CHAPTER 17

Borderline Personality Disorder

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Borderline personality disorder (BPD) can be characterized by the remarkable instability that pervades many if not all aspects of personality functioning, including relationships, self-image, affect, and behavior. For example, Natasha, a 29-year-old who had been married for several years, sought help after being "too tired" to work for more than a year, lying in bed for most of the day. Her problems seemed to have started with a relationship conflict at work that affected her performance. She started an affair with her boss, despite his engagement to another woman. Natasha ended it when he proceeded with the marriage that he had planned before the affair. She felt strongly disappointed by him and started an affair with someone else. According to Natasha, her boss resented this, gave her work below her former level, and criticized her so much in front of other personnel that she became "burned out." Diagnostic impression after the first interview was an adjustment disorder with mixed emotional features and relational problems. After the second interview, the picture was much more complicated. She described her marriage as characterized by lots of fights and aggressive threats, expressed resentment toward her family, and admitted high use of cannabis and alcohol. She repeatedly said that she found that life had no use and expressed mistrust of other people. When asked what should be done in treatment, her answers were rather vague, such as "I have to feel at home with myself." Although the therapist thought that Natasha probably suffered from high levels of anxiety, sadness, and loneliness, she presented a tough appearance, and it was easy to imagine how this could provoke others to anger.

Noting evidence of further psychopathology, the therapist proceeded with semistructured clinical interviews. In addition to a number of symptomatic disorders, it became clear that Natasha's problems met the criteria of BPD, including many unresolved emotional problems related to her youth and relationships with her parents. The clinician raised the possibility that BPD was the main problem and they discussed the pros and cons of treating her long-standing personality problems. Natasha decided to start with a long-term cognitive therapy (CT) focused on personality problems. She reasoned that something fundamental should be done with the way she felt about herself and other people, and she wanted to emotionally process the painful experiences she had had with her parents.

BPD is a relatively common disorder (1.1–2.5% of the general adult population, usually about 70% women; American Psychiatric Association, 2013; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004), with enormous societal costs, comparable to schizophrenia (Linehan & Heard, 1999; van Asselt, Dirksen, Arntz, & Severens, 2007), high risk of suicide (about 8–10% die because of suicide in a 10- to 15-year period (Lieb et al., 2004; Paris, 1993), more than 50 times higher percentage than in the general population (Pompili, Girardi, Ruberto, & Tatarelli, 2005), and considerable impairment in the individual's life. The proportion of patients with BPD generally rises with the intensity of the health care treatment setting, from less than 10% in outpatient facilities to more than 50% in specialized inpatient units (American Psychiatric Association, 2013). Patients with BPD are a burden for relatives, friends, and colleagues, and there is a high risk that they induce psychopathology in their offspring (Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2011; Weiss et al., 1996). Many individuals with BPD are intelligent and gifted people, but their disorder prevents them from developing themselves, and many have troubles finishing education, do not work at all, or have jobs below their capacities. Although BPD symptoms often reduce with treatment, social functioning, societal participation, and quality of life remain long-lasting problems and should be more focused on in treatment (Gunderson et al., 2011; Zanarini, Jacoby, Frankenburg, Reich, & Fitzmaurice, 2009). Relational crises are common, including intense ups and downs in relationships with friends and colleagues. Most patients with BPD injure themselves (60–70%), though this is not unique to BPD, and they often abuse substances, usually as a form of self-medication. Although most patients with BPD seen in mental health care centers are female, male patients with BPD are prevalent in settings like forensic institutions and addiction clinics. Patients with BPD are also heavy users of physical health care facilities (van Asselt et al., 2007). Many seek help because of a crisis or because of posttraumatic stress disorder, depression, or addiction. They should be helped to view their difficulties in the perspective of their personality problems, simultaneously installing hope that these problems can be treated.

Notorious for their angry outbursts and their crises, patients with BPD have a bad reputation in health care, and many therapists are afraid of them. The belief that these people cannot really be helped is widespread. Recent research proves that this view is incorrect. Specialized forms of CT are among the most promising treatment options available. Although CT for BPD is in no way simple, many therapists have discovered that with this framework, treatment of individuals with BPD is a successful and rewarding experience.

CLINICAL SIGNS AND SYMPTOMS

Despite its high prevalence, BPD is often overlooked. When a clear, stable, and autonomous symptomatic disorder is the reason for seeking help, treatment may not be too problematic, though BPD might constitute a risk for treatment dropout (Arntz, 2014; Mulder, 2002). In many cases, however, the main problem is BPD and underdiagnosis constitutes a big problem that results in insufficient treatment.

DSM-IV-TR and DSM-5 describe BPD as characterized by instability and impulsivity. The instability can be evident in relationships that tend to be intense but are often suddenly stopped; in identity, with instability in self-views, ideals, future plans, and moral values; and in affect, with strong emotional reactions, which leads to sudden and strong switches among different emotions. Impulsivity manifests in potentially self-damaging activities that are rewarding in the short term but are engaged in impulsively, like spending, substance abuse, eating, and sex; in anger outbursts with difficulties with anger control; and in suicidal behavior and self-injury. Other criteria involve abandonment fears, with attempts to prevent being abandoned; chronic feelings of emptiness; and stress-related temporary paranoid experiences or dissociation. Five or more criteria need to be met to warrant a diagnosis of BPD. Although this theoretically leads to many possible combinations of BPD criteria, suggesting that patients with BPD differ considerably, the internal consistency of the criteria set, when treated as a dimension, is very high and suggests that the majority of these BPD features relate to one underlying dimension (Arntz et al., 2009; Giesen-Bloo et al, 2010). ICD-10 (World Health Organization, 2013) defines BPD as a subcategory of "emotionally unstable personality disorder" (F60.3). This broader personality disorder is defined as

> A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger often lead to violence or "behavioural explosions" that are easily precipitated when impulsive acts are criticized or thwarted by others. Two variants of this

personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control.

The subcategory borderline type (F60.31) is defined as follows:

> Several of the characteristics of emotional instability are present; in addition, the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants). (World Health Organization, 2013).

The overarching emotionally unstable personality disorder impresses as relatively more impulsive and aggressive than BPD defined by DSM-5 criteria and more akin to antisocial personality disorder. The borderline type misses, compared with DSM-5 criteria: stress-related dissociative and psychotic episodes (DSM-5 criterion 9). The agreement between the two diagnostic systems has been found to be limited (NICE, 2009).

