spectrum
Personality Disorder Service

SPECTRUM COMMON FACTORS TREATMENT: A BRIEF INDIVIDUAL INTERVENTION FOR BORDERLINE PERSONALITY DISORDER

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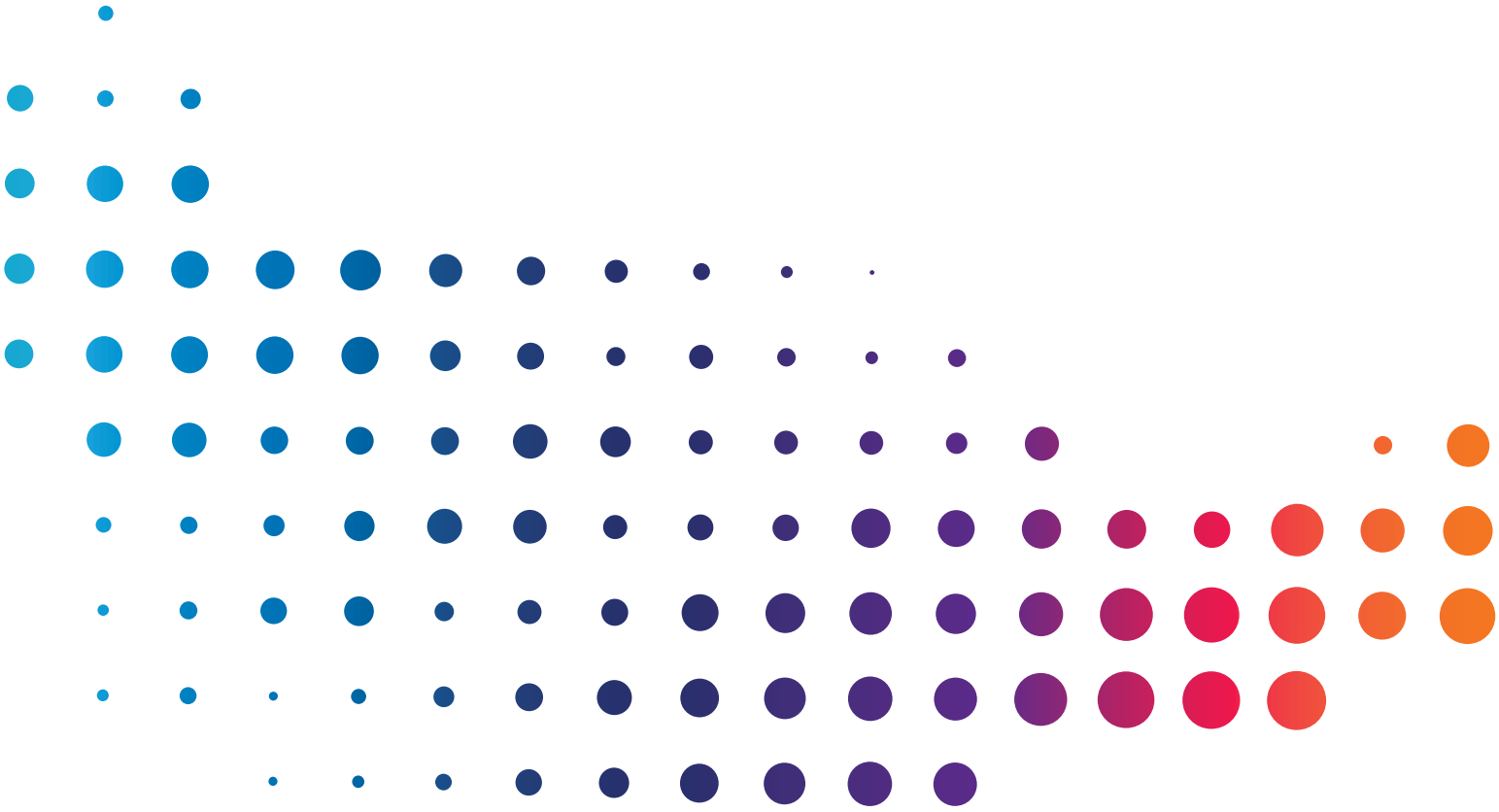

DISCLAIMER

Spectrum common factors treatment: A brief individual intervention for borderline personality disorder is based on the best available evidence and clinical experience at the time of writing. This Resource should not be used as a substitute for specialist advice and/or information for the treatment of people with Borderline Personality Disorder (BPD).

