aircraft purchase agreement sec. aircraft purchase agreement stark. aircraft purchase agreement word. aircraft purchase agreement fillable. aircraft purchase agreement fly-by-night stark. aircraft purchase agreement uk