The Beginning Psychotherapist and Borderline Personality Disorder: Basic Treatment Principles and Clinical Foci

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Borderline personality disorder is a prevalent psychopathology; thus, most graduate students in psychology, residents in psychiatry, and early career clinicians will encounter patients with this disorder in the course of their training or initial professional practice. This paper provides clear and concise guidelines for conducting treatment geared toward the clinician's developmental level. It builds upon the knowledge and skills that are typically acquired during graduate education and training to provide an accessible framework for undertaking psychotherapy with patients who have borderline personality disorder. This paper draws upon common psychotherapeutic factors and existing evidence-based treatments for the disorder to identify principals and interventions that are likely to contribute to therapeutic action. It uses behavioral, cognitive, and psychodynamic interventions to address the patient's multidimensional psychopathology. This approach offers a coherent and integrated treatment framework for the beginning psychotherapy practitioner.

KEYWORDS: borderline personality disorder; borderline; psychotherapy; integration; common factors

INTRODUCTION

Borderline personality disorder (BPD) appears to be a prevalent diagnosis within health care and other treatment settings in the United States. Research indicates that nearly 6% of primary care patients (Gross et al., 2002), 9% to 22% of psychiatric outpatients (Korzekwa, Dell, Links, Thabane, & Webb, 2008; Zimmerman, Rothschild, & Chelminski, 2005), and 31% to 43% of psychiatric inpatients (Grilo et al., 1998; Leontieva & Gregory, 2013) may suffer from the disorder. It seems particularly widespread in prison populations; in one study (Black et al., 2007), nearly 30%

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of male offenders and 60% of female offenders met diagnostic criteria for BPD.

Given BPD's prevalence, most beginning psychotherapists will likely encounter patients with the disorder during their training or initial professional practice. The beginning psychotherapist is defined as: currently in training; recently graduated; or newly licensed for independent practice. Thus, this paper applies to graduate psychology students on practicum or internship, psychiatry residents, postdoctoral fellows, and early-career mental health clinicians.

Beginning psychotherapists who lack experience with patients who have BPD will find the present paper particularly relevant. In clinical programs, tension often exists between providing a broad education and more specialized instruction (Bell, 2009; Roberts, 2006). Beginning psychotherapists may be familiar with psychopathology and psychotherapy fundamentals, although they might not receive specific training for BPD. While this paper is no substitute for such training, it can serve as a preliminary resource by providing information to supplement the beginning psychotherapist's knowledge base and skill set. Given that competent and ethical treatment of personality disorders requires appropriate education, training, and supervision (Magnavita, Levy, Critchfield, & Lebow, 2010), this paper can play an integral role in preparing the beginning psychotherapist to work with BPD patients.

The BPD literature is geared toward experienced psychotherapists. A global approach ignores the beginning psychotherapist's developmental needs, even when intended for different levels of experience or described as appropriate for novice and experienced clinicians. Cambanis (2012) captured the current situation for a trainee working with a patient who has BPD: She struggled to find resources appropriate for her level of training and found the existing literature difficult to implement.

Beginning clinicians need clear and concise guidelines for organizing and conducting treatment with a patient who has BPD. This paper builds upon the typical graduate student's knowledge and skills and provides an accessible framework for doing psychotherapy with BPD patients. This paper also has an integrative focus. I present a framework that draws upon common psychotherapeutic factors and evidence-based BPD treatments to identify principles and interventions that likely contribute to therapeutic action. Behavioral, cognitive, and psychodynamic interventions are used to address the BPD patient's multidimensional psychopathology. Overall, this approach offers an integrated and coherent treatment framework.

Initial challenges for the beginning psychotherapist include making an accurate diagnosis and identifying a case suitable for treatment. Diverse and complex symptoms can make diagnosing BPD difficult. Furthermore, comorbidity research (Grant et al., 2008; Skodol et al., 2002; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2004) consistently finds that patients with BPD often present with mood symptoms, trauma, substance use, and/or eating disturbances. The prominence of these symptoms and behaviors often leads to misdiagnoses (Ruggero, Zimmerman, Chelminski, & Young, 2010). A practical solution is to use a structured or semistructured diagnostic interview (First, Gibbon, Spitzer, Williams, & Benjamin, 1997; Loranger, Sartorius, Andreoli, & Berger, 1994). These instruments require clinicians to ask certain dysfunction-specific questions to assess for personality disorders, which increases the likelihood of identifying BPD (Ryder, Costa, & Bagby, 2007).

Next, assessing the disorder's severity guides beginning clinicians in selecting a case appropriate for their skill level. In addition to the diagnostic interview, a self-report measure (Millon, 2009) may help determine symptom severity and degree of impairment. Severe cases should be referred to a psychotherapist more experienced with BPD or a specialized BPD treatment. The beginning clinician also needs to be alert to various behavioral contraindications, including frequent hospitalizations, active substance use, eating disorders, frequent legal entanglements, and antisocial features. Patients with these markers will likely place additional burdens on the beginning psychotherapist and should be referred to more experienced therapists (Arntz & van Genderen, 2009; Yeomans, Clarkin, & Kernberg, 2002).

Evidence-based BPD treatments emphasize the importance of supervision or consultation with a more experienced clinician. For trainees, supervision is mandatory. For the newly licensed clinician, a supervision group or ongoing consultation is immensely helpful. Given the intensity, pressure, and confusion that can emerge when working with BPD patients, supervision provides valuable external support and guidance. The beginning psychotherapist needs instruction, validation, and timely feedback (Fazio-Griffith & Curry, 2009). A supervisor helps the clinician process the raw experiences that occur, provides recommendations for interventions, and fosters advanced clinical skills. An effective supervisor possesses the necessary knowledge and experience to treat BPD and sufficient supervisory skills, such as being appropriately didactic, supportive, containing, and directive (Fazio-Griffith & Curry, 2009).