DIFFERENTIAL DIAGNOSIS

The usually high comorbidity associated with BPD may complicate diagnosis, especially in determining the primary diagnosis and initial treatment plan. Almost all disorders can be comorbid to BPD, notably mood disorders, substance abuse/dependence, anxiety disorders (especially social phobia and posttraumatic stress disorder), psychotic disorders, and other personality disorders. Because BPD is viewed as one of the most severe personality disorders, BPD is recommended as the primary personality diagnosis and treatment is adapted to address comorbid disorders along with the BPD. Antisocial and narcissistic personality disorders might be an exception, especially when criminal features are present.

Some disorders need priority in treatment when comorbid to BPD. Most prominent are bipolar disorder, severe depression, psychotic disorders (other than transient, stress-related psychosis, which overlaps with criterion 9 of BPD), substance abuse that needs (clinical) detoxification, attention-deficit/hyperactivity disorder, and anorexia nervosa. These disorders should be treated first. These disorders are also problematic because they partially overlap in criteria with BPD and can make the diagnosis of BPD highly problematic. Bipolar disorder, for instance, can be mistaken for BPD, or the other way around. Finally, some conditions can lead to apparent personality changes that are similar to BPD, such as posttraumatic stress disorder and chronic substance abuse (e.g., cocaine).

Structured assessment of both syndromal and personality disorders is perhaps the best safeguard against diagnostic mistakes. Given the high costs incurred by, and suffering of patients with BPD, and the difficult and long treatment, the effort of executing semistructured clinical interviews is minimal.

CONCEPTUALIZATION

There are, roughly speaking, three cognitive-behavioral conceptualizations of BPD: Linehan's dialectical–behavioral view, Beckian formulations, and Young's schema mode model.

Linehan's Dialectical–Behavioral View

According to Linehan's (1993) model, patients with BPD are characterized by a dysfunction in emotion regulation that is probably temperamental. This dysfunction causes both a strong reaction to stressful events and a long time until emotions return to baseline. A second assumption is that the environment of the patient with BPD was, and often still is, invalidating. Denying, punishing, or incorrect responses to emotional reactions of the child are hypothesized to contribute to the problems in regulating, understanding, and tolerating emotional reactions. Later on, patients with BPD invalidate their own emotional reactions and adopt an oversimplistic and unrealistic view toward emotions. Primary targets of treatment are inadequate emotional reactions, notably the poorly controlled expression of impulses and self-damaging behavior, including (para)suicidal behavior. Therapists use a dialectical stance, on the one hand accepting emotional pain (instead of trying to change it), and on the other hand changing antecedents of stress and the way the patient tries to cope with the emotions. Acquiring skills in emotion tolerance and regulation, as well as validating emotional reactions, are central to Linehan's dialectical behavior therapy (DBT). DBT was originally developed to treat (para)suicidal patients, before it was clear that most of these patients would be diagnosed with BPD. Of the specialized BDP treatments, DBT has been studied most often, though not necessarily in the methodological best studies (Stoffers et al., 2012). Effect sizes are on average moderate (Kliem, Kröger, & Kosfelder, 2010).

Beckian Formulations

Early Beckian formulations of BPD stressed the role of assumptions in the disorder. Beck, Freeman, and Associates (1990) hypothesized that a large number of assumptions common to other personality disorders are active in BPD. Pretzer (1990) further hypothesized that three key assumptions are

central in BPD: "The world is dangerous and malevolent," "I am powerless and vulnerable," and "I am inherently unacceptable." The first assumption in combination with the second is hypothesized to lead to high levels of vigilance and interpersonal distrust. In addition to hypervigilance, two other cognitive characteristics are assumed to be central to BPD: dichotomous thinking and a weak sense of identity (i.e., a poorly articulated self-schema). The three key assumptions and the three cognitive characteristics are assumed to play a central role in the maintenance of the disorder and are consequently major targets for therapy. For instance, the somewhat paradoxical combination of dependent assumptions (the belief of the patient to be weak and incapable, whereas others are strong and capable) and paranoid assumptions (the belief that others cannot be trusted and are malevolent) are thought to fuel the unstable and extreme interpersonal behavior of the patient with BPD, alternating between clinging to other people and pushing others away out of distrust. Dichotomous thinking contributes to the emotional turmoil and extreme decisions, as lack of ability to evaluate things in grades of gray contributes to the abrupt and extreme shifts made by patients with BPD and should be addressed early in treatment, as soon as a working relationship is established.

Layden, Newman, Freeman, and Morse (1993) further elaborated the cognitive model and suggested numerous other biases and processes and related these to early child development and presumed stagnation of development of patients with BPD. Layden and colleagues (1993) also stress the role of nonverbal elements in core schemas of patients with BPD, which they also link to early preverbal development. Consequently, Layden and colleagues emphasize the use of experiential techniques, notably imagery work, in treatment. Arntz (1994) related Pretzer's (1990) observations to findings of high prevalence of childhood abuse in BPD, suggesting that the way the abuse was processed by the child led to the formation of the key assumptions and cognitive characteristics of the patient with BPD. He proposed an integration of Beckian here-and-now CT with historical work to process childhood abuse and correct pathogenic conclusions from the abuse. In accordance with Layden and colleagues, the importance of experiential methods in treatment of early childhood memories is stressed (see also Arntz, 2011; Arntz & Weertman, 1999). There are few studies testing Beckian CT for BPD. Brown, Newman, Charlesworth, Crits-Cristoph, and Beck (2004) tested CT in an open trial and found moderate effect sizes. Cottraux and colleagues (2009) compared CT with supportive Rogerian therapy, and found better treatment retention and some better effects in CT, but high dropout rates in both arms. Davidson and colleagues (2006) tested whether a limited number of CT sessions added to treatment as usual would have positive effects. On the primary outcome no evidence for this was found, but limited evidence was found on secondary outcomes (4 of 11 outcomes), notably on suicidal acts, and on the Young Schema

Questionnaire (Young, 2006). A cost-effectiveness study did not reveal notable differences between the two conditions in difference in costs versus difference in quality-adjusted life years (Palmer et al., 2006).

