Borderline Personality Disorder
Theoretical models and treatments

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Problems with Applying Standard CBT to Personality Disorders
(Young, Klosko, Weishaar, 2003)

The patient does not comply with protocol

Standard CBT assumes that patients are motivated to reduce symptoms, learn skills and solve problems and that, therefore, with a little encouragement they will comply with all treatment procedures.

The patient lacks the ability to identify and monitor his/her emotions and communicate them to the therapist

Standard CBT assumes that patients can do this with minimum training. Many patients use cognitive and affective avoidance as a coping strategy for negative affect.

Standard CBT takes for granted that the patient can change his/her problematic cognitions and behaviours through empirical analysis, logic, experimentation, gradual steps and repetition.

This is not enough when dealing with PD patients.

Standard CBT assumes that the patient can relate effectively with the therapist after a few sessions

Since interpersonal issues are normally the core of the problem, the therapeutic relationship is one of the best domains in which to assess and treat these patients.

Patients with personality disorders are rigid

Therefore, they respond much less to cognitive-behavioural strategies. They change more slowly.

Standard CBT assumes that the patient has problems that are readily identifiable as targets for treatment

The problems of these patients are ill-defined, chronic and pervasive.

Clinical Consequence

- As in any relationship, BPD patients may not mention or manifest their problematic behaviours or experiences at the beginning of therapy.
- Failing to recognise the presence of BPD usually leads to the application of a standard CBT protocol for an Axis I disorder.
- This may not work adequately, frequently leading to a rupture of the therapeutic alliance.

Clinical Consequence

- Careful diagnosis and conceptualization are essential.
- Even if you decide to (or have to) target the Axis I disorder, it is of great importance to be aware of the presence of BPD in Axis II.

Diagnosis – A Little History

- The term *borderline* was coined by psychoanalysts in order to explain the presence of psychotic symptoms in an otherwise neurotic patient.
- Different diagnostic criteria were postulated in the works of Stern (1938), Deutsch (1942), Schmideberg (1947), Rado (1956), Esser and Lesser (1965), Grinker, Werble and Drye (1968)

Diagnosis – A Little History

- DSM-IV criteria rely mostly on the "eclectic-descriptive" approach by Chatham (1985) and the work of Gunderson (1984).
- Borderline patients have a reputation of being difficult and untreatable.
- How do therapists feel about them? Let's have a look at the history of diagnostic criteria.

Schmideberg's criteria (1947)

- Unable to tolerate routine and regularity.
- Tends to break many rules of social convention.
- Often late for appointments and unreliable about payment.
- Unable to reassociate during sessions.
- Poorly motivated for treatment.

Schmideberg's criteria (1947)

- Fails to develop meaningful insight.
- Leads a chaotic life in which something dreadful is always happening.
- Engages in petty criminal acts, unless wealthy.
- Cannot easily establish emotional contact.

Rado's criteria (1956)

- Impatience and intolerance of frustration
- Rage outbursts
- Irresponsibility
- Excitability
- Parasitism
- Hedonism
- Depressive spells
- Affect hunger

Esser and Lesser (1965)

- Irresponsibility
- Erratic work history
- Chaotic and unfulfilling relationships that never become profound or lasting.
- Early childhood history of emotional problems and disturbed habit patterns.
- Chaotic sexuality, often with frigid and promiscuity combined.

A Person Drowning in the Sea Diagnostic Criteria (Keegan, 2007)

- Makes frantic efforts to attract attention and keep afloat
- Brought problem on himself by irresponsibly swimming too far away
- Presents high arousal and extreme emotional behaviour

A Person Drowning in the Sea (Keegan, 2007)

- Entitlement (e.g., the person is unwilling to wait for life guard to finish lunch before performing rescue)
- Clings desperately to life guard, putting both lives at risk
- Idealizes saviour, forgets him/her the following day

DSM-IV Criteria

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Frantic efforts to avoid real or imagined abandonment. **Note**: Do not include suicidal or self-mutilating behaviors covered in Criterion 5

DSM-IV Criteria

- DSM-IV criteria are more neutral, less judgemental about the patient's behaviour.
- But they do not pay too much attention to cognitive aspects (e.g., black-and-white thinking).
- Young (2003) has questioned the validity of these criteria, suggesting that they are a list of coping responses to the pathological modes that are the core of the disorder.

DSM-IV Criteria

(2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) Identity disturbance: markedly and persistently unstable self-image or sense of self

(4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note**: Do not include suicidal or self-mutilating behaviors covered in Criterion 5

DSM-IV Criteria

(5) Recurrent suicidal behavior, gestures or threats, or self-mutilating behavior

(6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety lasting a few hours and only rarely more than a few days)

(7) Chronic feelings of emptiness

DSM-IV Criteria

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, state-related paranoid ideation or severe dissociative symptoms

Prevalence of BPD
(DSM-IV, 1994)

- 2% of the general population (estimated)
- 10% of psychiatric outpatients
- 20% of psychiatric inpatients
- 30% to 60% prevalence in clinical populations with personality disorders

Course of BPD

- Chronic instability at the beginning of adulthood, with episodes of intense emotional and behavioral dysregulation, and intense use of mental health resources.
- Deterioration and risk for suicide are greater in the early years of adulthood, declining after 30 years of age.
- They achieve more stability in their relationships and work in the 4th/5th decade of their lives.

Family Pattern of BPD

BPD is five times more frequent in first-degree relatives of BPD sufferers, compared to the general population.

Organization of DSM-IV Criteria (Linehan, 1993)

Self Dysfunction: inadequate sense of self, sense of emptiness.

Behavioral Dysregulation: impulsive, self-damaging, and/or suicidal behaviors.

Emotional Dysregulation: emotional lability, problems with anger.

Interpersonal Dyregulation: chaotic relationships, fears of abandonment

Cognitive Dysregulation: depersonalization, dissociation, delusion.

Jealous Guy (Lennon, 1971)

I was dreaming of the past,
And my heart was beating fast,
I began to lose control,
I began to lose control,

I didn’t mean to hurt you,
I am sorry that I made you cry,
I didn’t want to hurt you,
I am just a jealous guy.

Jealous Guy (Lennon, 1971)

I was feeling insecure,
You might not love me anymore,
I was shivering inside,
I was shivering inside,

I didn’t mean to hurt you,
I am sorry that I made you cry,
I didn’t want to hurt you,
I am just a jealous guy.

Jealous Guy (Lennon, 1971)

I was trying to catch your eye,
Thought that you was trying to hide,
I was swallowing my pain,
I was swallowing my pain,

I didn’t mean to hurt you,
I am sorry that I made you cry,
I didn’t mean to hurt you,
I am just a jealous guy,
Watch out, I am just a jealous guy,
Look out baby, I am just a jealous guy.

Subtypes and Cognitive Profiles of BPD

(Layden, Newman, Freeman, Morse, 1993)

- Since there are so many ways in which criteria for BPD can be met, it is reasonable to assume the existence of subtypes of BPD.
- Their cognitive profile can be somewhat different. This helps in achieving a more precise cognitive conceptualization.
- Two people with BPD can share the same abandonment schema, but may develop different assumptions or compensatory strategies.

Subtypes of BPD

- **Assumption**: *I must not be too close to anybody, since sooner or later that person will abandon me.*
- **Resulting behaviour**: emotional and social avoidance.
- **Assumption:** *I must make everything possible for someone to love me, and I must also overwhelm him with my presence and passion, since this is the only way to keep him near me.*
- **Resulting Behaviour:** Overtly seductive and histrionic behaviour.

Clinical Consequence

- The identification of the schema will be identical in both cases, but the change strategy will be different in each case.
- The goal, however, is similar: to reduce the expectation of being abandoned, to moderate the emotional and behavioural responses (maintaining factors) and to develop healthier, more stable relationships.

Subtypes of BPD

- Avoidant/Dependent bordeline personality
- Histrionic/Narcissistic borderline personality
- Antisocial/Paranoid borderline personality

Avoidant/Dependent BPD

- They are very anxious and have low self-esteem
- The incompetence schema prevails (Young 1990)
- They believe they can't face the challenges of life, therefore they avoid problems and challenges.
- Thus, they don't mature, reinforcing the incompetence schema and the feelings of hopelessness and helplessness.
- Their beliefs are: *I can't take care of myself, others must make decisions for me, I can't live alone.*

- They are hypersensitive to criticism.
- Their high level of demand is a great burden for their relationships.
- They are afraid of losing their identity and autonomy if they relate to somebody.
- Thus, they can put an end to their relationships in order to survive as individuals. They fear that their ideas, aspirations and needs will be overwhelmed by the assertive people around them.

- They repeat the same pattern in therapy, oscillating between withdrawing and making excessive demands on the therapist.
- They avoid thinking of sensitive material (cognitive avoidance).
- Attempts at teaching them skills can be read as “trying to get rid of them”.
- They have problems with homework, that makes them anxious.

Histrionic/Narcissistic BPD

- Characterised by marked mood lability, stormy relationships, overwhelming needs of care and affection and extreme anger when their needs are not met.
- They oscillate between and idealising and vilifying their therapists.
- They resort to exhibitionistic behaviours or melodramatics to hold on to love and care.
- Their abandonment and unlovability schemas are salient.

- They are the most likely of any subtypes to make suicidal threats and gestures as cries for help or as ploys to manipulate the therapists or others.
- They have serious difficulties in understanting boundaries in interpersonal relationships.
- They think their needs are evident to others, that they require immediate attention and that they are congruent with the needs of the nurturer.
- They oscillate between demanding a symbiotic relationship and believing that nobody will be able to help them (punishing the other).

- They seek stimulation, excitement and novelty around them intensely, but they hate to generate changes within themselves.
- They seek continuous reassurance and approval to support a fragile self-esteem. They think the love of others will solve all of their problems.
- They idealise a person and become deeply disappointed at the smallest hint that this person will not be able to meet all their needs.