AN ACCESSIBLE, INTEGRATED, AND COHERENT TREATMENT FRAMEWORK

Patients with BPD can be difficult to treat. Although dropout rates vary in clinical trials, with lows of 10% to more typical rates of 25% to 36%, they can reach 50% (Cottraux et al., 2009; Giesen-Bloo et al., 2006). If psychotherapists trained in treating BPD struggle, what hope can there be for the beginning clinician? While a trainee or newly independent practitioner may not perform at the level of a more experienced clinician, I argue that beginning psychotherapists can effectively treat an individual with moderately severe BPD by focusing on common psychotherapeutic factors and using interventions drawn from evidence-based BPD treatments under appropriate supervision. Deranja, Manring, & Gregory (2012) found that psychiatry residents trained using a manualized BPD treatment compared favorably to expert practitioners on measures of treatment adherence and patient outcome. When psychology trainees (Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012), postdoctoral fellows (Clarkin et al., 2001), and psychiatry residents (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Goldman & Gregory, 2010) participated as psychotherapists in randomized controlled trials for BPD treatments, the results suggest that they can provide effective therapy when instructed in BPD and supervised by BPD-knowledgeable clinicians.

This paper presents a treatment framework rooted in empirical and clinical knowledge about general psychotherapy outcomes and BPD treatment outcomes. Research typically indicates common factors are associated with positive outcomes across many diagnoses (Beutler, Forrester, Holt, & Stein, 2013; Norcross & Wampold, 2011). Common factors refer to components that are likely present in most treatments, such as the therapeutic alliance and a therapist's attributes. When treating a personality disorder, however, common factors need to be supplemented with specific factors to address unique features of the disorder (Critchfield & Benjamin, 2006). Specific factors refer to components that supposedly characterize particular psychotherapies, such as contingency management or transference interpretations.

Currently, a number of treatments are more effective for BPD patients than generic forms of psychotherapy, including dialectical behavior therapy (Koerner, 2012), mentalization-based treatment (Bateman & Fonagy, 2006), transference-focused psychotherapy (Yeomans et al., 2002), and schema-focused therapy (Arntz & van Genderen, 2009). This suggests that while common factors may be necessary components to any effective

treatment, they are insufficient for addressing a BPD patient's psychopathology. Yet most BPD treatment studies indicate only whether or not an entire treatment package is effective. Research identifying specific mutative components is scarce, although Goldman & Gregory (2010) found certain interventions were effective for various BPD symptoms. Thus, this paper draws upon empirically grounded factors that are common to most psychotherapies, as well as more specific factors from evidence-based BPD treatments that are logically and clinically likely to be effective in addressing a BPD patient's psychopathology.

Treatment Principles

In this section, I identify principles for organizing and conducting psychotherapy with a BPD patient. These principles build upon generic common factors (Norcross & Wampold, 2011) and incorporate relevant BPD treatment factors (Arntz & van Genderen, 2009; Bateman & Fonagy, 2006; Goldman & Gregory, 2010; Koerner, 2012; Yeomans et al., 2002) to create a structured, consistent, coherent treatment that may promote the therapeutic alliance, facilitate change, and reduce the likelihood of negative outcomes.

Create and Maintain Boundaries

Lack of structure is one of the best predictors of a negative outcome with any patient (Mohl, 1995). A well-structured treatment seems particularly important for patients with BPD, given their often chaotic lives. Without structure, clinical evidence suggests that BPD psychopathology can overwhelm a treatment (Bateman & Fonagy, 2006; Koerner, 2012; Yeomans et al., 2002). Creating and maintaining the therapeutic frame is an excellent way to structure a treatment. Doing so establishes the treatment boundaries and defines responsibilities for both psychotherapist and patient.

Creating the frame orients the patient to the treatment though making basic arrangements and agreements regarding scheduling the day, time, length, and frequency of sessions, fee, appropriate payment methods, vacations, and cancellations. It also includes attaining informed consent and identifying the limits of confidentiality. Clinicians who are psychology graduate students or psychiatry residents should explain their training status and that their work is supervised by a licensed clinician. The potential duration of treatment should also be explained clearly (e.g., "You and I will have until next June to work together"). The patient with BPD also needs clear guidelines about contacting the therapist outside of sessions, including what qualifies as a crisis and what to do if in one; this

may include providing the patient specific methods to tolerate distress (Koerner, 2012) when the therapist is unavailable.

After establishing boundaries, the therapist maintains them by addressing departures from the agreed upon framework (e.g., non-payment, recurrent tardiness or cancellations, frequent phone calls between sessions). Maintaining the frame is an important responsibility, requiring a firm and consistent, yet flexible, approach (Bateman & Fonagy, 2006; Yeomans et al., 2002). Compromises may be negotiated when circumstances change or if there is a clinical indication to do so. While altering the frame is a collaborative process, the therapist retains final say and conveys expectations of compliance.

Some BPD treatments employ a written contract to delineate boundaries and responsibilities (Koerner, 2012; Yeomans et al., 2002). While there is some evidence that contracts are effective in building a therapeutic alliance and reducing dropouts (Yeomans et al., 1994), other BPD treatments do not use contracts (Bateman & Fonagy, 2006). According to Bateman & Fonagy (2006), "fluctuating mentalizing capacity means that a patient who agrees to a contract at one point may not actually have the same competence in a different context or have access to his state of mind when he agreed to the contract" (p. 48). Furthermore, they argue that a contract can be used, unintentionally, to punitively rein in the patient's emotional dysregulation and behavioral impulsivity (Bateman & Fonagy, 2006). For trainees, the decision whether to use a contract should be discussed thoroughly with a supervisor. For newly licensed therapists, consulting with a BPD-experienced clinician may provide valuable guidance for how best to proceed on any particular case.

Be a "Good Enough" Therapist

A psychotherapist's attributes and attitudes are considered important common factors (Norcross & Wampold, 2011). Evidence indicates that a therapist's abilities to be genuine (Kolden, Klein, Wang, & Austin, 2011), express empathy (Elliott, Bohart, Watson, & Greenberg, 2011), and provide positive regard (Farber & Doolin, 2011) contribute to positive outcomes. Gunderson (2008) suggested that successful work with patients who have BPD requires additional attributes and attitudes, including optimism, adaptability, composure, and perseverance; alternatively, passivity, depression, frustration, anxiety, and rigidity likely contribute to negative outcomes.

Beginning psychotherapists typically lack confidence, are self-critical, and worry about doing the "right" thing (Hill, Sullivan, Knox, &

Schlosser, 2007). An effective antidote may be Winnicott's (1953) "good enough" caregiver concept. From observing infants we know that 70% of caregiver-infant interactions lack synchrony (Tronick, 2007). Mismatches occur when a caregiver misreads or misunderstands the infant's emotional or behavioral signals, when signals are understood but response is delayed, or when goals differ. Mismatches are "normal, typical, and inherent to an interaction" (Tronick, 2007, p. 159). Winnicott recognized that a caregiver cannot attend perfectly to an infant; rather, a "good enough" caregiver is reasonably attuned and attempts to resolve mismatches in a timely manner. Problems emerge from persistent and pervasive failures to recognize and resolve mismatches (Tronick, 2007).