Young's Schema Mode Model

The conceptualization of the core pathology of BPD as stemming from a highly frightened, abused child who is left alone in a malevolent world, longing for safety and help but distrustful because of fear of further abuse and abandonment, is highly related to the schema model developed by Young (McGinn & Young, 1996). To understand the abrupt changes in the behavior of patients with BPD, Young elaborated on an idea, introduced in the 1980s by Aaron Beck in clinical workshops, that some pathological states of patients with BPD are a sort of regression into intense emotional states experienced as a child. Young conceptualized such states as schema modes, and in addition to child-like regressive states, he also stipulated less regressive schema modes. A schema mode is an organized pattern of thinking, feeling, and behaving based on a set of schemas, relatively independent from other schema modes. Patients with BPD are assumed to sometimes flip suddenly from one mode into another. As Beck observed, some of these states appear highly childish and may be confusing for both the patient and others. Young hypothesized that four schema modes are central to BPD: the abandoned/abused child mode, the angry/impulsive child mode, the punitive parent mode, and the detached protector mode. In addition, there is a healthy adult mode, denoting the healthy side of the patient.

The abused and abandoned child mode denotes the desperate state the patient may be in related to (threatened) abandonment and abuse experienced as a child. Typical core beliefs are that other people are malevolent, cannot be trusted, and will abandon or punish you, especially when you become intimate with them. Other core beliefs are "My emotional pain will never stop," "I will always be alone," and "There will be nobody who cares for me." The patient may behave like an upset and desperate child, longing for consolation and nurturance but also fearing it. Usually the patient fears this mode, not only because of the intense emotional pain and the reactivation of trauma-related memories and feelings but also because its activation can be followed by an activation of the punitive parent mode. This indicates a severe self-punitive state, during which the patient seems to condemn him- or herself as being bad and evil, deserving punishment. Expressions of negative emotions, opinions, and wishes were usually punished by caregivers, attributing these to character, either explicitly ("You are a bad child") or implicitly (e.g., ignoring the child for days). Threats of abandonment ("I'll send you to an orphan home"), verbal or physical aggression, and (threats of) severe punishments by caregivers are supposed to be internalized in this mode. Typical core beliefs are "You are bad (evil) and deserve

punishment," "Your opinions/wishes/emotions are ill founded," "You have no right to express your opinions/wishes/emotions," and "You are only manipulating." Often the patient not only experiences these punishing thoughts but adds punishing acts to them, such as self-injury, damaging the good things in his or her life, and not coming to treatment sessions. Guilt is the prominent feeling. The patient might evoke punishing reactions in others, including the therapist.

One of the other modes the patient (and the therapist!) frequently fears is the angry/impulsive child mode. This denotes a stage of childish rage or self-gratifying impulsiveness that is in the long run damaging for the patient and his or her relationships. Whereas Young, Klosko, and Weishaar (2003) state that patients with BPD typically avoid the experience and expression of anger, the tension of suppressed anger may build up and suddenly be expressed in a relatively uncontrolled way. These tantrum-like states are, according to the model, typically followed by an activation of the punitive parent mode. Impulsive, immediate, need-gratifying behaviors are also attributed to this mode. Underlying beliefs are "My basic rights are deprived," "Other people are evil and mean," and "I have to fight, or just take what I need, to survive." In the model, this mode is not seen as expression of greediness, but as rebelliousness against (perceived) maltreatment—thus as a basically good and understandable state (given the maltreatment patients with BPD experienced as children), though leading to dysfunctional actions.

Although patients with BPD are notorious for their crises and anger, therapists who work for longer periods with these patients have observed that they tend to be detached most of the time. They do not seem to really make contact with others, or with their own feelings and opinions. According to Young and colleagues (2003), they are in the detached protector mode, a sort of protective style the child developed to survive in a dangerous world. This mode is hypothesized to serve to protect against attachment risks (because attachments will be followed by pain, abandonment, punishment, or abuse), emotional experience, self-assertiveness, and development, as each of these signals potential pain and activation of the punitive mode. Core beliefs are that it makes no sense to feel emotions and to connect to others, that it is even dangerous to do so, and that being detached is the only way to survive and to control one's life. Often the patient uses a bulk of strategies to maintain this mode, including cognitive avoidance of feeling and thinking; not talking; avoidance of other people and activities; sleeping, developing, and complaining about somatic discomforts; use of drugs and alcohol; and even (para)suicide. Superficially, the patient may seem rational and healthy, but this is not really healthy because the patient suppresses important aspects of human functioning.

Therapy based on Young's model (schema therapy; Young et al., 2003) aims to reduce the use of the detached protector mode, heal the abandoned/

abused child mode by offering safety and processing traumas, shape the angry/impulsive child mode into healthy forms of assertiveness, expel the punitive parent mode from the patient's system, and increase the strength of the healthy adult mode. Treatment studies have found very strong effects of this model, both in individual, group, and combined format, and very low dropout rates—which is important given the usually high dropout from treatment by patients with BPD (McMurran, Huband, & Overton, 2010).

KEY TREATMENT GOALS

The key treatment goals depend on the possible duration of treatment. With shorter treatments, the goal is usually restricted to reducing the most severe BPD manifestations, such as suicide attempts and self-injury, other forms of self-damaging impulsivity, substance abuse, and so on. Typically many problems remain (even when the patient does not formally meet DSM diagnosis of BPD), thus the patient should be referred for further treatment if the means for that are available.

For a more extensive treatment, the key treatment goals usually include:

1. Reduction of all BPD symptoms (including problems in relationships, fear of abandonment, identity problems, emotional instability, and emptiness).
2. Feeling safe with experiencing and expressing emotions and needs, and with personally connecting to others.
3. Developing a satisfying life on personal, social, and societal levels.

With a time- and objectives-limited treatment, goal setting with the patient can be much easier than with the longer approach. In the latter case, the goals are necessarily global and stated in terms of reduction of the influence of core schemas and dysfunctional strategies and the creation and increase of healthy schemas and strategies. Formulating the latter can be complicated because many patients with BPD have no idea what healthy views and strategies are.