- Impulsivity, impatience and low frustration tolerance are the hallmark of this subtype. They readily express their anger to those who have –in their perception- wronged them.
- They believe a lot in their emotions (they are highly valued) and very little in sensible, rational thinking.

Antisocial/Paranoid BPD

- *Boys will be boys, bad boys, bad boys.*
- They show a marked disregard for the formal and informal rules that regulate social behaviour.
- They break these rules to their own benefit, to gain money, power and stimulation at somebody else's expense.
- They have a grandiose view of their self-importance, together with an attitude of open defiance.

- Their interests always come first; the need or desires of others have no importance for them.
- They show a pervasive mistrust of others' motives. They are always alert to the potential threats of others, whether real or imaginary.
- Jealousy and anger are extreme and easily triggered. Criticism is taken with great animosity and indignation.

- The grandiose presentation of self disguises a deep feeling of self-doubt.
- They get involved in the same impulsive, hostile and destructive behaviours of the "pure" antisocial or paranoid person, but for different reasons.
- Antisocials seek self-benefit. BPDs tend to act out their pain and hostility, hurting themselves and others.
- "I don't care what happens to me, so I can do as I please".

- Hostility, suspiciousness and recklessness are the hallmark of the subtype. They have a malevolent view of others (mistrust schema) and a false sense of power.

- They tend to use and abuse those who they love.

- They rarely have stable relationships.

- They do not feel close to anyone, but are extremely possessive, demanding and jealous in their relationships.

- Anger is the most common expressed emotion, frequently under the form of recklessness or physical attacks on others (engaging in frequent fights).

- Gunderson and Zanarini (1987) have postulated that this subtype would be typically male.
- A tendency to suicide could correlate with a tendency to homicide.
- They cannot tolerate boredom and are thus inclined to substance abuse, increasing their impulsivity and lack of self-control.
- They show contempt for themselves (badness schema) in the form of self-destructive behaviours.

Characteristics of BPD
Linehan's Model (1993)

Emotional Vulnerability

Self-Invalidation

Unrelenting Crises

Inhibited Grieving

Apparent Competence

Emotional Vulnerability

A pattern of pervasive difficulties in regulating negative emotions, including high sensitivity to negative emotional stimuli, high emotional intensity, and slow return to emotional baseline, as well as awareness and experience of emotional vulnerability. May include a tendency to blame the social environment for unrealistic expectations and demands.

Self-Invalidation

A tendency to invalidate or fail to recognize one's own emotional responses, thoughts, beliefs and behaviors. Unrealistically high standards and expectations for self. May include intense shame, self-hate and self-directed anger.

Unrelenting Crises

A pattern of frequent, stressful, negative environmental events, disruptions and roadblocks –some caused by the individual's dysfunctional lifestyle, other by an inadequate social milieu, and many by fate and chance.

Inhibited Grieving

The tendency to inhibit, avoid or overcontrol negative emotional responses, especially those associated with grief and loss, including anger, guilt, shame, panic and anxiety.

Patients may seem to “survive” loss quite well, only to experience difficulties later on.

Active Passivity

Tendency to passive interpersonal problem-solving style, involving failure to engage actively in solving of own life problems, often together with active attempts to solicit problem solving form others in the environment; learned helplessness, hopelessness.

Apparent Competence

A tendency for the individual to appear deceptively more competent, capable or effective than he/she really is; usually due to failure of competencies to generalize across expected moods, situations and time, and failure to display adequate nonverbal cues of emotional states., in many situations.

Apparent Competence (cont.)

Due to emotional instability, they can sometimes cope with certain situations or challenges and sometimes they cannot. Some BPD patients perform well at work or are creative, intelligent, and artistic, but they may not be so at times. This creates confusion in people around them.

Young's Model
Schemas and Modes

- Young's original model (1990) posited that personality disorders were the result of the prevalence of certain –and different- schemas (unconditional, rigid, basic cognitive structures).
- BPD patients scored high on almost all of the 16 schemas of the Schema Questionnaire. It became evident that a more inclusive unit of analysis was necessary.
- The original model was a trait rather than state model. This could hardly account for the ever-changing behaviour of BPD patients.

- Schema modes are the emotional states and the coping responses –adaptive or maladaptive- that we experiment at a given time. They are the schemas or schema operations that are active in a person at a given time.
- Schema modes are triggered by vital situations to which we are hypersensitive.
- The object of the therapy is to move from a maladaptive schema mode to an adaptive one (the healthy adult).

- A mode is the conceptual answer to the question "*what group of schemas or schema operations is the patient enacting at this present moment?*"
- A dysfunctional schema mode is activated when certain dysfunctional schemas or coping responses have emerged, giving place to painful emotions, avoidance or dysfunctional behaviours that take control of a person's functioning.

- A schema mode is an aspect of the self, involving schemas or schema operations that has not been fully integrated with other areas of the self.
- They can thus be described in terms of the degree in which they are dissociated from the rest of the self.

Origins of BPD – A Hypothesis
(Young, Klosko & Weishaar, 2003)

Biological Factors

The temperament of BPD patients is characterised by intense and labile emotionality. This would represent a biological predisposition to the disorder.

The higher frequency of BPD in women could be a result of temperamental differences or of the higher frequency of sexual abuse or of submission and restraint in the expression of anger.

It could also be that BPD is less diagnosed in men.

Environmental Factors

- Family environment is unsafe and unstable
- Family environment is characterised by emotional deprivation
- Family environment is harshly punitive and rejecting
- Family environment is subjugating.

Schema Modes and BPD

- Young (2003) postulates five schema modes:
- *The Abandoned Child*
- *The Angry and Impulsive Child*
- *The Punitive Parent*
- *The Detached Protector*
- *The Healthy Adult*

The Abandoned Child

- It is the part of the patient that feels the pain and the terror associated to most of the schemas (*abandonment, abuse, deprivation, deffectiveness, and subjugation*).
- The patients is fragile and childish. They are sad, desperate, frantic, lost. They feel terribly alone and are obssesed with finding a parental figure that takes care of them. They idealise their nurturers and have fantasies of being rescued. They desperately seek not to be abandoned by their carers.

The Angry and Impulsive Child

- This mode prevails when the patient is furious or acts impulsively because their basic needs are not met. Young believes it is the less frequent one, but it is the one that therapists most associate with BPD patients.
- Patients make demands that suggest they feel entitled or that they are spoiled, alienating them from others. They really reflect desperate attempts to meet their emotional needs.
- It is activated as a result of the unresolved tensions between the activation of the Punitive Parent and the Detached Protector.

The Punitive Parent

It is the internalized voice of the parent, that criticizes or punishes the child.

- The patient becomes a cruel nemesis of himself.
- The voice punishes the child for doing something “wrong”, like expressing needs or feelings.
- It is the internalization of the hatred, anger or contempt of one or both parents, together with the submission of the patient.

The Detached Protector

- The patient blocks all of his/her emotions, disconnects from others and functions in a robotic-like manner.
- It is the défault mode of BPD patients.
- They may seem normal and “good” patients, acting appropriately, but suppressing their needs and feelings.
- Its presence can be detected by depersonalization, feelings of emptiness, boredom, substance abuse, binges, self-mutilation, robotic compliance and feeling blank.

The Healthy Adult

- Very weak and underdeveloped in most BPD patients, since they have not acquired a soothing, caring parental mode (thus, their intolerance of separation).
- The therapist models the healthy adult mode until the patient learns to do it by himself/herself.
- Implication 1: therapy is about learning to behave like healthy adults
- Implication 2: therapists can act like healthy adults.

BPD as Dialectical Failure
(Linehan, 1993)

Borderline and suicidal individuals frequently vacillate between rigidly held yet contradictory points of view, and are unable to move forward to a synthesis of the two positions.

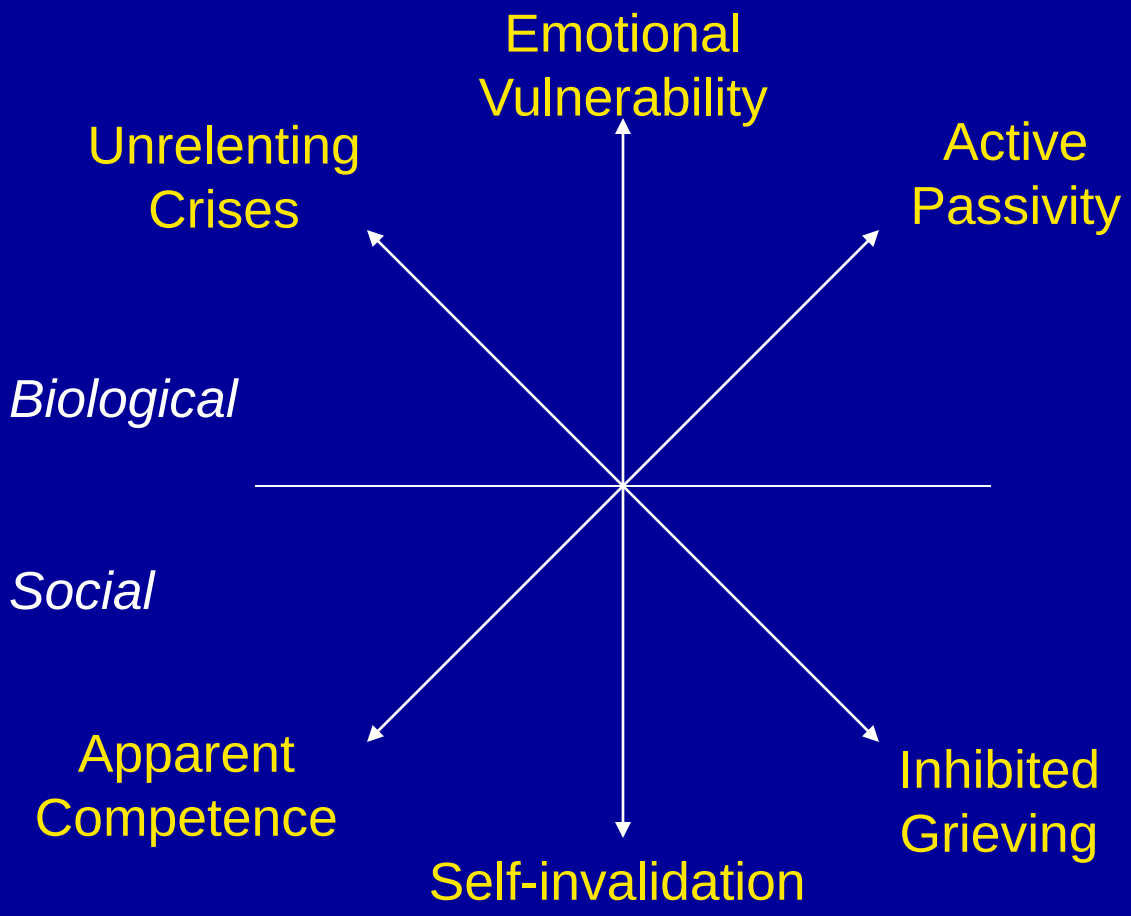
They tend to see reality in polarized categories of *either-or*, rather than *all*.