Research and clinical experience in the treatment of people with BPD is ongoing and continues to evolve at a rapid pace. Therefore, clinicians are encouraged to critically assess the information contained in this resource and use their own clinical judgement in relation to making any treatment decisions.

Whilst the Spectrum and other authors are happy for the ideas in this Resource to be used by clinicians and service providers, they disclaim any responsibility for the consequences in clinician practices. Whilst great care has been taken to provide accurate information, the Spectrum cannot accept any legal liability for any errors which may inadvertently be in the text.

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FORWARD

The monograph 'Brief Intervention for Borderline Personality Disorder' fills a yawning gap in the literature on treatment interventions available for people with borderline personality disorder (BPD). Most publications on BPD focus on 'branded' psychotherapeutic approaches specifically developed for the treatment of BPD or structured treatment frameworks that employ the factors common to the branded approaches. Both these mainstream approaches for BPD have been validated as effective in randomized controlled trials (RTCs). Although effective, they are not widely available because of their duration (12 months or more) and the extensive clinician training required.

Increasingly the field of personality disorders, in particular BPD, has called for brief interventions within a stepped care model of treatment so that more people with BPD can get the help they need. Given an estimated community prevalence of BPD of around 1.6%, there are insufficient resources to treat all who seek treatment. This document provides succinct, experience–based instruction for clinicians wanting to implement a brief, ten session intervention for people with BPD, particularly those recently diagnosed. This intervention promises to go some way to meet the unmet treatment need. Some who receive the brief intervention may not need further treatment, or not at that time, while those that do will be clearly identified in the course of the intervention.

The monograph articulates the process that clinicians can use to work towards a shared formulation of the problems experienced by someone with BPD, how to give the diagnosis if it is not already known, and details of four modules designed to address common difficulties faced by people with BPD. These can be worked on according to the patient's choice after the diagnosis is confirmed and the specific difficulties the patient experiences have been identified. Situations for which this brief intervention is not recommended (acute suicidality, current significant self–harm, risk of harm to others, frequent attendance to EDs) are listed.

In many cases, the information about BPD and the module or modules covered with the patient during this brief intervention will assist with current difficulties and enable patients to get on with establishing a life worth living in the knowledge that further assistance is available when and if needed. At the same time, as already mentioned, people with BPD for whom the brief intervention is inadequate will be identified in the course of the intervention. They can then be assisted to get the further help they need.

Importantly, this brief intervention has been tested in day programs run by clinicians at Spectrum the Personality Service for Victoria, receiving positive feedback from participants. It is practical, down to earth, and provides a wealth of information in 14 appendices which inform clinicians about topics highly relevant to BPD including mindfulness, attachment, and making a crisis plan.

'Brief Intervention for Borderline Personality Disorder: A Spectrum Guide' is likely to be particularly useful for psychologists in Australia who treat patients with BPD for the 10 sessions rebated by Medicare under the Better Access Scheme. But this document is not only useful for psychologists. The structure for sessions, the clarity of recommendations, and the extent of information provided in the appendices render this document invaluable for all clinicians who want to offer a brief intervention for people with BPD who, too often, have lacked informed mental health care.

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INDEX

RATIONALE FOR BRIEF INTERVENTIONS

Traditionally, treatments for Borderline Personality Disorder (BPD) have aimed to achieve substantial personality change. Treatments such as Dialectical Behaviour Therapy (DBT), Mentalization Based Treatment (MBT) and Schema Focused Therapy (SFT) require at least 12 months and more commonly, 18 months to 2 years. However, there are a number of difficulties with these approaches:

- *Lack of availability:* Typically these treatments are only available to a small proportion of people diagnosed with BPD, often accompanied by very long waiting lists.
- *High clinician competency:* Specialist treatments involve a significant time and resource commitment to training that in turn may limit the number of clinicians able to deliver longer–term treatments.
- *People with BPD have diverse needs:* Not all people with the diagnosis may want long–term treatment.

There is clearly a role and rationale for shorter term interventions that orient people towards treatment as an initial step towards personal recovery. This intervention is:

- Designed to be brief: 10 sessions;
- Not intended to provide substantial treatment aimed at personality change;
- Not an intervention for general distress, but is rather an initial step (conceptualized within a stepped care model) to respond to issues that commonly arise in the early stages of a broader recovery process for people with a diagnosis of BPD.