Applying this concept to psychotherapy, beginning clinicians strive to be "good enough" rather than perfect. They acknowledge limits to their knowledge and skills, learn from mistakes, cope with uncertainty, and accept human foibles. They demonstrate commitment to their responsibilities in a reliable and mature manner. They recognize it is impossible to be available or empathic all the time and certain realities (e.g., vacations, illnesses) may frustrate a BPD patient. They are reasonably attuned and endeavor to address mismatches. By doing these things, a therapist's attributes and attitudes likely capture those of the "good enough" caregiver (Arntz & van Genderen, 2009).

Balance Acceptance and Change

Psychotherapists face an unavoidable paradox: They must immerse themselves in the moment to empathize with patients and emotionally distance themselves to maintain boundaries or offer perspectives to foster change (Bateman & Fonagy, 2006). Philosophically, therapists strive to adopt a dialectical stance in which they simultaneously accept the patient while facilitating change in the patient (Koerner, 2012). From a practical standpoint this means switching between validation and change during a session, often in the same intervention, and flexibly navigating this contradiction (Koerner, 2012).

Validation means acknowledging and understanding the patient's experience. The therapist listens attentively, accurately reflects what the patient says, then communicates understanding in an empathic way. Koerner (2012) stated that "active, disciplined, precise validation is required to motivate emotion regulation and create conditions for other change" (p. 112). Validation appears to reduce physiological and psychological arousal in the patient and is believed to promote more adaptive responses (Shenk & Fruzetti, 2011).

Finding validity in every thought, feeling, or behavior of a patient who has BPD can be challenging. When difficulty arises, therapists should consider how the patient's experience fits his or her psychology and circumstances. Even when a patient's thoughts are irrational or behaviors are maladaptive, it typically means that he or she is making a best effort to deal with a demanding situation. The paradoxical task is to validate the patient's experience without accepting maladaptive components. Koerner's's (2012) recommendation: "Validate the valid; invalidate the invalid" (p. 121). This requires both sensitivity and directness; the therapist reflects, describes what makes sense and what does not, and then invites the patient to consider alternatives. For example, a patient argued with her boyfriend, became enraged when he insulted her, and chased him from their apartment with a baseball bat. The therapist reflects, then seeks to validate the patient's experience while invalidating her behavior: "It makes sense you felt angry after he called you a 'lazy bitch.' I imagine part of you wanted to hurt him because he hurt you, and that makes sense too. I'm not sure attacking him with a baseball bat was a good idea. I wonder if you and I can consider other ways of coping when you're angry and feel like hurting someone after they've hurt you."

Interventions that validate the BPD patient's experience are believed to contribute to a successful outcome (Bateman & Fonagy, 2006; Koerner, 2012). Yet validation can also lead to alliance ruptures (Prunetti et al., 2008). Validation typically brings therapist and patient closer, and while the patient may initially like this, it can also evoke considerable anxiety. For example, a patient was distraught over her dog's recent death and the therapist validated her feelings. At the session's end, the patient thanked the therapist for acknowledging her feelings, as friends and family told her to "get over it already." In the next session, the patient announces that the therapy is not working and this is her last session. While a method for dealing with ruptures is covered subsequently, the therapist recognizes that his validation in the previous session probably triggered an alliance rupture. The clinician identifies and describes the dilemma, and predicts its onset whenever the patient feels close to the therapist. Such a prediction may normalize the reaction and might help to prevent it (Appelbaum, 2006).

Change involves both addressing the patient's typical ways of dealing with problems and then teaching effective coping methods and problem-solving skills. While the patient's usual ways can provide relief, they are invariably maladaptive and the therapist must persistently address the

patient's behaviors when they cause problems. The therapist focuses on the behavior's consequences rather than the patient's motivations, and tactfully identifies unpleasant, incongruent, or self-defeating aspects. The next step involves generating more adaptive coping methods or new solutions to problems.

For example, a patient who is chronically passive wants a new job but does nothing to pursue one. In session, she repeatedly talks about her current job's long hours and low pay.

> Therapist: It doesn't sound like a very good place to work.
> Patient: It's the worst.
> Therapist: You're stuck in a place you don't want to be.
> Patient: I don't have any time to do anything about it. After work I'm exhausted and on weekends I just want to relax.
> Therapist: Looking for a new job feels like a big project to tackle.
> Patient: It makes me tired just thinking about it.
> Therapist: Let's break it down into components, which may make it feel more manageable.
> Patient: Maybe you could update my résumé!
> Therapist: Well, I can help you think about how to break the task down into manageable pieces. We can also discuss those things that may interfere with doing it. If you want a new job, then you'll have to make some effort.

In this example, the therapist constructively addresses the patient's inertia after frequent job-related complaints and then focuses on the results of her passivity, particularly the unpleasant and self-defeating aspects. The therapist validates the difficulty involved and then proposes an adaptive skill that may promote change. Finally, the therapist indicates that while he is willing to help, he alone cannot make the patient better; she must take some responsibility (Yeomans et al, 2002).

Interventions that facilitate change are important components of an effective treatment (Arntz & van Genderen, 2009; Koerner, 2012). Both therapist and patient need to temper expectations concerning the nature and pace of change, as it occurs gradually and incrementally. Clinical evidence suggests that while some symptoms may recede within six months, it may take more than a year for sustained change (Bateman & Fonagy, 2006; Yeomans et al, 2002). Furthermore, change typically requires interventions the patient experiences as invalidating, which can lead to an alliance rupture. Thus, therapists may hesitate to pursue change for fear of a patient's reaction. Similar to negative reactions to validation, the

therapist recognizes that facilitating change is part of therapy and addresses any rupture.