BPD as Dialectical Failure

This tendency has been termed *splitting* by psychoanalysis (Kernberg, 1984).

This process is known in cognitive models as schema vacillation (Young, 1990).

Borderline Behavioral Patterns: The Three Dialectical Dimensions

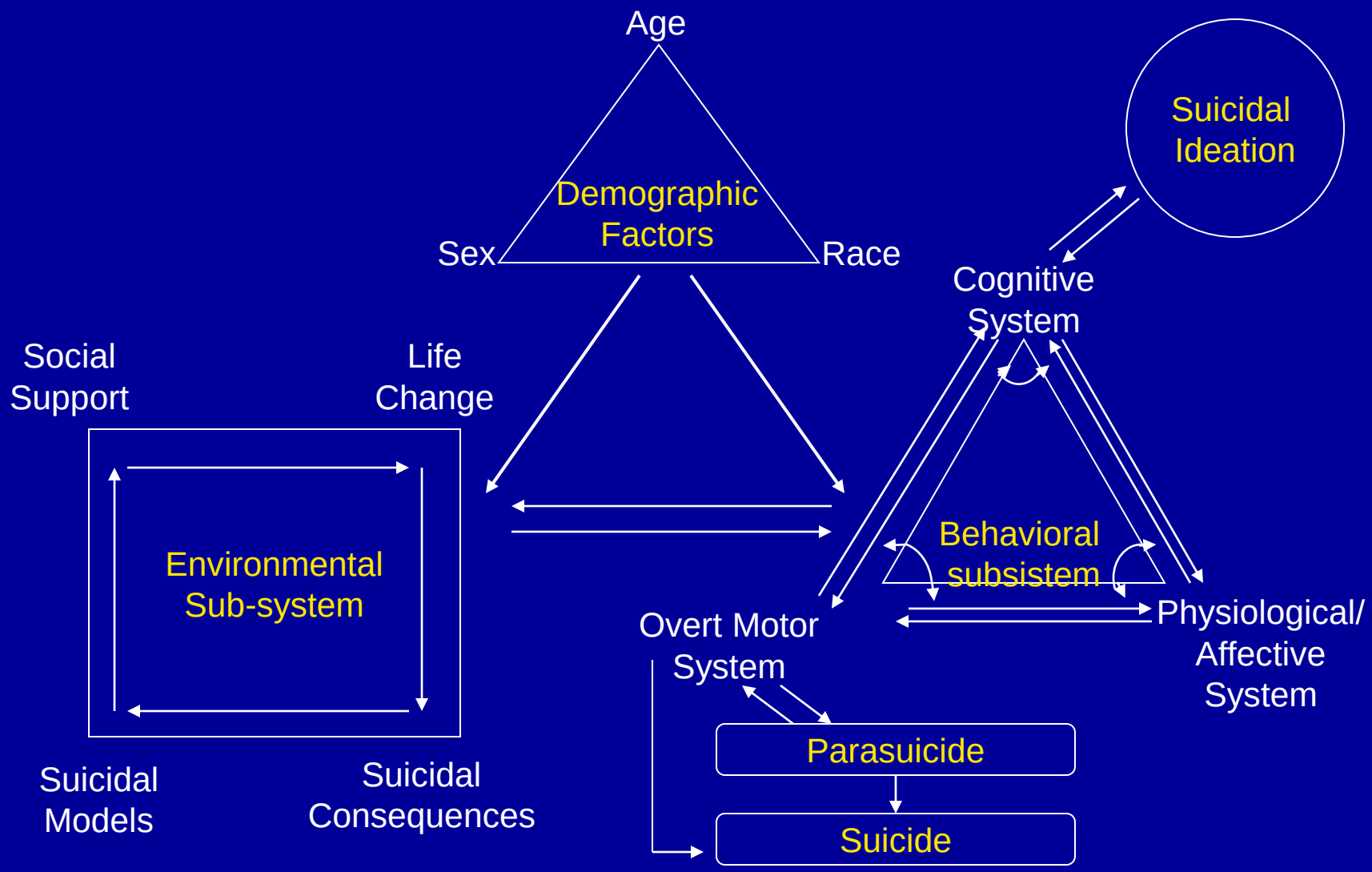


Biosocial Theory: A Dialectical Theory of BPD Development

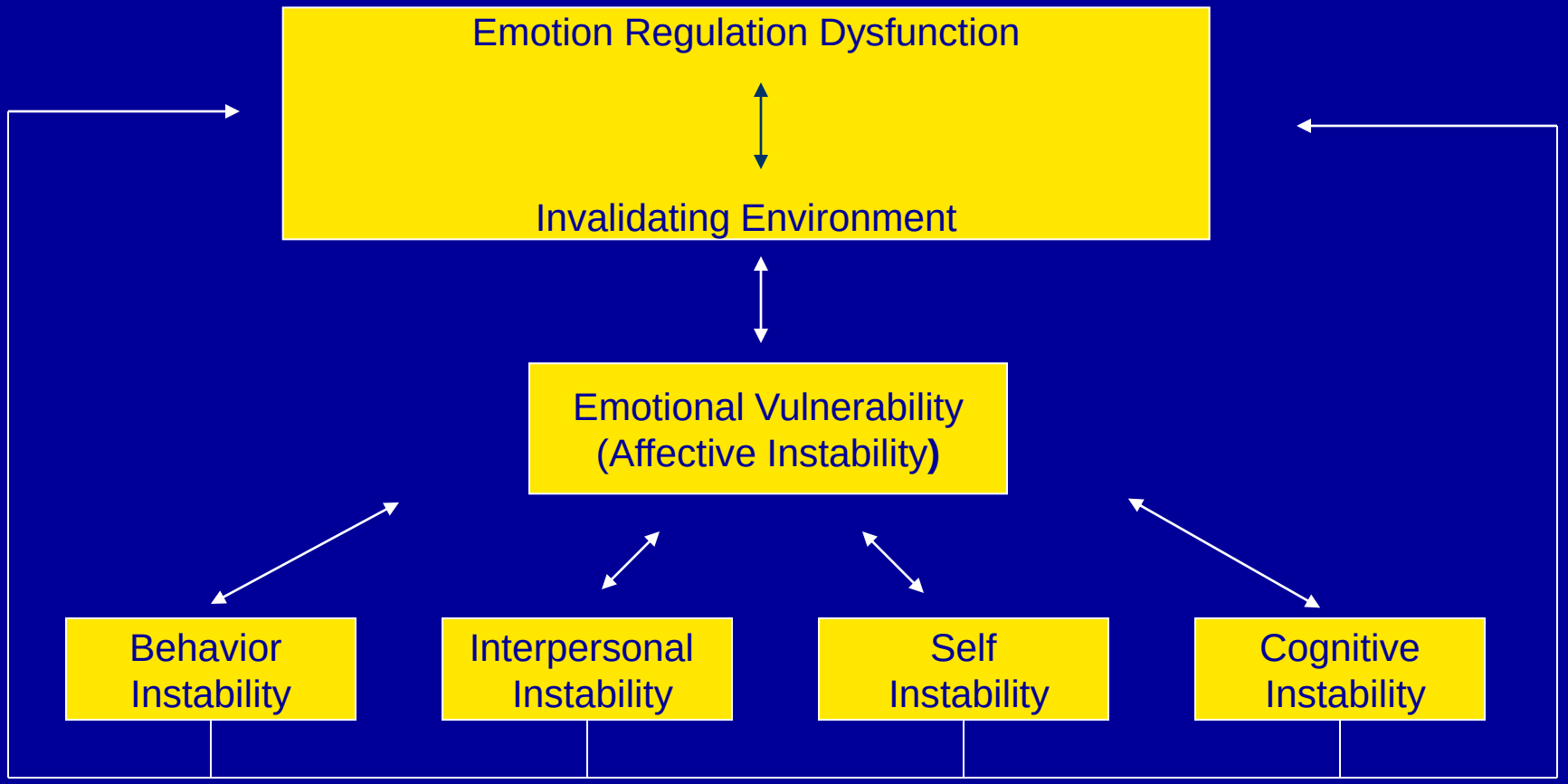
(Linehan, 1993)

BPD is primarily a dysfunction of the emotion regulation system, resulting from biological irregularities combined with certain dysfunctional environments, as well as from their interaction and transaction over time.

Social-Behavioral Model of Suicidal Behavior: An Environment- Person System



Emotion Dysregulation and Borderline Behavior Patterns. The Biosocial Theory



Biosocial Theory: A Dialectical Theory of BPD Development

(Linehan, 1993)

Invalidating environments during childhood contribute to the development of emotional dysregulation, also failing to teach the child how to tolerate emotional distress, and when to trust his own emotional responses as reflections of valid interpretations of events.

Biosocial Theory

As adults, borderline individuals adopt the characteristics of the invalidating environment.