Stepped care model: Advocacy work in Australia has highlighted the limited availability of treatment for people with BPD. There is an urgent need for a stepped care model that provides a range of interventions suited to the needs of consumers at different stages of recovery. This proposal reflects a wider call for a stepped care model for treatment of BPD in Australia.

SITUATIONS IN WHICH A BRIEF INTERVENTION IS NOT INDICATED

A brief intervention does not provide comprehensive treatment. The current intervention is designed to assist with issues that frequently arise for people recently diagnosed with BPD. A brief intervention is not suitable for the following situations:

- Acute crisis;
- Acute indicators of intentions to harm others;
- Very high levels of risk.

This intervention is designed for people with mild to moderate symptoms of BPD. Where there is regular non–suicidal self–injury (NSSI), a comprehensive treatment plan that addresses the NSSI should be developed with this intervention as a component of the treatment plan.

RATIONALE FOR SHORT–TERM, NON–SPECIALIST INTERVENTIONS

Generalist clinicians are able to provide efficacious treatment for people diagnosed with BPD

- Specialist treatments such as DBT, MBT and SFT were originally evaluated within studies that compared them with 'treatment as usual.'
- However, in these early studies, 'treatment as usual' was not organized to address the needs of people with BPD.
- More recent evaluations compare specialised treatments with generalist psychiatric care provided by generalist clinicians willing to work with people diagnosed with BPD.
- Two 'good enough' psychiatric care interventions have been developed: Good Psychiatric Management (GPM) and Structured Clinical Management (SCM). The results of randomised controlled trails (RCTs) that compared (i) GPM with DBT and (ii) MBT with SCM suggested that the generalist treatments had similar outcomes to the specialist treatments. For instance, in relation to BPD symptoms, generalist treatment demonstrated similar effectiveness to specialist treatments.

Treatment factors that are shared by specialised and generalised models ('common factors') have been identified and incorporated within stepped care models for BPD, resulting in a new, integrated treatment model. This integrated approach may be effective for many people with BPD.

The proposed stepped care models would reserve the longer duration specialist treatments for BPD that is non–responsive to generalist treatments or has a severe and high risk presentation inclusive of suicidality and NSSI. For some newly diagnosed clients or in cases where symptoms are milder, generalist treatment provided within a clear integrated model appears to be effective.

A 10–SESSION INTERVENTION FOR BPD: ORIENTING CLIENTS TO TREATMENT

The program outlined here describes a brief intervention for recently diagnosed or milder expressions of BPD that is intended to orient clients to treatment. The aim is to work collaboratively with the client to:

- Identify issues that typically arise in the context of the diagnosis;
- Understand the specific difficulties that the client is experiencing;
- Explore how these difficulties might be addressed and identify the need for further treatment.

A flexible structure for 10 individual sessions is outlined below. The structure and content of these sessions are based on a number of fundamental principles:

- *A Flexible Structure:* The decision regarding the content covered in a given session is made by the therapist in relation to the needs and progress of the client.
- *A Number of Common Tasks:* The first 3 to 4 sessions cover common themes that typically arise in the context of the BPD diagnosis.
- *A Modular Structure:* The focus of the latter sessions, for instance focusing on emotional regulation or interpersonal functioning, is determined by the needs of the client.

It is important to acknowledge the centrality of the therapist's stance throughout the intervention. This has a fundamental effect on rapport and the effectiveness of the therapeutic relationship.

THERAPIST STANCE: WORKING WITH BPD

The principles that underpin any effective therapeutic relationship also apply when working with individuals diagnosed with BPD:

- The work should be collaborative;
- The therapist must be authentic and 'real';
- Skills such as validation of difficult experiences and careful listening are critically important;
- Regular assessment and feedback on the therapeutic alliance is sought;
- Any difficulties identified in the therapeutic alliance are addressed.

When providing treatment and support to a client with BPD, it is vital to maintain a balance between an emphasis on change and acceptance of the client as they are. This means that maintaining validation alongside change–oriented intervention is essential. For instance, the emphasis in CBT on challenging a client's thoughts can be too confronting for someone with BPD. At times a greater emphasis on validation is needed than may be typical in CBT.

While these skills may seem basic to people who are already working with BPD clients, they remain the most important skills in any intervention. As the research indicates, therapeutic alliance as rated by the client is a major factor in creating a safe space where change can happen.