Before treatment proper starts, the therapist should decide as to what treatment he or she wants to offer. On the one hand, a relatively short treatment directed at reducing the most problematic and dangerous BPD problems can be offered. The objectives of such a treatment are a reduction of impulsiveness and self-injury, and perhaps substance abuse, and gaining some control over emotions and insight into the problems, so that the patient is suitable for further psychotherapy. The studies by Linehan, Armstrong, Suarez, Allmon, and Heard (1991) and Brown and colleagues (2004) demonstrated that these objectives are achievable in a 1-year treatment. For a real recovery of all BPD-related problems a longer therapy is

necessary, during which an intensive personal relationship between therapist and patient (or among group members in the case of group therapy) usually develops. Patients with BPD have such a fundamental distrust of other people, especially when they become intimate with them, and their attachment style is so pathological, that it simply takes extended time to overcome these interpersonal barriers (Gunderson, 1996). Thus, for a real treatment of BPD, time to develop a new secure attachment as a fundamental correction to what went wrong during childhood is necessary. Related to this is the attention that should be given to the treatment of traumatic childhood memories, which also takes time.

COLLABORATIVE STRATEGY

The type of relationship the therapist tries to develop with the patient depends on the duration and goals. With the first option, the therapist should keep a bit more distance from the patient because treatment stops soon and discontinuing treatment when secure attachment just develops can be particularly problematic, and even damaging to patients with BPD. Crisis support should always be provided, but with the first treatment option the therapist does not need to be deeply involved in treatment of crisis. Frequency of sessions can be once or twice a week.

With the second option, on which the remainder of this chapter concentrates, the therapist tries to develop a more personal and caring relationship with the patient. The therapist actively breaks through the patient's detachment, is actively involved in crises, soothes the patient when sad, and brings in him- or herself as a person. Frequency of sessions is initially twice a week—this will foster safe attachment and refresh new insights gained in sessions before it is lost in memory. Compared with most syndromal treatments, the therapist is more directive with content and process, as the patient lacks healthy views to use in Socratic dialogues. Thus, the therapist uses psychoeducation to inform the patient about healthy views on emotions, needs, and relationships; on child development and healthy parenting; and refers to the universal rights of children and adults (e.g., refer to United Nations declarations; *www.un.org/cyberschoolbus/humanrights/resources/plainchild.asp*; *www.un.org/cyberschoolbus/humanrights/resources/plain.asp*). The therapist is also more personal and direct, showing more care and interest, as patients with BPD need this. The therapist uses self-disclosure as a powerful means to educate the patient and to make the relationship a bit more personal—when it is helpful to the patient (and not when it is too overwhelming or scaring the patient). Also different from the standard syndromal approach, the therapist tries to meet the needs of the patient within professional boundaries, to directly correct dysfunctional schemas in the therapeutic relationship.

Young and colleagues (2003) called this approach "limited reparenting" by which he referred to the aim to partially repair what went wrong during the patient's childhood.

This approach is highly appreciated by most patients—studies have found higher therapeutic relationship quality reported by patients and less dropout in treatments using this approach. But it can also provoke discomfort in the patient, triggering core schemas, which is good because these can be subsequently addressed in therapy. Thus, this "reparenting" approach is an essential ingredient of treatment. E-mail contact between sessions, and calling the therapist in case of crisis, is encouraged, to promote secure attachment. Personal connection in between sessions refutes the patient's beliefs that there is nobody who really cares and that expression of negative feelings will be followed by punishment or abandonment, and reinforces a secure attachment. Talking, and especially listening, in an accepting way to patients when in crisis is most effective to teach them to tolerate and accept negative feelings. It demonstrates to patients that with such an approach, negative feelings usually calm down. Given a means to reach the therapist in between sessions does not imply that the therapist should be always available, or is omnipotent. In addition to the option of contacting the therapist, a crisis facility should be available, in case the therapist cannot be reached or the patient is unable to calm down when speaking to the therapist.

This approach requires therapists to be able to set limits when the patient goes beyond their personal boundaries. Frustrating the patient by setting personal limits is essential in a reparenting approach, as it is in real parenting, and can be curative, especially when the patient can test negative beliefs about consequences such as "Setting a limit means total disapproval of me as a person" and "Expression of my anger about the limit will be followed by punishment or abandonment by the therapist." There are two important caveats in communicating personal limits to the patient with BPD. One is that the therapist should only address patient behavior and not make character attributions, as caretakers often did. Furthermore, the therapist should give a personal motivation for the limit and not rationalize solely on the basis of institutional or professional rules. For example, the therapist may limit phone responses to certain times of the day due to other personal commitments. The following is an example of a dialogue concerning the communication of personal limits:

NATASHA: This weekend I'll have my 30th birthday party, and I would like to invite you to be there, so that I can introduce you to my husband and friends.

THERAPIST: That is very nice of you to invite me to your birthday party, but I'm afraid I don't want to attend.

NATASHA: Why not? I so much hoped that you could be with me.

THERAPIST: I like you very much, but I want to spend my leisure time with my family and friends.

NATASHA: (*getting angry*) So you are not considering me as a friend? And you said that I could expect therapy to be a very special place, which would evoke deep feelings, and that you would take a special role and care for me? Like a parent toward a child? And now I'm asking you something personal, something that is very important to me, and you just say no. You lied to me! I must have been a fool to trust you!

THERAPIST: You are right, I don't think of you as a friend, though I like you a lot, and I need my time with my family and friends to recuperate. So this is my personal decision, I like to see and work with you here, but I don't want to come to your party.

NATASHA: Jesus, you don't need to repeat that, you don't need to pour salt into a wound. I heard what you said. (*becoming afraid now*) Oh my God, I shouldn't have asked it. I knew it. I knew that you would refuse and resent me for asking such an impertinent thing. I want to go. I cannot stay here. (*Stands and starts to leave the room.*)

THERAPIST: Don't leave, please stay. I see that my refusal is hurting you very much. I also see that you are now extremely afraid that I will hurt you even more because you dared to ask me. Am I correct? Let's talk it over. It doesn't feel good to me if you leave now. Can we try to do that?

NATASHA: (*Sits again and starts to cry.*) Okay, but I feel so ashamed . . .

This approach requires the therapist to tolerate high levels of negative emotions, especially anger directed toward him or her, as well as sadness and despair. Positive emotions directed toward the therapist can be challenging as well, especially lovesickness and other unrealistic expectations of him or her. Consultation with colleagues who work with similar patients is invaluable.

The objectives of the therapeutic relationship are clear, but its application is not without hassles. Though patients with BPD long for a caring relationship, they also deeply fear it, and have serious troubles with tolerating the fears and distrust that are evoked by long-lasting personal and emotionally open relationships. Thus, the therapist should try to balance distance and intimacy and adapt this to the phase of treatment but also actively address the fears and distrust that are evoked by treatment. As Pretzer (1990) stated, "Trust is most effectively established through explicitly acknowledging and accepting the client's difficulty in trusting the therapist (once this becomes evident), and then being careful to behave in a consistently trustworthy manner" (p. 191). Relating the problem to underlying core schemas (or modes, if the therapist uses a mode model) can also be helpful in putting such problems in a new perspective and instilling hope that the problems will be overcome by treatment.