They tend to:

(a) invalidate their own emotional experiences

(b) look to others for accurate reflections of external reality

(c) oversimplify the ease of solving life's problems

Biosocial Theory

These behaviors leads to unrealistic goals, use of punishment rather than reward, and self-hate following failure to achieve these goals.

They become self-invalidating.

Clinical Implications of the Biosocial Theory

If we consider BPD as a dialectical failure, then treatment must focus on overcoming an either-or perception of reality and self, enabling the patient to achieve a holistic perception instead.

One basic principle in this endeavour is to observe an adequate (and difficult) balance between acceptance and change.

Temperament and Environment

Thomas and Chess have suggested that goodness of fit or poorness of fit of the child with the environment is crucial for understanding later behavioral functioning.

Invalidating Environments

An environment in which communication of private experiences is met by erratic, inappropriate, and extreme responses.

The expression of emotions is not validated, instead, it is often punished, and/or trivialized.

The individual's interpretation of his own behavior, including the experience of the intents and motivations associated with behavior, are dismissed.

Invalidating Environment

It tells the individual that he is wrong in both the description and analysis of his own experiences, particularly in his views about what causes his own emotions, beliefs and actions.

Invalidating Environment

It attributes experiences to socially unacceptable characteristics or personality traits. The environment may insist that the person feels, likes or has done something different from what the person thinks he feels, likes or has done.

Invalidating Environments

- They are generally intolerant of displays of negative affect, at least when not accompanied by public events supporting the emotion.
- The attitude communicated is that anyone who tries hard enough can make it.
- This is similar to the pattern of high expressed emotion (Leff & Vaughn, 1985).

Consequences

An invalidating environment does not teach the child to label private experiences, including emotions, in a manner normative in the larger community.

By oversimplifying the ease of solving life's problems, it does not teach the child to tolerate distress or to form realistic goals.

Consequences

Extreme emotional displays often become necessary to provoke a helpful response from the environment.

It fails to teach the child when to trust his own emotional and cognitive responses as reflections of valid interpretations of individual and situational events.

Types of Invalidating Families

Chaotic Families

Little time or attention is given to the children; their needs are disregarded and, therefore, invalidated.

“Perfect” Families

Parents cannot tolerate negative emotional displays from their children. They tend to simplify the difficulties in solving problems.

Invalidating Families

Typical Families

The individuated self in Western culture is defined by sharp boundaries between self and others. Mature persons are assumed to be controlled by internal rather than external forces. Self-control is expected, and defined as the ability to control one's behavior by using internal cues and resources.

Invalidating Families

The emphasis on individual independence as normative behavior is unique to, and pervasive in Western culture.

It appears that there is a “poorness of fit” between women’s interpersonal style and Western socialization and cultural values for adult behavior (Linehan, 1993).

Sexual Abuse

- Sexual abuse is 2 to 3 times greater for females than for males (Finkelhor, 1979).
- Of 12 hospitalized patients, 9 (75%) reported a history of incest (Stone, 1981).
- Childhood sexual abuse was reported by 86% of borderline inpatients (34% in other psychiatric patients) (Bryer et al., 1987).
- Childhood sexual abuse was reported in 67% to 76% of borderline outpatients (26% in other psychiatric patients) (Herman et al., 1989, Wagner, Linehan & Wasson, 1989)

Sexual Abuse

- Sexual abuse might be uniquely associated with BPD (Linehan, 1993).
- A similar link has been found between childhood sexual abuse and suicidal, parasuicidal behaviors. Up to 55% of these victims go on to attempt suicide.
- Sexually abused women engage in more medically serious parasuicidal behavior.
- Individuals with suicide ideation or parasuicide were 3 times more likely to have abused in childhood (Bryer et al, 1987).

Sexual Abuse

- Abuse may not only be pathogenic for individuals with vulnerable temperaments, it may “create” emotional vulnerability by affecting changes in the central nervous system.
- Chronic stress may have permanent adverse effects on arousal, emotional sensitivity and other factors of temperament.

Sexual Abuse

- It is a form of extreme invalidation. The victim is told that abuse is O.K. but that they must not tell anyone else.

- If the child says something about the abuse she may be disbelieved or blamed by family members.

Emotional Dysregulation and Invalidating Environments

A slightly vulnerable child, within a slightly invalidating family can, over time, evolve into one in which the individual and the family environment are highly sensitive to, vulnerable to, and invalidating of each other (Linehan, 1993).

The child's response to invalidation reinforces the family's invalidating behavior.

Emotional Dysregulation and Invalidating Environments

- Caregivers may expect more or different behaviors than the child is capable of emitting. Excessive punishment and insufficient modeling, instructing, coaching, and reinforcement follow.
- Needed help is not offered to the child. Unavoidable punishment increases his negative emotions, leading to an extreme expression of emotion.
- This is so aversive for caregivers that they stop attempts at control.

Emotional Dysregulation and Invalidating Environments

Caregivers unwittingly reinforce the functional value of extreme expressive behaviors, and extinguish the functional value of moderate emotional expression.

Appeasement after extreme emotional expression may create the BPD pattern of behavior in adults.

Emotional Dysregulation

Most borderline behaviors are either attempts on the part of the individual to regulate intense affect or outcomes of emotional dysregulation (Linehan, 1993).

Emotional Dysregulation and Impulsive Behavior

Suicide and other impulsive, dysfunctional behaviors are usually maladaptive solution behaviors to the problem of overwhelming, uncontrollable, intensely painful negative affect.

Borderline patients report substantial relief from anxiety and intense negative affect after cutting themselves (Leibenluft, Gardner & Cowdry, 1987)

Emotional Dysregulation and Identity Disturbance

Unpredictable emotional lability leads to unpredictable behavior and cognitive inconsistency, preventing the development of a stable self-concept or sense of identity.

The numbness associated with the inhibition of emotional responses is experienced as emptiness, that contributes to the absence of a strong sense of identity.

Emotional Dysregulation and Interpersonal Chaos

Successful relationships require a capacity to self-regulate emotions in approppriate ways, to control impulsive behaviors, and to tolerate stimuli that produce pain to a certain degree.

Effective Treatments for BPD

- A number of interventions have proven – with varying degrees of empirical backing- to be efficacious for BPD.
- These are Dialectical Behavior Therapy (DBT, Linehan), Transference-Focused Psychotherapy (TFP, Kernberg), Schema Therapy (Young), Mentalization-Based Treatment (MBT, Bateman & Fonagy), Cognitive Therapy (Beck, Newman).

Common Features of Effective Treatments for BPD

- Well-structured
- They devote considerable effort to the enhancing of compliance
- Clearly focused, be it on problem behavior (self-harm) or on interpersonal relationship patterns
- Theoretically highly coherent to both therapist and patient

Common Features (cont'd)

- They are relatively long term
- They encourage a powerful attachment relationship between therapist and patient, enabling the therapist to take an active rather than passive stance
- Well-integrated with other services available to the patient

Bateman & Fonagy (2004)

Common Factors
(Bateman & Fonagy, 2004)

- Warmth, acceptance and a supportive environment contributes to the effectiveness of all psychotherapies.
- But what are the precise aspects of interpersonal processes that are therapeutic for people with BPD?

Common Factors
(Bateman & Fonagy, 2004)

- All these treatments focus on the capacity for mentalization, that is, on the implicit or explicit perception or interpretation of the actions of others or oneself as intentional (i.e., mediated by mental states or mental processes).
- The crux of the value of psychotherapy with BPD is the experience of other human minds having the patient's mind in mind.

Common Factors (cont'd)

- The therapist, in holding on to his view of the patient symultaneously fosters mentalizing and secure attachment experience.
- Feeling recognized creates a secure base feeling that in turn promotes the patient's freedom to explore herself/himself in the mind of the therapist.

- An increased sense of security reinforces a secure internal working model and through this, a coherent sense of self.
- The patient is increasingly able to allocate mental space to the process of scrutinizing the feelings and thoughts of others, perhaps bringing about improvement in fundamental competence fo the patient's mind interpreting functions.
- This, in turn, generates a far more benign interpersonal environment.

Common Factors (cont'd)

- Therapists will need:

  a) to identify and work with the patient's limited capacities

  b) to represent internal states in themselves and in their patients

  c) to focus on these internal states

  d) to sustain this in the face of constant challenges by the patient over a significant period of time

Common Factors (cont'd)

Mentalizing techniques will need to be:

a) offered in the context of an attachment relationship

b) consistently applied over time

c) used to reinforce the therapist's capacity to retain mental closeness with the patient

Dialectical Dilemmas in the Treatment of BPD

A group of three dimensions defined by their opposite poles:

(1) emotional vulnerability versus self-invalidation

(2) active passivity versus apparent competence

(3) unrelenting crises versus inhibited grieving

The Dialectical Dilemma for the Therapist

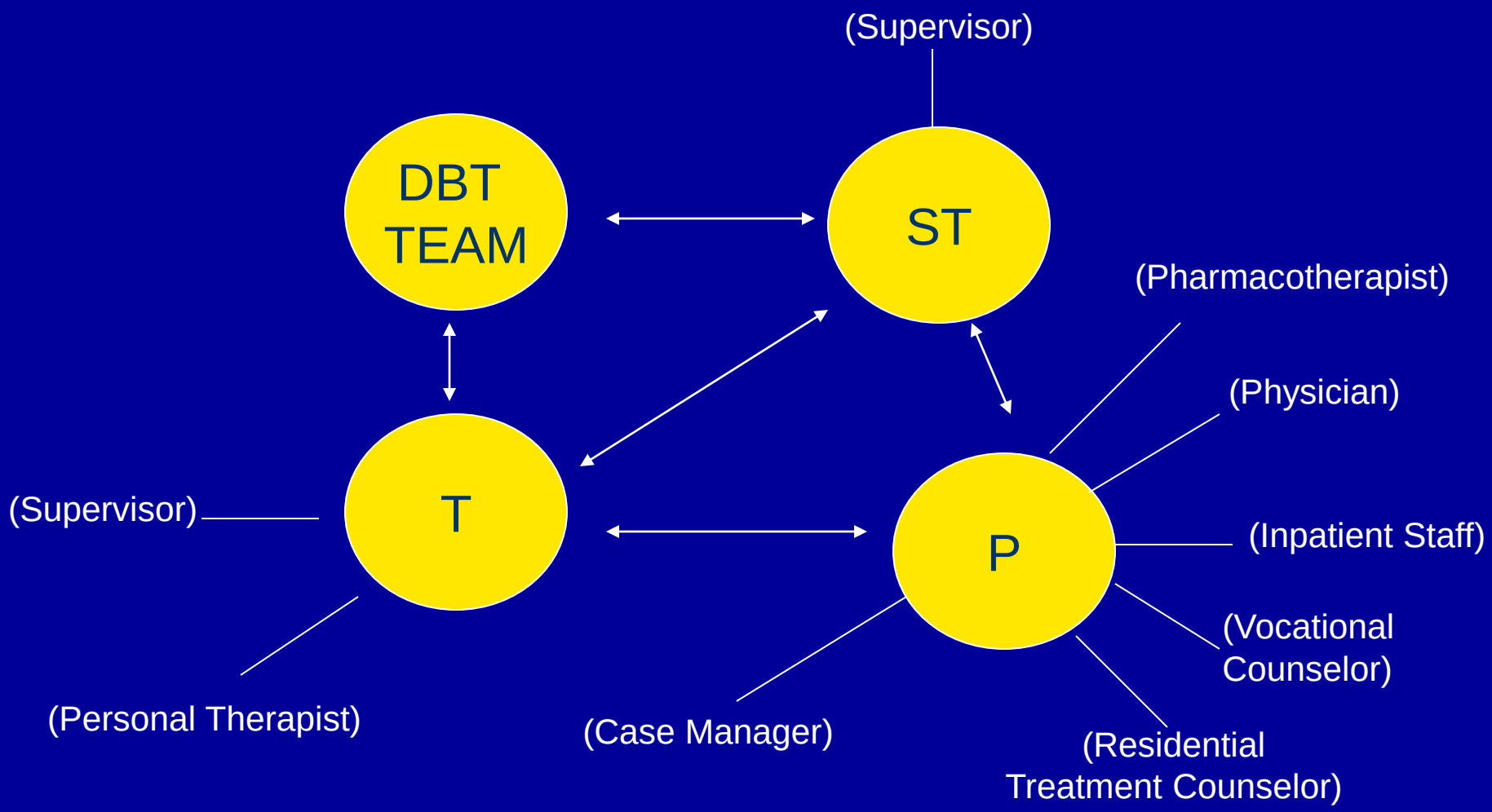
The therapist must strive for a dialectical balance between validating the essential wisdom of each patient's experience (especially her vulnerability and sense of desperation) and to teach the patient the requisite capabilities for change to occur (Linehan, 1993).

Overview of Treatment

DBT for BPD consists of two basic interventions: individual therapy and skills training, offered initially for a one-year period, on a once-a-week basis for each intervention.

The treating team also meets once a week for consultation/supervision.

A Possible Ancillary Treatment Scenario in DBT



Structure of DBT

Stages of disorder, stages of treatment

The treatment frame is informed both by the biosocial-transactional theory and by a model of the stages of the disorder, creating a hierarchy of interventions.

The central goal of DBT is creating a life worth living, according to the core values of the patient.

The hierarchy of interventions is determined by this goal.

Structure of DBT

Primary targets

The treatment focuses on the behaviors that interfere most with the goals of each stage (e.g., cutting).

Secondary targets

These are patient behaviors, environmental events or behaviors of others that are “on the chain” toward the primary target (e.g., on the chain of the cutting behavior)

Structure of DBT

Pretreatment

The patient is informed of the nature of treatment, including:

- how it is conducted and evaluated,
- the modes of treatment available,
- treatment target hierarchy,
- assessment procedures,
- agreed upon length of treatment (including factors that can result in more or less tx),
- rules of the treatment setting.

Structure of DBT

Pretreatment

Therapist and patient evaluate the pros and cons of entering treatment. Clients complete daily monitoring sheets, therapist demonstrates process of treatment. Both evaluate factors that may interfere with active participation and commitment.

Agreement is usually reached after 2 to 4 sessions in an outpatient setting.

Structure of DBT
Individual Therapy

Stage 1

The main difficulty is behavioral dyscontrol. The goal for the patient is to achieve behavioral control across all relevant contexts.

This involves three domains:

- Life-threatening behaviors
- Therapy-interfering behaviors
- Severe quality-of-life interfering behaviors

Stage 1

Life-threatening behaviors

Suicidal and parasuicidal behaviors, aggression, violence, child abuse and neglect.

Therapy-interfering behaviors

Absence from sessions, noncollaborative behaviors, interfering with the treatment of other patients, behaviors that can burn the therapist/team out or decrease motivation-to-treat.

Stage 1

Severe quality-of-life-interfering behaviors

Severe drug abuse, a severe eating disorder, being homeless or in jail, or any out-of-control behavior that limits an acceptable quality of life.

Stage 1

- This stage involves teaching self-management skills, strengthening them and generalizing them to the natural environment.

- It also involves changing environments to make them safer or more compatible with skillful living.

Stage 2

The main difficulty is emotional misery, thought to be related to deficits in emotional experiencing (BPD patients are emotion-phobic). The prototype problem in Stage 2 is Posttraumatic Stress Disorder.

The client must learn to experience emotions effectively (without escalating or blunting them).

Stage 2

- Treatment strategies in this stage may originate a return to problematic behaviors addressed in Stage 1. If so, stage 1 strategies are applied again until stabilization is achieved.

- Effective experiencing of emotions demands a validating environment. A therapist may provide this during exposure treatment for PTSD.

Stage 3

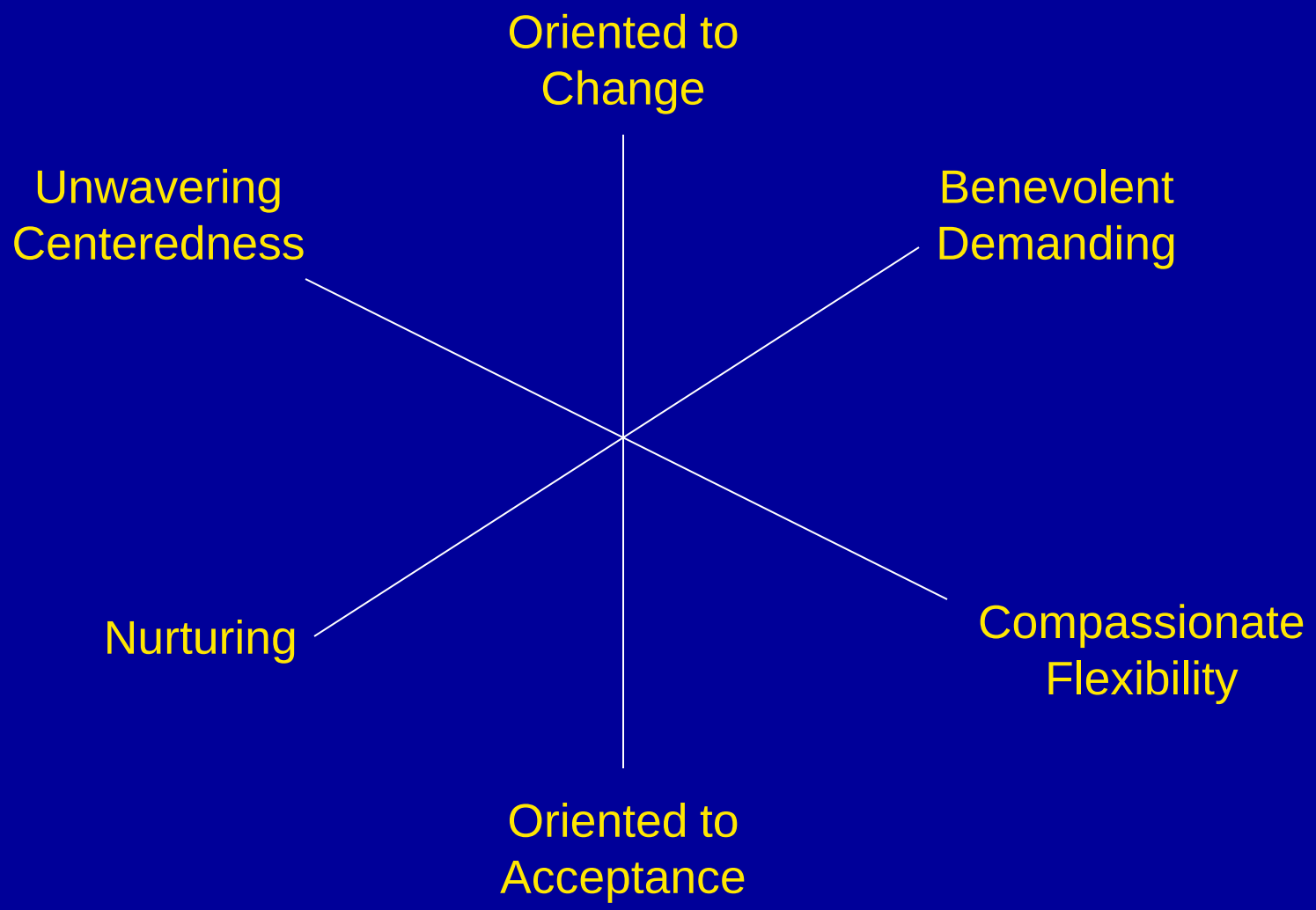
- The main difficulty in this stage is life problems. The target is to ameliorate major life problems.
- The focus flows from problem solving (change) to problem management (accepting problems in a way that minimizes associated difficulties).
- Topics normally revolve around education, employment and relationships.

Stage 4

- The target in this stage is to enhance the capacity for sustained contentment and joy; dealing with the “incompleteness” of human experience.

- When basic problems have been solved, human beings must still struggle with meaning, isolation, intimacy.