Beyond these basics, the therapist needs an:

- *Active Approach:* Taking an active approach indicates that the therapist has heard the client and seeks clarification when something is unclear.
- *Affective Focus:* Pay close attention to the client's emotional response to information and what it means in the context of their own experience.
- *Non-expert and Curious Approach:* Take a non–expert approach and remain curious about what an experience means to the client rather than presume to know how the client responded or what is best for the client.
- *Ability to Monitor the Therapeutic Relationship:* Build trust to promote help–seeking, assess the strength of the therapeutic relationship from the client's point of view, encourage future engagement with treatment services.
- *Ability to Set Limits:* Clearly articulate the limits to the relationship at the beginning of the relationship.

Maintaining this therapist stance is key throughout the intervention.

SUGGESTED SESSION BY SESSION OUTLINE

Sessions 1 & 2	*Common Tasks:* Assessment of Current Functioning/Development of a Crisis Plan/Developing Treatment Goals / Formulation with Client.
Session 3	*Common Tasks:* What is BPD?/Exploring the Client's Experience of Symptoms.
Session 4*	*Common Tasks:* Exploring What the Diagnosis Means to the Client/Exploring Client's Treatment Priorities/Brief Discussion of Models of BPD/Preparation for the Carer Session.

Session 5	*Informational session with partners, family members or other non–professional carer(s)* (with client consent). This session is optional and depends on the client's specific carer relationships.
Sessions 5 (or 6) to 9	*Modular/Flexible Approaches:* Begin to Explore Key Issues and Introduce Information about Treatment Options/Discuss the End of the Relationship.
Session 10	*Review:* Explore the Experience of the Intervention/Discussion of Other Treatment Options as Indicated.

*Development of a shared understanding of current problems and developmental pathways (formulation) is essential and should be prioritised over specific modules. This may take more than 1–2 sessions.

ROLE OF ASSESSMENT AND FORMULATION

The approach to assessment and formulation is reliant on the information that is available at the time of referral. For example:

1. Collateral information is available from a psychiatrist or other professional who has made a diagnosis of BPD, or from other sources such as a case manager.

2. No diagnosis has been made or a GP has queried BPD in the absence of a definitive diagnosis.

Two sessions have been allocated for assessment and formulation. However in the situation where no existing assessment or formulation is available, the clinician may decide to allocate further sessions to assessment. It is difficult to proceed with therapeutic tasks contained within the modules without a shared formulation that is well understood by the client. It may be that a majority of all sessions is spent attempting to formulate a client's issues and this would be preferable over moving on to interventions.

SHARING THE FORMULATION WITH THE CLIENT

Feedback to the client about the formulation in non–technical, easy–to–understand language is essential and should:

- Wherever possible use language that the client has used to describe his or her difficulties;
- Include a brief written statement about the formulation for the client to keep;
- Revisit the client's goals and link the formulation to those goals;
- Include a treatment plan that outlines what will be addressed in the remaining sessions;
- Include opportunities for the client to question or change aspects of the formulation.

GENETICS

This intervention suggests a brief general discussion of genetic factors associated with BPD. It is important to note that genetic factors (also referred to as heritability) are known to play a role in the underlying predisposition to BPD. Studies have shown that people with BPD have sensitive temperaments; disorders of emotion regulation and hypersensitivity are disproportionately higher in their families. This suggests that there is a role for the transfer of a genetic predisposition to BPD through family lines.

ATTACHMENT THEORY: A USEFUL APPROACH TO FORMULATION

ATTACHMENT

We recommend that the formulation process include a discussion of attachment theory for anyone with BPD. The intent is to encourage clients to understand the impact that their early life attachments may have on their current life difficulties, particularly with regard to relationships.

- Attachment can be a very triggering topic for some people with BPD. Discussion of childhood attachment can lead some people to feel they have been permanently damaged by their early difficulties with attachment figures.
- It is important to consider what is appropriate for each client.
- For many clients, it is important for them to understand what a secure attachment may look like. This can be validating for clients who have not had a secure attachment. This can help distinguish their experience from optimal attachment patterns.
- In some cases, discussions about attachment may be mostly limited to adult attachments.
- In other cases it may be useful to discuss childhood attachments and to provide clear information on attachment–related terms.
- It is important to instil hope that attachment styles can change and that people with previously disrupted or difficult attachments are able to develop secure attachment.

The information contained in Appendix A suggests broad information that can be provided to clients, though how much and how it is delivered should be specific to each client.