The big problem of dropout risk should be targeted early on. The therapist should be active in keeping patients in therapy, by calling those who do not show up for sessions, asking for (and actively suggesting to break through detachment) the reasons for avoiding therapy, and adapting his or her behavior to what the patient needs. Common reasons for staying away from treatment are related to detaching strategies (not connecting to people, avoiding and pushing away feelings and thoughts about difficulties as ways to survive), fear of being abused or abandoned by the therapist, and self-punitive attitudes ("I don't deserve therapy" and " I should destroy positive things to punish myself"). Such underlying beliefs should be clarified and the patient empathically confronted with the reality that staying away from therapy would mean continuation of pathology and missing the chance to correct the underlying beliefs.

Cognitive therapists who are used to working on symptomatic problems should resist their usual habit of immediately looking for biased interpretations that led to dysfunctional emotions. Instead they can instill healthier schemas for emotion regulation by accepting and validating emotional experience, but discouraging impulsive emotional acts. Through modeling and direct instruction, this will help patients to correct characteristically negative beliefs about experiencing feelings, thinking that their feelings are ill founded, that they are "bad" to have such feelings, that they will lose control of urges to act on their feelings, and that other people (including the therapist) will punish or reject them for these feelings and actions.

A last important relationship technique is empathic confrontation, a confrontational message consisting of three elements: (1) empathic expression that the therapist understands why a dysfunctional strategy is chosen; (2) confrontation with the negative effects of the strategy and the continuation of the disorder if really followed; and (3) explicit formulation of a new, functional alternative strategy and asking the patient to follow it up. The following example illustrates how empathic confrontation can be used to suggest to the patient that functional instead of dysfunctional behavior can be used to deal with a stressful interpersonal situation.

> Although I understand why you are so are upset about what Mark said, because it hurts you deep in your heart, and I understand that you now feel a strong inclination to physically hurt yourself, to show him what a bastard you think he is, I ask you not to do that because if you do, it will further complicate your relationship. He will get more angry, and you will become more afraid, and this escalation will strengthen your idea that other people are evil, and that there never will be someone for you to trust. In other words, by following your old strategy you will continue your problems. Instead, I ask you emphatically to try a new strategy, that is, to tell him that what he did was painful for you, and explain to him why it was painful for you, and ask him to stop it. In that way you don't hurt yourself; you remain in control of your behavior. This is a healthy way to deal with the problem. And, if he doesn't

stop, we will work on how you can react to that. I know this is difficult and even frightening for you to do, but I insist on it because it will help you to learn more healthy ways to deal with such problems.

CLINICAL APPLICATION OF THE INTERVENTION

Hierarchical Approach

In choosing which problem to address, it is wise to use a hierarchical approach. Table 17.1 offers an overview. Issues of life and death should always be given priority. Suicidal impulses and other dangerous behaviors are among them, including behaviors that threaten or endanger the lives of others, particularly dependent children. Next on the hierarchy are issues that threaten the therapeutic relationship. These include the premature wish of the patient to stop therapy, move to another city, not come to therapy, and start another therapy next to the current one; negative feelings of the patient toward the therapist and of the therapist toward the patient; coming late to sessions; using a cell phone during the sessions; and so on. The reason that issues that threaten the therapeutic relationship are so high on the hierarchy is that a good therapeutic relationship is a prerequisite for the other issues. Third, although not immediately life threatening, many self-damaging behaviors are so disruptive that there is no room to address underlying schemas. Self-injury, substance and medication abuse, not attending work, impulsive acts and decisions, not having adequate food and housing, and poorly controlled emotional outbursts are among the disruptive behaviors. Although it is useful to repeatedly address these behaviors, ask the patient to stop them, and work on alternatives and solutions, the therapist should not expect, and certainly not insist on, change early in treatment. The pathology of the patient can be so severe that the therapist has to bear it for a long time, which does not mean that it should not be placed repeatedly on the agenda. Last but not least, other issues, including schema work and trauma processing, should be addressed.

The hierarchy is not only an aid for deciding on agenda issues within a session but also for planning the therapy process as a whole. Therapists should be warned that it can be necessary to readdress issues 1–3 above when they are in a phase of therapy in which schema work is done. Addressing

TABLE 17.1. Hierarchy of Issues to Be Addressed

1. Life-threatening issues.
2. Therapeutic relationship.
3. Self-damaging issues.
4. Other problems, schema work, and trauma processing.

childhood traumas can, for instance, bring about life-threatening behavior, which should move into priority position, after which the focus can again be placed on trauma processing.

Handling Crises

Although there should always be a crisis facility, the therapist is the most important person in treating the crisis. As said, most crises are fueled by the patient's negative beliefs about experiencing intense emotions. The primary strategy to counter these beliefs is to take a calm, accepting, and soothing stance. Empathic listening to the patient, asking for feelings and interpretations, and validating the feelings are important. Often, self-punitive ideas and actions (in Young and colleagues' (2003) model: the punitive parent mode) play a dysfunctional role and it is important to actively inquire for these thoughts and to counter them (e.g., "That's not true, you are a good person," "It is absolutely okay to feel sad and angry when your husband leaves you," and "I'm happy that you tell me about your feelings").

Availability during a crisis can be helpful because an early intervention often prevents worsening, self-mutilation, drug abuse, or other maladaptive actions and reduces the need for hospitalization. Early or later in treatment it is possible to come to an agreement with the patient that he or she will not engage in dysfunctional behavior (like self-injury) before talking to the therapist. We have learned that in many cases empathic listening and talking to the patient on the phone dampens the crisis in 15–20 minutes. During treatment, the patient gradually internalizes this new attitude toward difficult feelings and can apply it to him- or herself, so that immediate help of others is less needed. The therapist can help with this transition by making an audiotape with soothing words spoken by the therapist, and by making flash cards the patient can use to recall soothing thoughts.