Therapist Characteristics in DBT



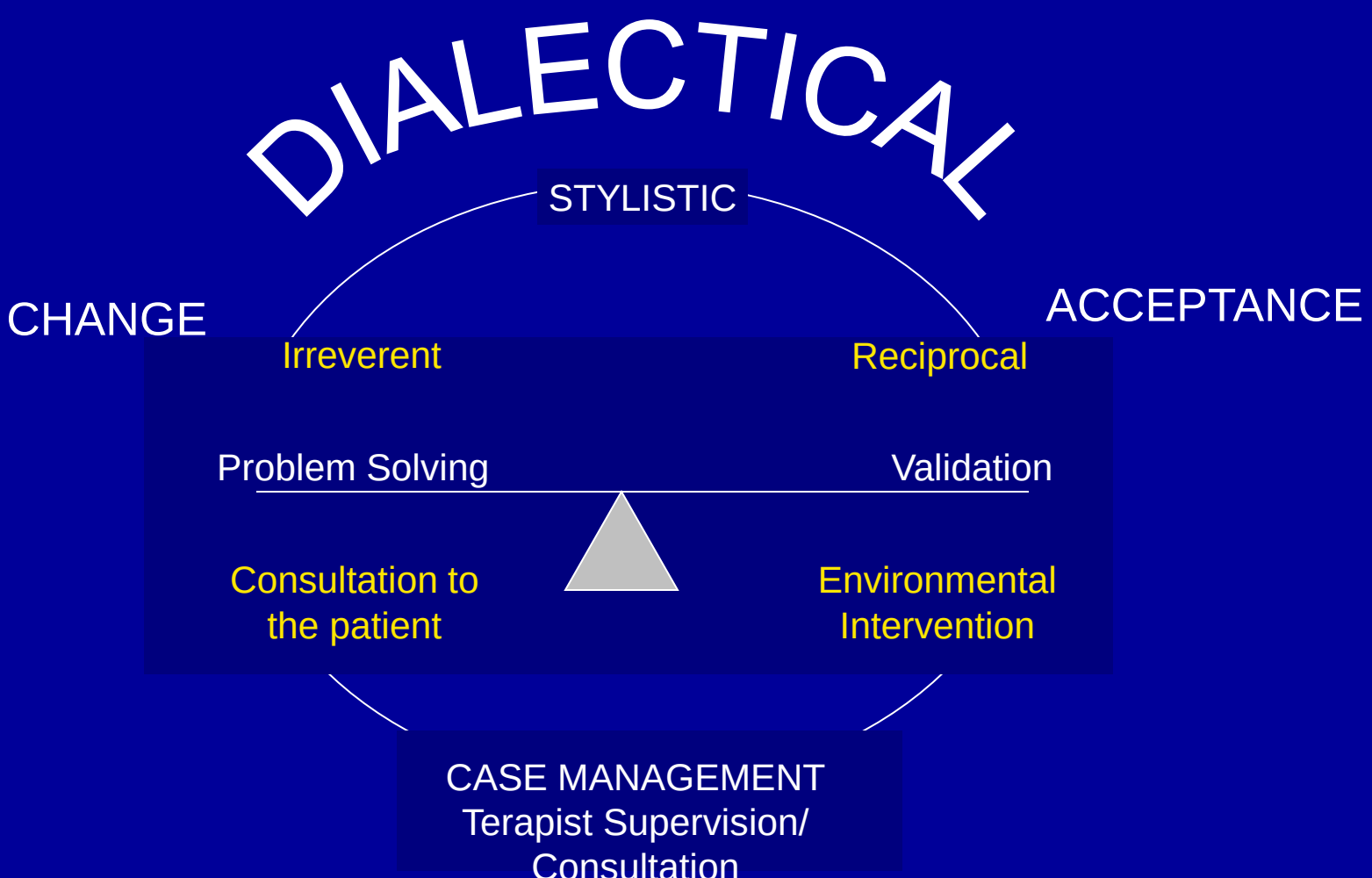
Dialectical Behavior Patterns: Balanced Lifestyle

1. Skill enhancement vs. self-acceptance
2. Problem solving vs. problem acceptance
3. Affect regulation vs. affect tolerance.
4. Self-efficacy vs. help seeking
5. Independence vs. dependence
6. Transparency vs. privacy.
7. Trust vs. suspicion.

Dialectical Behavior Patterns: Balanced Lifestyle

8. Emotional control vs. emotional tolerance.
9. Controlling/changing vs. observing.
10. Attending/watching vs. participating
11. Needing from others vs. giving to others
12. Self-focusing vs. other-focusing
13. Contemplation/meditation vs. action

Treatment Strategies in DBT



Skills Training
Group Therapy

- Mindfulness skills
- Emotion regulation skills
- Distress tolerance skills
- Interpersonal effectiveness skills

Mindfulness Skills

- Training in attention control
- Awareness of self and others
- Reducing emotional reactivity
- Provides a foundation for self-validation, reducing feelings of emptiness and self and cognitive dysregulation

Emotion Regulation Skills

- Ability to identify and label emotions
- Reduction of vulnerability to negative emotion
- Reduction of suffering associated with negative emotion
- Ability to change negative emotion, reducing emotional lability, and problems associated with anger and other negative emotions.

Distress Tolerance Skills

- Counterbalance of impulsivity
- Learning how to inhibit dysfunctional actions (substance abuse, parasuicide)
- Learning to tolerate intense emotional pain and urges to engage in problematic responses (not to exacerbate misery or suffering)

Interpersonal Effectiveness Skills

- Learning how to achieve interpersonal goals.
- Manage relationships effectively
- Maintain self-respect in interpersonal situations.
- Learning the –difficult- balance between situational objectives with relationship objectives while maintaining self-respect.

Basic Treatment Strategies

1. Dialectical Strategies

2. Core Strategies

3. Stylistic Strategies

4. Case Management Strategies

Dialectical Strategies

Two levels of therapeutic behavior:

- Alert to the therapeutic interaction
- Teach and model dialectical behavior patterns out of the therapeutic interaction

Specific Dialectical Strategies

- *Entering the paradox*

  Patient's own behavior, the therapeutic process and reality in general.
- Using metaphors, parables and stories
- The Devil's Advocate Technique
- Extends the seriousness or implications of patient's comunication

Specific Dialectical Strategies II

5. Activating “Wise Mind”
6. Making lemonade out of lemons
7. Allowing natural change in therapy
8. Dialectical Assessment: examining both the individual and the broader social context

Core Strategies

1. Problem-solving strategies

2. Validation strategies

Defining Validation

- The therapist communicates to the patient that her responses make sense and are understandable within her *current* life context or situation
- Validating the patient's history is not the same as validating her current behavior
- Three steps: Active Observing, Reflection, Direct Validation

Emotional Validation Strategies

1. Providing opportunities for emotional expression

2. Teaching emotion observation and labeling skills

3. Reading emotions: timing and offering multiple-choice emotion questions

4. Communicate the validity of emotion

Behavioral Validation Strategies

1. Teaching behavior observation and labeling skills
2. Identifying the “Should”
3. Countering the “Should”
4. Accepting the “Should”
5. Moving to the dissapointment

Cognitive Validation Strategies

1. Eliciting and reflecting thoughts and assumptions
2. Discriminating facts from interpretations
3. Finding the “Kernel of Truth”
4. Acknowledging “Wise Mind”
5. Respecting differing values

Cheerleading Strategies

1. Assuming the best
2. Providing encouragement
3. Focusing on the patient's capabilities

   (a) communicating that the patient has what it takes to succeed,

   (b) expressing belief in the therapeutic relationship,

   (c) validating the patient's emotions, behaviors, thinking

Cheerleading Strategies

1. Contradicting/modulating external criticism
2. Providing praise and reassurance
3. Being realistic, but dealing directly with fears of insincerity
4. Staying near

Levels of Problem Solving

1. The entire DBT program can be seen as a general application of problem solving

2. Figuring out which strategies and procedures should be applied to *this* specific patient, at *this* moment, for *this* problem

3. Addresses specific problems: reviewing diary cards, responding to questions about suicide ideation or parasuicide

Behavioral analysis strategies

1. Defining the problem behavior (describing the problem specifically): frequency, duration, intensity and topography

2. Chain analysis :
   a. Select one instance of problem to analyze;
   b. Attend to small units of behavior in terms of emotions, bodily sensations, thoughts and images, overt behaviors and environmental factors.

3. Generate hypotheses about variables influencing or controlling the behaviors in question: use the previous analysis to guide the current one

Insight (Interpretation) Strategies

5. Highlighting the patient's behavior: the therapist gives the patient feedback about some aspect. In the case of negative behaviors, try to balance highlighting of a patient's strengths with a focus on problematic responses

6. Observing and describing recurrent patterns (thoughts, affective responses, behavioral sequences): look for those relationships that will throw light on causal patterns

Insight (Interpretation) Strategies

1. Commenting on implications of behavior**:** “if - then” rules or relationships of which the patient may not be aware. Be particularly careful about suggesting that consequences are painful or socially unacceptable

2. Assessing difficulties in accepting or rejecting hypotheses**:** recurrent pattern or implication that is not recognized by the patient; the pattern or implication may be recognized, but the patient may have difficulty either acknowledging it to the therapist or accepting its reality

Didactic strategies

1. Providing information about the development, maintenance, and change of behavior in general

2. Giving reading materials about behavior, treatments, BPD

3. Giving information to family members

Solution Analysis Strategies

1. Identifying goals, needs and desires: help to redefine wishes to engage in parasuicidal behavior as expressions of desire to decrease pain and improve quality of life; redefine lack of desire to change or inability to generate goals as an expression of hopelessness and powerlessness

2. Generating solutions: brainstorm; specific coping strategies to shortcircuit impulsive, self-damaging behaviors

Solution Analysis Strategies

1. Evaluating solutions: focus on consequences, short- and long-term; discuss problem solution criteria; identify factors that might interfere with problem solutions