NOTES TO CLINICIAN

A discussion of attachment is best covered as part of a client–specific formulation based on their early developmental history. It is suggested that attachment comprises one part of a broader formulation. It is not necessary to use the specific vocabulary cited; it may be more useful for clients to be able to understand attachment in terms of their own relationship patterns.

Detailed information about attachment is included in Appendix A.

VALIDATING THE EXPERIENCE OF TRAUMA

- Many people with a diagnosis of BPD have experienced trauma. Trauma is commonly understood as referring to abuse, neglect and attachment trauma.
- The focus within this intervention is on how these experiences have shaped the present reality for the client.
- Encouraging discussion of detailed descriptions of trauma or engaging in any other form of trauma work should be avoided. The reason for this is that people with BPD may have current difficulties regulating their emotions; discussion of past trauma is very likely to cause distress beyond their current coping capabilities.
- When the person does not have the ability to manage distress in the present, discussion of past trauma may cause additional iatrogenic difficulties. The brief nature of this intervention does not lend itself to completing trauma work. Exposure–based work in particular is not recommended in a brief intervention context.
- The focus that is most likely to be helpful within a brief intervention is to validate the current emotional experience of a person with a trauma history. This can range from miserable and depressed to frightened and agitated. The person's current experience can be explored, heard and validated.

BEST EFFORTS TO COPE

- Rather than focusing on the negative consequences of certain behaviours, it may be more constructive to understand behaviours such as dissociation, non–suicidal self–injury or substance misuse as examples of the person's best efforts to cope.
- Understanding these behaviours as coping strategies (albeit ones that the client may wish to change) may help to reduce shame.
- Validating these behaviours as being best efforts to cope can facilitate the client's current decision to change old patterns of behaviour.

Note Regarding Self–Destructive Behaviours or Behaviours of Concern.

- *Dissociation:* Treatment of dissociation is based on the use of grounding techniques and therapists are encouraged to read Boon, Steele and Van der Hart (2011).
- *Substance misuse:* Since this is a common issue among people diagnosed with BPD, it is assumed that therapists have some skills in treating substance misuse. Detailed treatment recommendations are beyond the scope of the current document.

MINDFULNESS / PRESENT MOMENT ATTENTION

Everyday Mindfulness/Dedicated Mindfulness Practice: The emphasis in this Brief Intervention is on 'everyday mindfulness' rather than having the clinician insist on a dedicated mindfulness practice. Of course, if the client is able to dedicate a short period of time each day (maybe 10 minutes) to a dedicated practice, that is to be encouraged and supported. But if this is not possible, encouraging clients to direct their attention to their present experience is valuable. This might be through activities such as mindfulness while drinking a cup of tea or coffee or brushing their hair.

Avoiding Body Focused Practices: Many clients with BPD find body–focused present moment practices, such as mindfulness of the breath, too confronting. These practices may even trigger memories associated with past traumatic bodily experience. We discourage use of these kinds of practices in these cases.

Mindfulness Practice in Session: A brief two to three minute mindfulness practice is recommended at the beginning of each session. However it is also possible that some clients will find this confronting; clinician judgement is needed here.

The aim of each of the specific modules included in this Brief Intervention monograph is to increase awareness of present moment experience. Each module approaches this in distinctly different ways.

Detailed mindfulness scripts are included in Appendix B.

CRISIS PLANNING

- A crisis plan should be developed during the earliest stages of the intervention (session 1 or 2);
- A stepped approach is encouraged with an initial focus on self-management including any self–soothing strategies that clients identify;
- Clients are encouraged to use supports within their social networks;
- The discussion should include emergency responses such as when it might be constructive to phone psychiatric triage.

A template for this is available in Appendix C

COMMON TASKS WITHIN A BRIEF INTERVENTION

Personality change is not necessarily the focus of brief interventions. Their short duration makes them ideal for targeting a number of common, clinical tasks relevant to people diagnosed with BPD. These include:

ASSESSMENT AND FORMULATION

- Brief exploration of current functioning with particular reference to current risk factors such as suicidal thinking, suicide attempts or NSSI behaviours;
- Exploration of what brought the client to consult the therapist and discussion of key difficulties from the client's perspective;
- Developing a shared understanding of the client's difficulties based on their developmental history.

GOAL SETTING

- It is recommended that a significant portion of Session 1 and/or 2 is spent creating collaborative goals that will provide a focus for therapy;
- Research tells us that clients are more likely to return to therapy after their problems are formulated and treatment goals negotiated during initial sessions (Tryon & Winograd, 2011);
- Once the basic treatment focus is identified and agreed upon with the client, it can be altered as needed during the course of the intervention.