Manage Countertransference

While many psychological disorders can generate strong feelings in a clinician, few stir such intense reactions as BPD. Patients with BPD are also often viewed as difficult (Cleary, Siegfried, & Walter, 2002) and provocative (Brody & Farber, 1996) when compared to patients with other diagnoses. In a survey of clinical psychologists, a patient with BPD features was ranked the least desirable to treat when compared to someone with depression or schizophrenia (Servais & Saunders, 2007). These attitudes towards patients with BPD probably impact their care. Private-practice clinicians may be reluctant to treat them and some evidence shows that public-practice clinicians limit services and decrease expressions of empathy for BPD patients (Markham, 2003).

Patients with BPD typically evoke intense reactions within the therapist that can be difficult to manage. When the patient is distressed, the therapist often feels helpless, guilty, and pulled to rescue. When the patient is belligerent, the therapist often feels incompetent, angry, and pulled to retaliate. Patients who have BPD exhibit an uncanny ability to identify a therapist's personal and professional vulnerabilities. Gabbard & Wilkinson (1994) argued that even experienced clinicians get caught in countertransference enactments. Comments about the beginning therapist's experience, training status, and competence should be expected, as should appeals for more time after a session ends, physical contact, extra-clinical contact, and special privileges. Therapists may react in ways that are critical, collusive, hostile, passive-aggressive, seductive, symbiotic, rigid, rejecting, or blaming (Gabbard & Wilkinson, 1994). Such reactions are associated with poor outcome (Binder & Strupp, 1997; Lambert & Barley, 2002).

Effective countertransference management enhances treatment and promotes better outcomes (Hayes, Gelso, & Hummel, 2011). Certain skills facilitate dealing with countertransference reactions, including self-insight and an ability to delay internal reactions (Hayes et al., 2011). Self-insight means awareness of one's own issues and conflicts and how they may influence treatment. Every patient affects a therapist in ways based on the therapist's own psychology. For example, one therapist dreaded meeting with her new BPD patient and "listening to him play the victim and rant for 50 minutes." During the first few months of treatment, the therapist began several sessions late; despite

always having an explanation for her tardiness, the behavior did not occur with other patients. The therapist began to consider her countertransference feeling of dread relative to her tardiness. Upon reflection during her own psychotherapy and supervision, she realized the patient's sense of victimhood and grievance triggered some of her own issues. This insight promoted greater empathy for the patient and decreased the therapist's tardiness.

Therapists strive to postpone their own reactivity (Koerner, 2012; Yeomans et al., 2002). The ability to delay reacting immediately is rooted in the concepts of "holding" (Winnicott, 1945) and "containing" (Bion, 1962). "As therapists, we want to be as aware as we can be so that we harness our responses to the patient's benefit rather than simply responding to alleviate our own discomfort" (Koerner, 2012, p. 108). Sometimes this means taking a patient's invective without retaliating or not hugging a patient, despite pleas after a difficult session. This does not mean the therapist is passive, masochistic, emotionally withdrawn, or provides "unconditional" love (Gabbard & Wilkinson, 1994). The therapist maintains boundaries, reflects, validates, and clarifies until he or she is emotionally centered and the patient is in a better psychological space to handle what is occurring, which may be in a subsequent session. While showing restraint may feel ineffective to the patient, who wants the therapist to *do* something, it shows the patient that someone can manage the intense feelings that he or she finds intolerable. The patient needs to experience the therapist repeatedly over time as an emotionally stable presence capable of containing the patient's feelings, maintaining boundaries, and modeling adaptive behaviors.

A particular challenge with BPD is managing countertransference to patients' self-injurious behaviors and suicidality. Such behaviors and threats often evoke fear, despair, hatred, helplessness, and resentment. Gabbard & Wilkinson (1994) argued that therapists typically react by becoming either over-involved to "save" the patient or under involved to emotionally distance themselves. Both reactions originate in the therapist's countertransference and may detrimentally affect the treatment; the antidotes remain self-insight and self-restraint. As best as possible, therapists need to identify, understand, and process their own specific reactions before acting on them. While certain situations involving self-injury and suicidality may require greater therapist involvement, which will be addressed in a subsequent section, it should proceed from what is clinically

indicated for the patient rather than what alleviates the therapist's discomfort.

Repair Alliance Ruptures

A breakdown in collaboration between therapist and patient is called a rupture in the therapeutic alliance. BPD patients are prone to intense fears over perceived dangers and will take defensive action to restore a sense of safety, which typically leads to an alliance rupture. While ruptures with BPD patients are often dramatic and unpleasant, they can also manifest as decreased involvement (e.g. frequent tardiness or missed sessions). Whether the phenomenon is called "splitting" (Yeomans et al., 2002), "polarization" (Koerner, 2012), or "schema flipping" (Arntz & van Genderen, 2009), ruptures can occur with a speed and intensity that leave the therapist startled, confused, and frightened. Ruptures may seem to come "out of the blue" but typically occur around the therapist's physical absences, or failures in empathy or attunement. Regardless of the precipitating event, the therapist tries to repair a rupture.

The extent to which ruptures are sufficiently addressed can predict treatment outcome (Horvath & Symonds, 1991; Horvath, Del Re, Flückiger, & Symonds, 2011; Safran, Muran, & Eubanks-Carter, 2011). The quality of the alliance is also strongly related to symptom reduction and reduced alcohol use in patients with BPD (Goldman & Gregory, 2010). Empirically supported therapeutic practices can provide an effective method for managing ruptures (Safran et al., 2011). First, the therapist draws attention to a rupture if the patient has not already done so. While patients who have BPD often can communicate negative feelings about the therapist or the treatment, therapists still must be "attuned to subtle indications of ruptures in the relationship and take the initiative in exploring what is transpiring in the relationship when they suspect that a rupture has occurred" (Safran et al., 2011, p. 86). Next, the therapist validates and discusses thoroughly the patient's experience of the rupture. It is helpful for patients to share their thoughts and feelings and the therapist's ability to listen attentively and delay immediate reactions facilitates the process. If the therapist somehow contributed to the rupture, this is acknowledged and validated. Finally, the therapist explores possible reasons for the rupture's timing. This can establish a connection between the rupture and possible underlying dynamics.