2. Choosing a solution or implementing it: specific DBT procedures (case management, skills training strategies, exposure strategies, cognitive modification strategies, contingency management strategies)

3. Troubleshooting the solution: review the patient's ways in which attempts to solve problem can go wrong

Orienting strategies

1. Providing role induction: therapist orients patient to DBT and to her role in therapy

2. Rehearsing new expectations: therapist rehearses with patient exactly what she is to do in trying to respond to the problem

Commitment Strategies

1. Selling commitment: evaluating the pros and cons
2. Playing the Devil's Advocate
3. "Foot-in-the-door/Door-in-the-face" techniques
4. Connecting present commitments to prior commitments
5. Highlighting freedom to choose and absence of alternatives
6. Using principles of shaping
7. Generating hope: cheerleading
8. Agreeing on homework

Contingency Procedures

- Rationale for contingency procedures
- The distinction between managing contingencies and observing limits
- The therapeutic relationship as contingency

Contingency Management Procedures

- Reinforcing target-relevant adaptive behaviors
- Extinguishing target-relevant maladaptive behaviors
- Using aversive consequences … with care

Observing – Limits Procedures

1. Monitoring limits
2. Being honest about limits
3. Temporarily extending limits when needed
4. Being consistently firm
5. Combining soothing, validating, and problem solving with observing limits

Skills Acquisition Procedures

1. Instructions in skill to be learned: therapist specifies necessary behaviors and their patterning in concrete terms, breaks instructions down into easy-to-follow steps, begins with simple tasks, provides examples and gives handouts

2. Modeling skilled behavior: role-play, therapist uses skilled behavior in interacting with patient, thinks out loud (self-talk), tells stories illustrating skilled behaviors

Skills Strengthening Procedures

1. Behavioral rehearsal: role-play, therapist guides patient in session practice, imaginal (covert) practice and *in vivo* practice

2. Reinforcement of new skills

3. Feedback and coaching

Skills Generalization Procedures

1. Generalization programming: variety of skilled responses to each situation; therapeutic relationship

2. Between-session consultation: apply skills *in vivo*; therapist assist patient in applying skills to problem situations via phone calls

3. Providing session tapes for review: to listen to in-between sessions

Skills Generalization Procedures

4. *In vivo* behavioral rehearsal assignments: therapist gives specific tasks to practice with skills training therapists and skills training therapists gives task to practice with individual therapist (in standard DBT)

- Environmental change: therapist helps patient to create an environment that reinforces skilled behaviors

Exposure-Based Procedures

1. Providing nonreinforced exposure to cues that elicit problematic emotions

2. Blocking action tendencies associated with problem emotions: escape/avoid, hide or withdraw, repair or self-punish, hostile and aggressive responses

Exposure-Based Procedures

3. Blocking expressive tendencies associated with problem emotions: therapist helps patient express converse emotions to those he/she is feeling (therapist differentiates “masking” from expressing a different emotion).

4. Enhancing a sense of control over aversive events

Cognitive Modification Procedures

1. Contingency clarification procedures:

    1. Highlight current contingencies
    2. Communicating future contingencies in therapy

2. Cognitive restructuring procedures:

    1. Teaching cognitive self-observation
    2. Identifying and confronting maladaptive cognitive content and style
    3. Generating alternative, adaptive cognitive content and style
    4. Developing guidelines for when to trust and when to suspect interpretations

Schema-Focused Cognitive Therapy of Borderline Personality Disorder

Based on the developments of J. Young and C.F. Newman at the University of Pennsylvania

Borderline Personality Disorder: Diagnostic criteria. DSM-IV (APA, 1994)

- Frantic efforts to avoid…abandonment.
- Pattern of unstable and intense interpersonal relationships…(idealization and devaluation)
- Identity disturbance…
- Impulsivity in at least two areas that are potentially self-damaging (do not include self-mutilating).
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

BPD Diagnostic Criteria (continued)

- Affective instability…marked reactivity…
- Chronic feelings of emptiness.
- Inappropriate, intense anger.
- Transient, stress-related paranoid or dissociative symptoms.

Early Maladaptive Schemas (Adapted from J. Young, 1999)

- Abandonment.
- Mistrust and abuse.
- Defectiveness/ “Badness”/ Social exclusion.
- Failure / Incompetence.
- Vulnerability to harm.

Early Maladaptive Schemas (Continued)

- Dependence.
- Subjugation / Lack of individuation.
- Emotional deprivation.
- Unrelenting standards.
- Entitlement / Insufficient limits.

Schema Processes

- Schema activation (When the patient's "buttons get pushed." When they "make mountains out of molehills.")
- Schema maintenance (The "self-fulfilling prophecy." When patients keep bringing about their own worst nightmares.)
- Schema avoidance ("Out of sight, out of mind, out of touch." When patients structure their lives so as never to be able to test or disprove their most destructive beliefs.)

Schema Processes (Continued)

- Schema compensation ("The lady doth protest too much". When patients try to solve an extreme problem by going to the opposite extreme, thus causing a new problem without ever solving the old problem.)

- Schema antagonism and vacillation (Cognitive and emotional "gridlock." "Damned if you do, and damned if you don't." When patients hold mutually exclusive schemas simultaneously, or in sequence, thus leading to "roller-coastering."

Key Elements for Case Formulation

- Historical / Developmental
  - Family history of mental disorder, substance abuse, suicide.
  - Family structure, landmarks, secrets.
  - Quality of patient's relationships to parents or caregivers.
  - History of emotional, physical, sexual abuse.
  - Quality of peer relationships before adulthood.

Case formulation (continued)

- Historical / Developmental (cont.)
  - Role of religion in the patient's upbringing.
  - Academic and employment history.
  - Significant romantic relationships and patterns thereof.
  - History of patient's use of alcohol and other drugs.
  - Patient's medical and legal histories.

Case Formulation (cont.)

- Current Life Situation
  - Typical daily activities.
  - Patient's personal strengths.
  - Patient's current mood state.
  - Patient's current level of suicidality.
  - Patient's beliefs about self, others, and future.
  - Environmental factors that maintain dysfunctional patterns and schemas.

Clinical Strategies and Techniques (Overview)

- Establishing, nurturing, and learning from the *therapeutic relationship.*
- *Crisis-intervention* and *limit-setting* strategies.
- *Standard cognitive therapy* self-monitoring and self-help skills.
- *Schema-focused* conceptualization and intervention.

The Therapeutic Relationship (Part 1)

- Acknowledge that therapy is *difficult*, requires *work*, and is not supposed to be *comfortable*.
- At the same time, strive to create a safe haven (free of abuse, rejection, and condemnation).
- Remain calm and cool, even if the patient is not.
- Remember important information about the patients from session to session.
- Give much attention for *wellness*.
- Neither avoid nor push uncomfortable issues.

The Therapeutic Relationship (Part 2)

- Ask for feedback. Be willing to answer questions within reasonable boundaries.
- Be careful giving personal compliments. Rather, give patients positive feedback for their *work in therapy*.
- Use your own reactions as cues to conceptualize.
- Do not make important clinical decisions as a result of feeling coerced or threatened. Feel free to defer a response, and to consult on the matter.

Dealing with Crises and Limit-Setting

- Elevated suicide risk is always the top-priority agenda item for discussion in a session.
- Generate “safe” alternatives to self-harming behaviors (e.g., the “ice cube” method).
- Ask guided discovery questions (i.e. do not rush in with extreme interventions).
- Remain calm, non-defensive, and empathic.
- Make distinctions between “normative life crises” and “schema activation crises.”

Dealing with Crises and Limit-Setting (continued)

- Teach the patients to use problem-solving skills instead of feeling hopeless, helpless, and angry.
- Teach patients the concept of “damage control.”
- Remember that you are not responsible for solving all of the patients’ problems for them, even if they think you are.
- Conceptualize the ways in which the patient’s schemas and behaviors interfere with the process of therapy itself, and suggest new approaches.

Setting Limits (continued)

- Set ground rules early in treatment (regarding phone contacts, missed appointments, behavior in session, etc.)
- Discuss the responsibilities of *both* the therapist *and* the patient in treatment.
- Explain what is and is not proper in a therapeutic relationship, especially if the patient has misconceptions.

Setting Limits (continued)

- Be quick to set limits, but not to end treatment.
- Sessions can be ended on the spot if the patient is impaired and/or if the therapist feels threatened with harm.
- Additional clinicians can be brought in.

Setting Limits (continued)

- Therapeutic Phone Contacts
  - Should be used primarily for *clinical emergencies*, not simply for the patients' full array of concerns.
  - Should not be used routinely in lieu of face-to-face therapy sessions.

Setting Limits (continued)

- Establish “rules of engagement” (e.g., therapist will terminate call if patient is abusive, or will phone for an ambulance if the patient has taken self-harming actions).
- Patients can “earn” phone time via homework (e.g., indicating assignments to be completed before next call).

Setting Limits (continued)

- Therapist Self-Care
  - Consult and document, document and consult!
  - Be a good role-model of self-respect for your BPD patients. Showing self-respect often involves asserting yourself with patients.
  - Do not try to be a “patient pleaser.” Be fair-minded and competent, but do not feel obliged to do as your patient commands.
  - Form professional support groups with colleagues (do not get trapped in shame and secrecy).

Standard Techniques

- Anxiety Reduction
  - Graded exposures to feared situations.
  - Breathing modulation.
  - Relaxation (use caution – some BPD patients feel excessively vulnerable during an induction).
- Problem-Solving
  - Define the problem *non-schematically*.
  - Generate possible solutions *without acting on them impulsively*.
  - Try the best choice, and monitor the results.

Standard Techniques (continued)

- Communication and Listening Skills
  - Patient listens to self on tape.
  - Teach the turning of accusations into requests.
  - Learn to reflect before responding to others.
  - Patients urged to abstain from the use of profanity.
- Rational Re-evaluation Skills
  - Combat all-or-none thinking, tunnel vision, jumping to conclusions, overgeneralizing, and disqualifying the positive.
  - Learn to ask *positive, literal questions* of oneself.