Starting too early to offer practical suggestions on how to handle the problem and the crisis is a common pitfall. This generally fuels the punitive beliefs ("So I did it wrong") and counteracts the creation of a healthy attitude toward experiencing emotions. Practical problems should be addressed when emotions are calmed down, and often the patient is then able to handle it for him- or herself. There are, however, circumstances when it is not productive to follow these guidelines. An example is when the patient is so intoxicated (alcohol, benzodiazepines, etc.) that talking to him or her makes little sense because he or she cannot control aggressive impulses. More medically oriented help is then indicated. Another example is when the patient engages in self-injury while talking to the therapist. The therapist should then set firm limits (e.g., "I want you to stop cutting yourself now, and then we will talk about your feelings, so put away that blade").

Limit Setting

Some behaviors are so unacceptable that they should be limited by the therapist. These include behaviors that cross the therapist's personal boundaries (e.g., stalking, threatening, or insulting the therapist). Unacceptable behaviors also include dangerous actions that threaten the patient's life or the continuation of therapy. Formal limit setting as outlined here should only be done when the therapist feels able to execute the last step: stopping therapy. If not ready for that step, the therapist should tolerate the behavior while continuing to confront the patient with it and working toward a change. In applying this technique, therapists should be firm about the limit, use their personal motives to explain it, and talk about the patient's behavior and not criticize the patient's character. Never assume that the patient should have known that the behavior was unacceptable for the therapist. The following example illustrates how limit setting can be used to address inappropriately calling the therapist.

> Yesterday you called me when you were in terrible emotional pain, as I asked you to do. But I learned that you were drunk and had taken a lot of benzos. Because you were intoxicated, I didn't think that I could talk to you in any reasonable way. It made no sense. So I want to ask you not to call me when you are already intoxicated. You are welcome to call me before you consider drinking so much and taking pills, so that I can really connect with you. Please call me before, not after, you do that.

The patient's behavior may persist, in which case, the therapist firmly repeats his or her limits:

> Two weeks ago I changed the conditions under which you could call me. I asked you not to call me when you are drunk and have used benzos. But last Wednesday you called me after taking pills and drinking a bottle of wine. I must say that I got a bit irritated when I found out that you were intoxicated. I don't like to talk to people who are drunk, and I don't want to start disliking you because you call me when you are intoxicated. So call me when you need me because you are in a crisis, but only when you are sober. Don't call me when you are intoxicated. Call me before you start to drink or take pills.

Table 17.2 summarizes the steps that should be taken in limit setting. As is clear from Table 17.2, consequences are only applied after a warning has been given, so that the patient has the chance to change his or her behavior. Furthermore, consequences should initially be light and, if possible, intrinsically related to the undesired behavior (e.g., a patient using too much of the therapist's time gets a shorter session next time). Limit setting can evoke strong anger, which can be dealt with according to the collaboration strategies outlined previously.

TABLE 17.2. Steps to Be Taken in Limit Setting

- Explain the rule; use personal motivation.
- Repeat the rule; show your feelings a little bit, repeat personal motivation.
- As above; add warning and announce consequence.
- As above; execute consequence.
- As above; announce stronger consequence.
- As above; execute stronger consequence.
- Announce a temporary break of therapy so that the patient can think it over.
- Execute temporary break of therapy so that the patient can decide whether he or she wants the present therapy with this limit.
- Announce the end of treatment.
- Stop treatment and refer the patient.

Note. Based on Young, Klosko, and Weishaar (2003, pp. 356–358).

Cognitive Techniques

Unraveling Underlying Schemas and Modes

Because patients with BPD have initially poor understanding of their own emotions, thoughts, and behaviors, an important part of treatment is devoted to help the patient understand them. Gaining clarity on which underlying schemas (or modes) play a role helps patients to reduce confusion and gain some control over their behavior. A daily diary of emotions, thoughts, and behaviors is useful in helping the patient to detect underlying schemas and modes. It is particularly useful to link unraveled underlying schemas (or modes) to the patient's history, so that the patient can see how the schema developed and what function it previously served.

As an example, Natasha (discussed in the beginning of this chapter) learned that she adapted a somewhat arrogant, challenging attitude, as if nobody could hurt her, when she felt uncertain and feared harm. This often triggered more hurtful behavior from others, which was the last thing she wanted. Natasha and her therapist found out that she had developed this attitude as a child to cope with her mother's threats and physical abuse. Showing her mother how she felt hurt or getting angry inevitably led to even more punishment, and adapting this attitude helped her, in a way, to maintain her self-worth and to punish her mother. This historical link made clear the protective function of her schema, and that it was adaptive when she was a child. Because it was triggered automatically when she became an adult, and she had been almost unaware of it until therapy, it took her a long time to understand how her own behavior led to more, rather than less, hurt in present situations. After that became clear, Natasha became interested in learning alternative ways to deal with situations that were threatening for her.

Tackling Dichotomous Thinking

Patients with BPD frequently think in dichotomous terms, fueling extreme emotions, polarizing conflicts, and prompting sudden, extreme, impulsive decisions. It is important to help them to become aware of this thinking style, its harmful implications, and teach them to evaluate situations in more nuanced ways. Structured exercises can be used to develop a more adaptive thinking style. One helpful method is to use a white board to illustrate the difference between black and white thinking and nuanced thinking. On the white board, the therapist compares putting an action or a person into one of two compartments (black or white), versus creating a visual analogue scale (VAS) of a horizontal line between two extremes. Thus, different people, actions, or character traits can be placed in the dichotomous system, or they can be placed along a continuum of the VAS. When multidimensional evaluations have to be made, it is wise to draw a separate VAS for each dimension.

Flash Cards

What has been achieved in a session is often difficult for patients with BPD to remember when they need it. If a schema has been really triggered, all their thinking and feeling seems to be determined by it, and they have great difficulty seeing other perspectives. Flash cards can be particularly useful as an aid to memory and to fight pathogenic schemas on the spot. Usually, on one side of the card the pathogenic reasoning and the activated schema (mode) are described, so that the patient can understand that his or her emotions are caused by the activation of that schema. On the other side, a healthy view is offered, together with a functional way to cope with the problems. Some patients always take flash cards with them as a sort of safety measure, not only because of the content but also because it makes them feel connected to the therapy and the therapist.