For example, a patient talks excitedly about an impending trip. About fifteen minutes before the session ends, the outer door to the therapist's suite is heard opening. The therapist looks at his watch. The patient's

enthusiasm dissipates abruptly and settles into a sulky silence. The therapist notices the change in demeanor:

> Therapist: What just happened a moment ago? You seemed excited to tell me about the trip, then suddenly you stopped talking.
> Patient (furious): You don't care what I'm saying! This is a waste of time and a sham! You know what? I'm going to report your fraudulent ass to the Board of Psychology!
> Therapist (tentative, curious): You're clearly angry about something I've done. I'd like to learn more about what happened.
> Patient (sarcastic): However much you paid for your degree, you should ask for a refund because they didn't teach you shit.
> Therapist: It's hard for me to know something before you tell me.
> Patient (angry): Why did you just look at your watch?
> Therapist: I heard the door open and thought it was early for my next appointment.
> Patient (sarcastic): You were really paying close attention to what I was saying.
> Therapist: When I looked at my watch you thought I wasn't paying attention to you. It makes sense you'd feel angry about that.
> Patient (accusatory): So you admit you weren't paying attention!
> Therapist: I'm trying to understand what it was like for you when I looked at my watch. You thought I wasn't paying attention.
> Patient (diminishing anger, emerging sadness): It felt like you cared more about whoever was opening the door. I felt like a piece of trash being thrown away.

In this example, a split leads to a rupture. In a single moment, the therapist goes from "good" to "bad" after looking at his watch. The therapist recognizes a rupture is occurring and tries to discuss the patient's experience. Initially rattled by the patient's vehemence and threats, the therapist feels like pulling away. Instead of retreating, the therapist remains alert to his countertransference and continues to reflect, validate, and seek understanding. By doing so, the therapist neither withdraws nor retaliates; he also conveys that even if he fears the patient's anger, he can withstand it. The patient's anger subsides and a sadness emerges as he describes feeling "like a piece of trash being thrown away" when the therapist looked at his watch. This leads to a fruitful discussion about the dynamics underlying the patient's reaction.

During a rupture, a patient may not be able to do any of the above. If this occurs, it is probably best to ride out the storm by using reflection and validation while attempting to regulate the patient's emotions. Over time, the therapist learns how to anticipate ruptures, endure the intensity and

urgency of the moment, and find ways to stay connected with the patient. Bateman & Fonagy (2006) argued that therapists who regain their psychological equilibrium as quickly as possible after a rupture may increase the odds of repairing it.

Clinical Foci

Patients with BPD require specific interventions to address their symptoms. While various BPD treatments are known to be effective, the mechanisms underlying therapeutic changes remain largely unknown. A clinician need not stumble through a trial-and-error exploration to find what works, nor succumb to nihilism. One approach is to break BPD down into relevant clinical domains and then target these domains with interventions that are known to be useful or likely to be helpful (Livesley, 2012). Some evidence suggests that a BPD treatment needs to be tailored in this manner (Goldman & Gregory, 2010). This paper draws upon interventions used in dialectical behavior therapy (Koerner, 2012), mentalization-based treatment (Bateman & Fonagy, 2006), transference-focused psychotherapy (Yeomans et al., 2002), and schema-focused therapy (Arntz & van Genderen, 2009) that are logically and clinically likely to be effective. Furthermore, these interventions are consistent with Goldman & Gregory's (2010) findings about which BPD-specific techniques may contribute to patient change.

While a BPD diagnosis involves some heterogeneity, the typical patient displays emotional lability, behavioral impulsivity, distorted cognitions, and a lack of self-reflection. Thus, these symptoms indicate pertinent clinical foci therapists can apply to most BPD cases: 1. affect regulation; 2. behavioral impulse control; 3. cognitive clarification; and 4. dynamic understanding. An intervention can focus on any of these domains.

If a patient begins a session in a state of emotional dysregulation, talking about suicide, and displaying paranoid ideation, then how does the therapist choose where to intervene? A hierarchy of clinical foci may be ordered as follows: overt threats to self or other; therapy-interfering behavior (e.g., missed sessions, deliberate dishonesty), and symptoms interfering with the patient's daily functioning (Koerner, 2012; Yeomans et al., 2002). "What is required is that you treat the highest priority target sufficiently, but this need not take up the entire session; most often multiple targets can be addressed within a single session" (Koerner, p. 76). The therapist is active, engaged in the process, and crafts brief, clear, and straight-forward interventions (Bateman & Fonagy, 2006). In general, initial work focuses on the patient's day-to-day struggles. The primary task

is developing more adaptive coping skills to aid symptom remission. Gradually, the more florid symptoms recede, and the therapist identifies certain patterns and conveys curiosity about their meaning. Ultimately, the therapist connects the patient's manifest issues and underlying personality dynamics.

Affect Regulation

Emotional reactivity and instability are considered to be core BPD features (American Psychiatric Association, 2013). Emotions easily overwhelm patients with BPD and can disrupt their psychological equilibrium. They have difficulty identifying and differentiating feelings, and they have little capacity for experiencing gradations of feeling (Levine, Marziali, & Hood, 1997). BPD patients often report having intense feelings that fluctuate rapidly and multiple emotions simultaneously (Ebner-Priemer, et al., 2007). Anger typically is the "umbrella" emotion, covering frustration, disappointment, and sorrow, and it is often expressed in raw ways (e.g., screaming, using expletives, hitting) rarely congruent with societal norms (Gardner, Leibenluft, O'Leary, & Cowdry, 1991; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005).

According to Reinecke & Ehrenreich (2005), the ability to regulate affect is rooted in an "integrated set of component skills that allow an individual to maintain a level of affective arousal that is appropriate for effective coping with stressful situations" (p. 170). These skills include affect labeling, mood monitoring, cue identification, and recognition of escalation points. Affect labeling involves the therapist identifying and labeling feelings to help the patient tolerate all feelings, even unpleasant ones, and experience gradations of affect. Since anger acts as the umbrella emotion, the therapist infers un-verbalized feelings and articulates the patient's emotional state (Bateman & Fonagy, 2006; Koerner, 2012). For example, "I know you're angry that Joe's traveling for work next month; I imagine you may also feel sad that he's going away from you." Also, gradations of a feeling are labeled: "I wonder if 'annoyance' might be a good word to describe what you were feeling toward the woman on the bus who was talking loudly on her phone?" When emotions are not labeled accurately, they do not appear to attain semantic representation and likely remain undifferentiated and difficult to regulate. Accurately identifying and labeling an emotion can have a regulating influence by dampening arousal (Kircanski, Lieberman, & Craske, 2012).