Standard Techniques (continued)

- Continua ratings (to counter all-or-none thinking).
- Activity schedules
  - Increase “mastery” activities.
  - Learn “self-soothing,” instead of self-harming.
  - “Create more, consume less.”
  - Plan activities proactively, and monitor the results.

Standard Techniques (continued)

- Behavioral experiments (to test beliefs, and to build new skills in everyday life, where it matters most).

- Homework
  - Supports the patient's *non*-dependence on therapist.
  - Provides valuable practice of self-help skills.

Major Targets for Standard Interventions

- Excessive Expectations of Others
  - Help patients to articulate and modify their *expectations* of themselves, others, and therapy.
  - Teach the principles of interpersonal *reciprocity*.
  - Examine the patients' history of feeling denied their "just due" from others.
  - Examine the patients' history of being over-indulged by others.

Major Targets for Standard Interventions (cont.)

- Empathy Training
  - Ask the patients about what *other* people in their lives may be feeling or thinking.
  - Give tactful feedback about how *you* feel in response to the patient's behaviors.
  - Study the pros and cons of caring about how others feel, and recognizing such feelings.
  - Look at the drawbacks of *assuming* how others feel, or what others want.

Major Targets for Standard Interventions (cont.)

- Self-Correction Skills
  - Teach self-monitoring skills, and assign such tasks for homework as soon as possible.
  - Examine the patient's past for clues about how *not* to repeat painful mistakes.
  - Appeal to the patient's "creativity" to discover new ways to solve old problems.
  - Use frustration as a "cue" to try something *different*, not the same thing even more!

Major Targets for Standard Interventions (cont.)

- Interpersonal Limits and Boundaries
  - Be a good role model for your patients.
  - Emphasize the importance of personal space and privacy for the patients *and for others*.
  - Examine the patients' history of having *their* personal boundaries violated, and what this teaches them about how to *steer clear* of unhealthy attachments.

Major Targets for Standard Interventions (continued).

- Extreme Opinions of Self and Others
  - Encourage patients *not* to use labels (e.g., “loser”)
  - Examine and modify the “saint-demon” dichotomy.
  - Learn to accept imperfections in self and others.
  - In evaluating self and others, look at the *evidence*, not just an immediate impression.

Modulation of Emotionality

- The therapist serves as a role model by acting gracefully and calmly.
- Help the patient to speak at a normal pace, with moderate volume, and while making appropriate eye contact.
- Teach patients to notice and to document their thoughts and behaviors that accompany their most extreme feelings.

Modulation of Emotionality (cont.)

- Instruct patients to *rate* the levels of their emotions on a scale, or a continuum, so that they do not view their emotions as “all or none.”
- Teach patients to breath slowly, steadily, and in the manner of a gentle wave; this will help moderate excessive sympathetic nervous system activity.

Modulation of Emotionality (cont.)

- Validate the patient's emotional experiences, while still testing the schemas and thoughts that are behind these emotions.
- Teach patients how to resist *acting impulsively* on their emotions.
- Help the patients to generate and utilize pleasant imagery.
- Evoke specific, pleasant memories.

When Patients Avoid Treatment

- Dealing with Patients Who Cannot or Will Not Discuss Issues in Session
  - Express respect for the patient's boundaries (i.e., do not force the discussion).
  - Gently explain your clinical rational for trying to discuss the issue in question.
  - Carefully ask the patients for their reasons for being averse to talking about the topic.

When Patients Avoid Treatment

- Dealing with Patients Who Cannot or Will Not Discuss Issues in Session (cont.)
  - Try to ask non-threatening questions.
  - Engage the patient in an exploration of the pros and cons of discussing difficult topics in therapy.
  - Ask for permission to return to the topic at a later time or date, if necessary.

Problems with Homework

- Homework assignments may activate the BPD patients' *incompetence* and/or *dependence* schemas, and thus they will feel overwhelmed and incapable.
- Homework assignments may activate the BPD patients' *subjugation* schema, and thus they may resent being "controlled" by the therapist.

Problems with Homework (cont.)

- Homework may activate the BPD patients' *emotional deprivation* schema, in that they may view self-help exercises as a poor substitute for the care, concern, and attention of the therapist.
- Homework may activate the BPD patients' *entitlement* schema ("I shouldn't have to do this").
- Homework may activate the BPD patients' schema of *badness* or *defectiveness*, and they may expect the therapist to judge or reject them.

Schema-Focused Techniques

- Teach patients to identify schemas and their processes (e.g., “My abandonment schema was just activated!”). Create and test alternatives.
- Utilize role-plays to re-enact, practice, or plan important interpersonal interactions, including those that represent *hope*.
- Imagery reconstruction (for empowerment).
- Use sensory experiences that evoke schemas, or that produce feelings *against* schemas.

Schema-Focused Techniques

- Identification of Schemas
  - Patients are taught that if they experience extreme emotions, or dissociative symptoms, they are to hypothesize the schema that has been activated.
  - Patients are taught to explain their schema-activation to loved ones who may otherwise be frightened or angered by the BPD patient's behavior.
  - Patients are instructed to apply a number of self-help skills to reduce the effects of the schema activation.

Schema-Focused Techniques

- Creating Alternatives to the Schemas (1)
  - Design behavioral experiments that require the patient to act in ways that are inconsistent with the schema.
  - Discover and write down experiences from the patient's life that are inconsistent with the schema.
  - Identify and pursue goals that are inconsistent with the schema.

Schema-Focused Techniques

- Creating Alternatives to the Schemas (2)
  - Identify situations in which the schema is activated. Think of new ways to perceive the situation that are inconsistent with the schema.
  - Change from “all-or-none” thinking style that is characteristic of the schema and discuss the *degree* to which the patient believes or feels something.

Schema-Focused Techniques

- Role-play situations that typically evoke schemas
  - Helps patients to learn interpersonal skills.
  - Enables the patient and therapist to “re-enact” significant interpersonal interactions from the BPD patient’s life.
  - Helps the patient to arrive at a better understanding of the reactions of other people.
  - Brings “hot cognitions” into the therapy session for evaluation and change.

Schema-Focused Techniques

- Role-Play Methods (Part 1)
  - The therapist takes the role of the patient.
    - Models new responses for the patient to copy.
    - Demonstrates comprehension and empathy about the patient.
  - The patient takes his or her own role.
    - To act “as if” he or she does not have the schema.
    - To practice interpersonal skills with no risk of rejection or negative judgment from the therapist.

Schema-Focused Techniques

- Role-Play Methods (Part 2)
  - The patient reads from a script that the therapist prepares (“healthy,” confident dialogue).
  - The patients write their own script and recite from it (information to fight against the schemas).
  - Therapist gives feedback to the patient.
  - Therapist addresses patient’s “hot cognitions.”

Schema-Focused Techniques

- Use multiple sensory experiences
  - Imagery (for example, of “safe” places, or of a happier future).
  - Tactile experiences (for example, a comfortable blanket, a warm bath).
  - Pleasant sounds (for example, soothing music, “nature sounds”).
  - Taste and smell (for example, comforting foods, fragrances).

Schema-Focused Techniques

- Imagery Reconstruction (Part 1)
  - For the purpose of changing the way that the BPD patient cognitively and emotionally processes the memory of painful memories.
  - Also for the purpose of *empowering* the BPD patient.
  - This technique does *not* attempt to “recover lost memories.”

Schema-Focused Techniques

- Imagery Reconstruction (Part 2)
  - Identify the schema (for example, *mistrust*, *unlovability*, *abandonment*, etc.)
  - Construct a hypothesis about the etiology.
    - Review important developmental/historical events.
    - Identify painful and traumatic memories.
    - Establish their relationship to current difficulties.
    - Establish their relationship to the schema.

Schema-Focused Techniques

- Imagery Reconstruction (Part 3)
  - Choose a specific, traumatic memory.
  - The patient describes the memory in detail.
  - The patient explores his or her thoughts and feelings *in the memory*.
  - Therapist helps the patient to think of new ways to view the memory, so as to reduce shame, blame, stigma, and schema activation.

Schema-Focused Techniques

- Imagery Reconstruction (Part 4)
  - Relaxation induction.
    - Pleasant, “safe” images.
    - Count backward from 10 to 1, slowly.
    - Slow, wavelike breathing.
  - Guide the patient to remember the traumatic memory, but in a very relaxed state, with eyes closed.
  - Prepare to “experience” the memory again.

Schema-Focused Techniques

- Imagery Reconstruction (Part 5)
  - Goals:
    - Conceptualize the traumatic memory with less shame, blame, and stigma.
    - Modify the schema associated with the trauma.
  - Methods:
    - Patients describes the images and events of the memory with great detail, assisted by the therapist's questions and encouragement.

Schema-Focused Techniques

- Imagery Reconstruction (Part 6)
  - In the image/memory:
    - What is the child (patient) thinking and feeling?
    - How does the child make sense of what is happening?
    - What are the negative consequences for the patient, as a child (in the memory) and as an adult in the present?
    - What does the child believe about others and self?

Schema-Focused Techniques

- Imagery Reconstruction (Part 7)
  - In the image/memory:
    - What effect does the traumatic event have on the patient's ability to feel loved, safe, competent, and healthy?
    - What are the schemas that correspond with this image/memory?
    - What are the rational responses that can be used against these schemas?

Schema-Focused Techniques

- Imagery Reconstruction (Part 8)
  - In the *new, guided*, image.
    - Introduce a “hero” who will help the child.
    - The “hero” can be anyone the child trusts and loves.
    - The “hero” can be…
      - The patient’s healthy self.
      - The abuser’s healthy counterpart.
      - A deceased loved one.
      - Anyone who represents care and nurturing.

Schema-Focused Techniques

- Imagery Reconstruction (Part 9)
  - As a result of the new, guided imagery:
    - What does the patient *now* believe about the traumatic memory?
    - What rational responses can the patient now give against the schema?
    - What has the patient learned about others and the self?
    - How much does the patient believe the new rational responses?