Experiential Techniques

Imagery Rescripting and Historical Role Play

A powerful technique to attain change in painful childhood memories on schema level is imagery rescripting. Detailed procedures are described elsewhere (Arntz, 2011; Arntz & Weertman, 1999). In most cases, a present negative feeling is taken as a memory bridge to a childhood memory, which the patient imagines with (if possible) the eyes closed. When the patient clearly imagines the childhood memory and affect is activated, the therapist (or another safe and strong person) should enter the scene and intervene. Patients with BPD are usually, at least in the beginning of treatment, not healthy and powerful enough to intervene themselves, so someone else

can serve as the intervener. The intervener stops the maltreatment, creates safety for the child, and asks the child what he or she needs. Special attention should then be given to correction of negative interpretations and soothing of the child, during which imagined physical contact should be offered, as it is the most powerful way to convey comfort and love to a child. If the patient does not accept physical contact, it should not be forced in any way.

In the following example, Natasha imagines a threatening childhood memory with her mother.

NATASHA: I cannot do anything. I'm too afraid.

THERAPIST: I am joining you. Can you imagine me standing alongside you?

NATASHA: Yes, I can see you beside me.

THERAPIST: Good. I'm talking to little Natasha now . . . what is it what you need? Is there anything I can do?

NATASHA: (*Does not say anything, seems very afraid.*)

THERAPIST: Okay, listen to what I say to your mother then . . . Madam, you are Natasha's mother, aren't you? I have to tell you that you are doing terrible things to your daughter. Her bike was stolen, there was nothing she could do about that, and she is emotional about that. That is normal, everybody feels emotional when you lose something of importance. But you are humiliating her in front of the rest of the family because she is emotional. And what is even worse, you are accusing her that she caused the theft. You are saying that she has always been a bad girl, always causing problems, and that she is the cause of your misery. But that is not true, Natasha is a good girl. She should get sympathy and consolation from you because you are her mother and she is in pain. And if you are not able to give her what she needs, and what every other child needs, that is enough of a problem. But in any case you shouldn't accuse her because you have a problem in handling emotions and being a parent. So, stop accusing her and apologize for having done that!

Natasha, look at your mom now, what is she doing? What is she saying?

NATASHA: She looks a bit surprised . . . she is not used to being talked to like that . . . she does not know what to say . . . well, she says that I should be taught a lesson because I should have known beforehand that it would go wrong with what I did with the bike.

THERAPIST: Listen to me, madam. That's nonsense, Natasha didn't know that beforehand and she feels sad about losing her bike, and if you cannot comfort her, stop talking like this or leave the room. What is she doing now, Natasha?

NATASHA: She stops talking and just sits in her armchair.

THERAPIST: How does little Natasha feel now?

NATASHA: I'm afraid that she will punish me when you go away.

THERAPIST: Is there anything that I can do to help you? Ask me!

NATASHA: I want you to stay and care for me.

THERAPIST: That is okay, Natasha, I'll stay and take care of you . . . what do you need now?

NATASHA: That you not only take care of me but also of my sister.

THERAPIST: Should I send your mother away, or take you and your sister with me?

NATASHA: Take us with you.

THERAPIST: Okay, I take the two of you with me: imagine that you take your stuffed animals and everything else you want and that we leave the house together with your sister. We drive to my place. There we enter the house, and you take a seat. Do you want something to drink?

NATASHA: I'm feeling sad now. (*Starts to cry.*)

THERAPIST: That's okay, do you want me to comfort you? Let me take you in my arms . . . can you feel that?

NATASHA: (*Cries even harder.*)

Note that the therapist takes several roles, intervening and protecting the child, correcting dysfunctional ideas about guilt and badness, and comforting the child so that the experience can be emotionally processed. The therapist acts, in other words, as a good parent would have done. The purpose of the rescripting is not to distort or replace the reality of the patient's childhood (which was generally bad) but to correct dysfunctional beliefs, to provide corrective experiences, and to evoke feelings that were avoided or suppressed. Usually imagery with rescripting is highly confrontational, as the patient begins to realize what he or she has missed and how he or she was maltreated. This can lead to a period of mourning. The therapist should help the patient through this period, balancing the focus between here and now and the processing of childhood memories. Role plays of situations from childhood can be used instead of imagery (Arntz & van Genderen, 2009; Arntz & Weertman, 1999). However, some behaviors are awkward or unethical to practice in a role play (i.e., therapist taking child on his or her lap), and imagery may provide an easier and safer strategy.

Empty-Chair Techniques

Punitive caregivers, threatening persons in the present, or a punitive schema mode can be symbolically put on an empty chair, and the therapist and/or

the patient can safely express feelings and opinions toward them. Often, it is wise that the therapist first models this technique, as patients might be too afraid to express themselves. As Natasha suffered frequently from her punitive schema mode, echoing her mother's verbal aggressiveness, the therapist repeatedly put this mode (i.e., her aggressive mother) on an empty chair, firmly contradicted her, told her to stop, and sent her away. It is helpful to make an audiotape that the patient can use at home. Later in treatment, the therapist helped Natasha to do this herself, and Natasha also started, with success, to do this at home, each time she was burdened by an activation of this mode.

Experiencing Emotions

Patients with BPD should learn to tolerate the experience of strong negative emotions, without acting out behaviors that serve to avoid or escape from the experience. Exposure techniques known from behavior therapy can be helpful, as are writing exercises, such as composing a letter to a former abuser (but not sending it) in which the patient expresses all of his or her feelings. Patients with BPD are especially afraid of experiencing anger, as they fear that they will lose control and become aggressive. As an intermediate stage, the therapist may model verbally expressing anger while banging on a cushion, asking the patient to join. This lowers the fear of anger. Later on, the patient can be asked to try to experience anger without engaging in any behavioral action. The patient then discovers that he or she can stand high levels of emotions without having to behaviorally express them and without losing control.

Behavioral Techniques

Role Plays

These techniques are useful for teaching interpersonal skills to patients, such as appropriate assertiveness and expressing feelings toward another person. The therapist usually models assertive expression first, as many patients with BPD are truly confused about how to execute an effective expression of feelings. Even when patients refuse to practice during a session, we have seen that the modeling is helpful to get them to begin appropriately expressing feelings and opinions outside the session.

Experimenting with New Behavior

A powerful way to reinforce new schemas and strategies is to ask the patient to behave according to them. Even when the patient reports that this new way of behaving feels strange (i.e., is not yet internalized), it is eventually

helpful, so the therapist should continue to encourage the patient to try it out. This is an important part of the later phases of treatment. Later in treatment, Natasha started to show more uncertainty and emotional pain instead of putting on her tough attitude when she was uncertain or hurt inside, and she found out that this was more functional as it led most people to accept her. After she divorced her aggressive husband, she also tried out new ways of behaving during dating. She found out that other types of men, more caring and less threatening than her former partners, were consequently interested in her.