Patients with BPD can also learn to monitor their own moods and identify internal cues that signal changes. For mood monitoring, the goal

is to help patients pay more attention to their feelings throughout the day and identify patterns associated with changes in mood. Patients can learn to ask themselves certain questions: "How did I feel today? Was I feeling high or low? What was I feeling? When did my mood change?" This leads naturally into cue identification, a skill that helps the BPD patient "identify internal cues that she is about to lose control rather than external triggers or precipitating events" (Reinecke & Ehrenreich, 2005, p. 171). The patient is asked to notice any somatic, affective, cognitive, or behavioral signals that something is happening. Cue identification can help the patient use the signal to choose a different response, rather than reacting spontaneously. Initially, this often means walking away from a situation. As cue identification improves, BPD patients may develop the ability to stay in the moment.

Finally, the patient is asked to identify an escalation point, which is the precise moment when a feeling intensifies beyond the ability to control it. When a patient describes these situations, there is invariably a moment when he or she says "and then I lost it." This is identified as an escalation point. At the very least, it offers an opportunity to prepare for such a situation in the future. In the short term, this may mean avoiding the stimulus; in the long term, developing a modulated response. Identifying escalation points also plays an important role in attaining insight into the patient's underlying dynamics.

Building affect regulation skills likely help BPD patients develop a language for their emotions. Once feelings are symbolized semantically, words may help a patient monitor his or her moods, perceive internal cues, and identify escalation points. This can create emotional distance from the present moment, and may make enacting feelings behaviorally less necessary. Research indicates labelling affects provides greater prefrontal control over amygdala hyperactivity (Hariri, Bookheimer, & Mazziotta, 2000; Lieberman et al., 2007). Increasing emotional competence may promote physical and psychological well-being, and improve adaptive functioning (DeStano, Gross, & Kubzansky, 2013; Nelis et al., 2011). Goldman & Gregory (2010) found that a BPD patient's ability to identify, label, and connect emotional experiences was significantly related to symptom reduction and moderately related to greater social support and less alcohol use.

Behavioral Impulse Control

Patients with BPD have a limited ability to modulate, delay, or control impulses without direct behavioral discharge. While dysregulated affect

does influence impulse control, factor analysis indicates that behavioral impulsivity is a core BPD feature (Sanislow, Grillo, & McGlashan, 2000). Paris (2008) argued that it should be treated on a parallel track to affect regulation. Furthermore, poor impulse control may include self-harming actions (e.g., bulimia, cutting, reckless driving, substance use) that require direct intervention (Arntz & van Genderen, 2009; Koerner, 2012).

The therapist provides behavioral self-soothing techniques (e.g., breathing and relaxation exercises) and suggests alternate ways to cope with impulses toward action. Socially appropriate activities such as exercising, listening to music, and creating artwork can act as pressure valves to discharge impulses. Therapists may need to be directive and set limits if a behavior presents an elevated risk for danger to the patient or others. If the patient does not take reasonable steps to limit self-harming or dangerous behaviors, then the therapist evaluates whether the therapy can continue (Yeomans et al., 2002).

Those with BPD often struggle to act reasonably and responsibly. Certain situations are too evocative and they engage in behaviors against their best interests. Helping the patient identify potential dangers and possible courses of action, as well as anticipate potential consequences, is believed to develop more adaptive responses (Arntz & van Genderen, 2009; Koerner, 2012; Yeomans et al., 2002). This may require delicacy by clinician because it is easy to judge the patient's behaviors and, in turn, for the patient to feel judged. Still, the therapist tactfully and repeatedly points out that behavior has consequences. The approach emphasizes teaching patients how to slow down and assess situations before acting. If the patient has already acted impulsively, discussing alternative responses may help the patient use a different option in the future. For example, a patient reports not receiving a promotion at work, and then calling in sick for several consecutive days. The therapist identifies, labels, and validates her disappointment and addresses the behavior's potential results by saying "you could get fired, and that would put you in a really bad spot." The therapist then helps the patient find other ways to cope with disappointment rather than continue calling in sick.

Suicidality, self-harming behaviors, and/or threats to harm others invariably complicate most BPD cases. According to Gunderson (2008), suicidality and self-harming behaviors are "so prototypical of persons with BPD that the diagnosis rightly comes to mind whenever recurrent self-destructive behaviors are encountered" (pp. 14-15). Indeed, such behaviors are a clinically significant component of a BPD differential diagnosis

since among DSM-V personality disorders, only antisocial personality disorder also has a criterion for danger to self or others.

The risk of suicide is real. Persson, Runeson, & Wasserman (1999) found that among patients 15 years or older presenting to a hospital with suicide attempts, 41% were diagnosed with BPD. According to Bongar, Peterson, Golann, & Hardiman (1990), at least 50% of chronically suicidal patients with four or more emergency room visits in a year have BPD. The prevalence of completed suicide among patients who have BPD is between 3% and 10% (Paris & Zweig-Frank, 2001; Stone, Stone, & Hurt, 1987).

Complications arise in the areas amid threat, attempt, and completion. Clinicians have long recognized that a patient's threats and behaviors often relieve painful feelings or elicit caretaking. While frequent threats and attempts may indicate the person does not actually intend to harm self or others, it is not a reliable indicator. A history of such behavior, regardless of the intent, increases the likelihood of a patient with BPD completing a suicide attempt (Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994). Those who have BPD can experience cognitive distortions, misperceive a situation's dangerousness, and underestimate an act's lethality.

Distinguishing among a cry for help, manipulation, or any other motivation is not easy. Gunderson (2008) argued that clinicians can become overly cautious or habituated to the threat. If overly cautious, a clinician may iatrogenically create the very situation he or she is working to avoid. Treatment in which the clinician overreacts and constantly "rescues" the patient with BPD likely increases the frequency of acting out behaviors through operant conditioning. If the clinician underestimates the threat, however, he or she may not properly assess risk. What begins as a reactive gesture by the patient can quickly spiral out of control due to the patient's misperceptions and miscalculations.

Good clinical practice focuses on informed consent, assessment, consultation, documentation, and addresses a threat's underlying motivations. A patient can make verbal threats without instigating immediate hospitalization or a duty-to-warn situation. In fact, clinicians want a patient to verbalize such thoughts and feelings in therapy rather than act them out, as verbalization provides a way to discharge the feeling or impulse. However, the clinician must understand the threat's context, as well as the intent, and availability of means. Gunderson (2008) recommended using an "acute-on-chronic" model when evaluating risk. The therapist neither ignores chronic danger, nor looks for it. An excessive focus on prevention can derail the treatment. The clinician is alert to short-term warning signs such as changes in mood, increased stress, life events involving separation

or loss, changes in substance use, or changes in daily activities. Evidence of an exacerbated or more acute situation suggests increased risk, which requires appropriate assessment, consultation, management, and documentation (Fowler, 2012).

Cognitive Clarification

The cognitive processes of a patient with BPD are generally intact. This often allows the patient to function on a day-to-day basis. However, reality testing, memory, attention, concentration, logic, and conceptual ability are easily compromised due to emotional dysregulation, which can result in perceptual distortions, paranoid delusions, and disordered thinking (Gergely, 2003; Judd, 2012; Seres, Unoka, Bódi, Áspán, Kéri, 2009). The patient may misperceive certain features of the environment and misattribute motives. Patients may become distracted, focus narrowly and rigidly on irrelevant details, and display paranoid ideation, ideas of reference, and delusions. Thoughts can become exceedingly concrete (e.g., a closed door means rejection), disconnected, prone to overgeneralization, emotional reasoning, personalization, and black and white thinking. Patients with BPD often expect others to know what they are thinking and feeling and to see situations in the same way they do.

A BPD patient's cognitive abilities can become compromised quickly. A variety of cognitive interventions can address this, such as: advantages and disadvantages; evidential analysis; generation of alternative explanations; and normalization (Arntz & van Genderen, 2009). Interventions typically cluster around assessing evidence related to conclusions, expanding a perspective, or challenging automatic thoughts. No matter how tactful, patients may experience a therapist's clarification of a cognitive distortion as being told that their thinking is dysfunctional. Thus, when addressing a distortion, the therapist's motivation may be misconstrued which could provoke a rupture. Still, the therapist sensitively addresses the distortion.

For example, a patient reports that her work phone is bugged and her boss is trying to fire her. The therapist seeks evidence by asking what leads her to believe the phone is bugged. The patient replies angrily, "Oh, that's great, you think it's all in my head!" The therapist says, "I don't know enough about what you're telling me to agree with you or not. If you tell me more, I may understand better." The patient calms down and describes hearing a clicking noise on her phone, meaning her boss is probably listening in to find out if she is making personal calls. The therapist simultaneously validates the experience and seeks a more nuanced per-

spective by generating alternative explanations: "I know you've been struggling at work lately; it makes sense you're afraid of getting fired and one way your boss could do that would be to bug your phone. Given that this is illegal and could get your boss in a lot of trouble, I wonder if you and I can explain the clicking noise a different way?" The patient agrees but struggles, so the therapist suggests some plausible alternatives.

Dynamic Understanding

Implicit mental functioning, or underlying dynamics, influences our subjective experiences. An underlying dynamic may be conceptualized as a schema, object relation, archetype, or internal working model. This paper uses the term "schema" since it is a generic, well-known term incorporating the essential features of the other concepts. Schemas are cognitive-affective templates of self, others, events, and relationships and can be healthy or pathological (James, Southam, & Blackburn, 2004). They originate in childhood as an individual mentally represents important and consistent sensations, perceptions, behaviors, and emotions experienced in temporal contiguity. Typically encoded in procedural memory, schemas allow people to process information quickly, to organize it, and to interpret it to deal with routine and novel situations. Schemas are implicit and operate outside our awareness. They are also always active, automatically filter internal and external stimuli, and assume prominence or fade into the background based on exigent circumstances.

A pathological schema contains painful and overwhelming impressions and feelings derived from childhood experiences that continue to exist, unmodified and without semantic representation, into adolescence and adulthood (Arntz & van Genderen, 2009; Yeomans et al., 2002). When pathological schemas predominate, as they do in personality disorders, all experience is filtered through these rigid, anachronistic lenses. This contributes to the emotional instability, behavioral impulsivity and cognitive distortions of a patient with BPD, and it interferes with their ability to adapt successfully to life.

A variety of schemas associated with BPD cluster around certain themes: abandonment/abuse; anger/impulsivity; victim/victimizer; detached protection; and punishment (Arntz & van Genderen, 2009; Bateman & Fonagy, 2006; Yeomans et al., 2002). These describe different ways the patient organized experiences and adapted to his or her childhood environment. For example, a BPD patient might have learned in childhood that the world was dangerous; people who should have had his or her best interests in mind did not (parental neglect and abuse) and abandonment

was inevitable. When in abandonment/abuse mode, the patient feels alone, vulnerable, mistrustful, and helpless.

Certain situations activate these schemas and can easily disrupt thoughts, feelings, and behaviors. Since schemas work outside our awareness, the therapist helps the patient notice their activation and effect. Paris (2008) argued that "self-observation is a skill that therapists need to teach all patients with BPD" (p. 148). Initially, they have a limited ability to reflect upon their own, or others', thoughts and behaviors and believe things happen either randomly or because other people are malevolent. They lack insight into how they might contribute to their symptoms and dysfunctional patterns, or how others may have differing preferences and beliefs. Also, they often project their own unacknowledged traits and fears onto other people, thus misattributing others' motives.

By noticing how the patient's mind works, the therapist may develop the patient's capacity for "mentalization" (Bateman & Fonagy, 2006). The task is to broaden and deepen the patient's awareness of an experience, focusing on the mental states of self and other (Bateman & Fonagy, 2006). Noticing when patients say something vague, confusing, problematic, or contradictory may gradually help them describe what is occurring in their mind and/or that of another person. Interventions that promote mentalization appear to improve the BPD patient's social support, reduce the need for institutional care, and decrease parasuicidal behaviors (Bateman & Fonagy, 2009; Goldman & Gregory, 2010).

This process leads naturally into a "chain analysis" (Koerner, 2012). Specific events—particularly when the patient was emotionally dysregulated, behaviorally impulsive, or experienced distorted cognitions—are reviewed thoroughly. The therapist helps the patient think about how the situation emerged and played out moment by moment. "There should be no fast forward but rather frame-by-frame progression, pausing frequently to rewind and explore" (Bateman & Fonagy, 2006, p. 36). What happened? Who was involved? What led to the patient's particular affective or behavioral reaction? What made the patient so angry in the moment? The therapist repeatedly explores mental states, how the patient relates to people, and copes with problems. Through this process, patients with BPD may gradually begin to notice precipitating events, controlling variables, escalation points, and to assess how their feelings intensified or were converted into maladaptive solutions.