Pharmacological Interventions

Patients with BPD may experience very high levels of negative emotions while having little tolerance for affect. Consequently, they are often prescribed medication. Unfortunately, often when one prescription does not help, a new prescription is added, leading to exotic, unnecessary, and possible harmful polypharmacy (Gunderson, 2011; Lieb et al., 2004). Clinicians should also realize that there is no medication with proven efficacy for BPD or for the severity of BPD symptoms in general (Feurino & Silk, 2011; Lieb, Völlm, Rücker, Timmer, & Stoffers, 2010; NICE, 2009; Stoffers et al., 2010). Although some reviews concluded that specific medications can be used to reduce specific symptoms (Stoffers et al., 2010), others are more reluctant (NICE, 2009). There is little evidence that selective serotonin reuptake inhibitors (SSRIs) have any specific merits, not even for depression in BPD patients (Feurino & Silk, 2011; Lieb et al., 2010). Currently, mood stabilizers and atypical antipsychotics are believed to be the most effective for specific symptoms in BPD patients, though there is lack of robustness of findings and more trials are needed (Feurino & Silk, 2011; Lieb et al., 2010). In general, pharmacotherapy is considered as a possible adjunct to psychotherapy, not as a treatment of BPD in itself. Moreover, there are specific risks in prescribing medication in this population: paradoxical effects, abuse, dependency, and use for suicide attempts are among them. This is particularly true for benzodiazepines, which might be prescribed when patients are in a state of acute fear or suffer from sleep problems. Often, the fear is fueled by aggressive impulses that the patient feels unable to control. Use of benzodiazepines might lead to a reduction of fear of the expression of the impulses and lowered threshold for expression, similar to alcohol (see Cowdry & Gardner, 1988; Gardner & Cowdry, 1985, for empirical evidence). We have often observed the intensification of an emotional crisis, leading to self-injury and suicide attempts, after the use of benzodiazepines, especially when used in combination with alcohol. This "paradoxical" effect should be explained to the patient and the patient should be asked to stop the use of benzodiazepines and alcohol. A short use of antipsychotics or antihistaminics is often a safe alternative, when

anxiety levels seem to become intolerable. Personal contact is often a better alternative. Long-term use of antipsychotics dampens many BPD symptoms but may make it impossible to address important feelings so is generally discouraged.

PROGRESS, LIFESPAN, AND TERMINATION CONSIDERATIONS

Because termination of treatment might be very frightening for the patient, it should be well prepared and discussed as part of the process of therapy. Feelings and negative beliefs about termination should be clarified. In addition, a list of remaining problems should be made and appropriate treatment strategies chosen. Gradually tapering off the frequency of sessions is recommended, so that the patient can find out how life is without the regular help of the therapist. Booster sessions may be especially helpful, to help the patient maintain functional strategies and prevent relapse into old schemas. Some therapists recommend an open end, in the sense that the patient can always come back for a few sessions when needed. Paradoxically, this possibility might lead to less relapse and health care use because it offers a safe base on which the patient can fall back. Because patients with BPD are generally not very healthy in their choice of partners, and treatment usually brings about enormous changes, subsequent relational problems can occur. A referral for marital therapy may be indicated, so that the couple can adapt to the new situation. However, many partners are so unhealthy that the patient decides to leave the relationship. The therapist can help the patient learn to choose healthier partners and thus prevent a relapse into old patterns. Some believe that former patients with BPD are, in the long run, best protected for relapse when in a good relationship with a caring partner.

Similarly, the patient should be encouraged to discover and develop his or her true interests and capacities. This might have implications for choice of study and work, as well as hobbies and friends. Creating a good and healthy context in the broadest sense should be high on the agenda in the final stage of therapy. There is a risk that the patient will want to terminate treatment too early, claiming that there are no longer problems, whereas the therapist knows that important issues were not addressed in treatment. When empathic confrontation with this detached strategy does not work, the best thing the therapist probably can do is offer that the patient can return for further treatment if the patient needs it.

BPD in Youth

There is no agreement as to whether BPD can be diagnosed in youth, given the rapid development and the rather common prevalence of some BPD

features. Nevertheless, clinicians see youth with problems that can be classified as BPD and that need to be addressed in treatment. The approach described in this chapter can be used to treat these youth, though care should be taken that maltreatment and other forms of negative influences in the family (or other systems the patient depends on) stop. Otherwise it might be impossible to correct in say 2 hours a week what is reinforced in so many other hours during the week. Also, the patient might be afraid of being disloyal to parents, as this would create the risk of severe punishment or abandonment. Thus, parents should be corrected (sometimes they need treatment themselves) or patients should live in a more healthy context so that they don't need to depend any longer on those who put them back into dysfunctional patterns.

COMMON CHALLENGES AND CLINICIAN SELF-CARE

Treatment of patients with BPD is for most therapists challenging. Among the major risks are burnout, transgression of professional boundaries, and development of negative feelings toward the patient (countertransference). It is therefore important to have a safe peer supervision group of therapists who work with the same model and who can help one another. The peer supervision group should validate difficult feelings evoked by patients with BPD, support one another, and empathically confront one another with dysfunctional attitudes and actions of the therapists. Emotionally detached therapists who have difficulties in being open and personal are usually not a good match for patients with BPD, as these patients need more personal connection than usual. Therapists with high levels of unsatisfied personal needs might be at risk to transgress personal boundaries, as they might be seduced to use the patient to meet their needs. Recent piloting with the combination of group and individual schema therapy indicated that therapists like this format, as it offers both a shared responsibility between group and individual therapists, and offers possibilities to do intensive individual therapy while the patient also profits from experiences in the group.

CONCLUSION

The approach presented in this chapter is based on an integration of cognitive-, behavioral-, experiential-, and therapy-relationship techniques in the framework of a cognitive model. This approach helps therapists to adapt treatment to the needs of the patient, while at the same time maintaining focus. Empirical tests have yielded evidence that this approach is highly effective and has a high degree of acceptability for patients. In the future, the development of variants that lead to faster results are expected.

Dismantling studies, experimental tests of ingredients, and possibly the combination of group and individual formats will contribute to this.

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