Ultimately, the goal is to help patients recognize patterns and to understand how underlying schemas contribute to their emotional dysregulation, behavioral impulsivity, and distorted cognitions. The therapist

does this through an interpretation, which connects the precipitating events, the resultant maladaptive solutions, and the schemas that appear to influence the experience. Interpretations are tactful, tentative statements that present an alternative viewpoint or possible explanation. The therapist pauses after making an interpretation, giving the patient a chance to respond. If the patient disagrees, the therapist suggests that there may be other explanations. Interpretations are believed to be an important change mechanism in a BPD treatment by promoting semantic representation of underlying schemas and integrating split-off representations of self and other (Yeomans et al., 2002).

In the following example, a patient reported drinking alcohol to the point of blacking out after her previous session and claimed not to know why she drank so much. The therapist conducts a thorough chain analysis to understand the patient's experience during the session and what followed. After gathering sufficient information, the therapist offers a possible explanation for the behavior:

> Therapist: What did we talk about last session that may have stirred things up?
> Patient: You leaving, being on vacation, don't know when though.
> Therapist: We've talked about the dates before so it wouldn't be a surprise for you. Perhaps the idea of my being on vacation, "my leaving," frightens and angers you?
> Patient: And at the end of last week's session I also said I felt better and like I could trust you more.
> Therapist: So feeling that I'm helping you and that you're more trustful may have provoked thoughts and feelings that I might abandon you. The last time you drank until you blacked out was last year, when you also worried about my going away.
> Patient: It's like some fight or flee response, I guess. If I drink that much, I don't have to think about you not being here; I can mentally check out and run away.

In this example, the therapist connects his impending vacation (precipitating event) to the patient's feelings (fear, anger, increased trust) and binge drinking (maladaptive solution); in particular, the therapist describes how the latent abandonment fear drove a repetitive, dysfunctional behavioral pattern (underlying schema). Indeed, abandonment is a core BPD schema (Arntz & van Genderen, 2009).

During the treatment, the therapist repeatedly focuses on the patient's mental states and connects events in the patient's present life to underlying schemas. This process may promote lasting personality change as habitual

maladaptive responses are encountered and identified through repeated experiences with the therapist. Archaic, maladaptive procedurally encoded knowledge and memories, which had operated automatically, are identified and modified into more contemporary, semantically encoded information that allows for more conscious, adaptive responses rather than unconscious, maladaptive reactions (Viviani, Kächele, & Buchheim, 2011). Such work is believed to develop a "healthy adult" schema (Arntz & van Genderen, 2009) that gradually modifies pathological schemas (Yeomans et al., 2002).

DISCUSSION

This paper presents an accessible, integrated, coherent treatment framework for beginning clinicians. The approach may raise objections, such as whether beginning psychotherapists should even treat BPD patients, the feasibility of integrating different treatments, and the nature of change. First, given the potential severity of BPD, the high dropout rate, and the challenging dynamics involved, it is reasonable to question whether a beginning clinician possesses sufficient clinical knowledge and skill. One solution is to make BPD training a postgraduate specialty requiring credentialing (Gunderson, 2008). However, the disorder's prevalence at sites where beginning clinicians are likely to train and attain initial employment suggests that BPD education and training should occur much earlier. Beginning psychotherapists likely are able to provide effective treatment when they receive instruction and supervision. This paper serves as a preliminary resource by disseminating empirically and clinically informed BPD treatment knowledge.

Next, challenges to integrating different BPD evidence-based treatments exist. Current research typically shows only whether a treatment package as a whole is effective; the studies are not designed to identify specific principles and interventions. Thus, determining what to integrate, and how, might be difficult. Also, different philosophical and theoretical assumptions underlie the systems of psychology upon which each approach is based, which can hinder integration. Maintaining a coherent framework might be challenging when mixing behavioral, cognitive, and psychodynamic principles and interventions, which could confuse both psychotherapist and patient.

Obstacles to integration can be overcome. Understanding the psychopathology of BPD may inform how to organize and conduct treatment in a coherent manner. Breaking BPD down into clinical domains and then

targeting these domains with interventions that are known or likely to be helpful may promote a coherent treatment. Integration can be facilitated further by focusing on factors that cut across theoretical boundaries. Thus, this paper draws upon factors that are logically and clinically likely to be effective in addressing a BPD patient's psychopathology. This approach provides a clear focus, permitting coherent implementation.

Finally, a long-standing tension exists within the psychotherapy community regarding what promotes and sustains change. Common factors proponents argue that certain mechanisms occur in any psychotherapy and are the most mutative factors. However, others emphasize specific factors, typically rooted in a particular theoretical orientation or therapy method. The common versus specific factors tension also emerges in BPD treatments. Certain BPD treatments are more effective than generic forms of psychotherapy, which suggests there are components unique to these BPD treatments that promote therapeutic action. Yet evidence from direct comparisons (Clarkin et al, 2007) and meta-analyses (Kliem, Kröger, & Kosfelder, 2010; Levy, Ellison, Temes, & Khalsa, 2013) indicate that no single BPD treatment is more effective than another. Although some suggest that different approaches may work by different mechanisms of change (Levy et al., 2006; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006), many have argued that outcome equivalence is likely due to overlapping principles and techniques (de Groot, Verheul, & Trijsburg 2008; Gunderson, 2008; Livesley, 2012, Paris, 2008).

Common and specific factors are not in opposition; rather, each complements the other. Common factors provide a framework for organizing and guiding the therapist's interventions in a sensitive and therapeutic manner. They also make specific interventions possible and allow for their potential mutative effect on the patient. Any specific intervention's effectiveness can only be understood within the context of its application. Future research should focus on the interplay between common and specific factors. There also needs to be a shift from comparing competing BPD treatments to identifying specific mechanisms of change and understanding how and why the change occurs (Clarkin & Levy, 2006; Kazdin, 2007). Such research could lead to more definitive BPD treatment guidelines for practicing clinicians. This paper's integrative focus is consistent with the burgeoning effort (e.g., de Groot et al., 2008; Goldman & Gregory, 2010; Livesley, 2012; Paris, 2008) to identify effective principles and interventions and combine them in a way that leads to a coherent treatment.

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