EXPLAINING THE DIAGNOSIS IN RELATION TO THE CLIENT'S EXPERIENCE

- Provide clear explanation of diagnostic criteria as they relate to the client's specific functioning;
- Explore how the diagnosis was provided to the client if a previous diagnosis has been made;
- Explore the client's specific symptoms using a non–expert stance that is curious about the client's experience;
- Explore how the client understands the diagnosis of BPD. For instance, does the client find their diagnosis helpful or does it represent a stigmatising label.
- At times, clients may want to read the DSM 5 criteria for themselves. The language of the DSM 5 can be difficult for clients to understand. However, some clients find the criteria match their experience so well that they accept the language and feel relieved to have their experience validated

BPD can also be explained to clients using the following broad descriptions of experience:

- Strong, overwhelming emotions and feeling;
- Difficult and sometimes unstable relationships;
- Impulsive, often self–destructive behaviour;
- Fragile sense of self.

EXPLORATION OF THE DIAGNOSIS: RELATING CRITERIA TO THE CLIENT'S EXPERIENCE

- *General Discussion of Client's Difficulties:* Before presenting the descriptions of the different aspects of BPD, it may be constructive to have a general discussion about the difficulties your client has identified. Information from the assessment and formulation phase may be useful.
- *Collaborative Exploration:* One way to ensure the collaborative nature of this discussion is for the clinician to check that their understanding of the client's difficulties is accurate from the client's point of view.
- *Listening and Using Appropriate Language:* Using words that the client has used may also indicate that you are listening carefully. For instance, the client might have said that she gets a 'red hot mind' and then 'anything can happen'. How you understand this in terms of the diagnostic criteria for BPD may be a useful starting point for a conversation around diagnosis.
- *Avoiding Abstract Language and Criteria:* It is important that the diagnostic criteria are not understood by the client as abstract descriptions that mean nothing to him or her. Rather, through a gentle conversation, the client may start to recognise his or her behavioural, emotional, and thinking patterns within the descriptions given by the DSM or the broad areas of experience noted above.

WHAT IS BPD?

Detailed clinical information about the diagnosis of BPD is included in Appendix D.

CARER SESSION

Where appropriate, a joint session that includes the therapist, client and carer(s) can be very constructive and is recommended. The decision about whether to include a carer session rests with the client. Some clients feel that there is no-one in their life who they regard as supportive or occupying a carer role. Advocating for a carer session in this situation is not appropriate. On the other hand, many clients can identify a caring and supportive person who may benefit from information about BPD to better understand the client's situation.

Some considerations in making this decision include:

- If the client has experienced trauma within the family, how will discussion of this issue be managed in the presence of the carer, particularly if the carer is a parent or family member?
- How can general information about BPD be introduced to the carer without encouraging a pathologising attitude towards the client or implying that the carer, if a parent, is to blame?
- Will the formulation be shared with the carer? If not, is general information about BPD likely to be constructive in the absence of reference to the client's individual formulation?
- If the formulation is to be shared, what is the best way to do this? How might the client wish to talk about the formulation and will they or the therapist lead this discussion?
- Are there any important messages the client wishes to convey to the carer? From a practical point of view, how will this be organized? For instance, will the therapist invite the client to introduce the session or summarize at the end of the session, or will the therapist take the lead?

EXPLORING THE FOCUS FOR THE REMAINING SESSIONS

- Discuss which particular key difficulties are able to be addressed in the remaining sessions. Some potential focus areas are emotional regulation, interpersonal conflict and relationships, distress tolerance, or identity and self–worth.
- Clearly acknowledge the limited time the client has to work with the therapist and set realistic expectations about what can be achieved.

ENDING THE THERAPEUTIC RELATIONSHIP/REFERRAL IF INDICATED

- Explore what the ending of the relationship will mean to the client. This would include ways of managing any responses to the end of treatment that are of concern.
- Fear of abandonment is one of the diagnostic criteria for BPD. Many people with BPD may experience distress at the end of the therapeutic relationship. This discussion should happen during the early stage of treatment, at least 4 or 5 weeks before the end.
- Refer to other services if that is indicated.

A MODULAR APPROACH: RESPONDING TO THE CLIENT'S IDENTIFIED PRIORITIES

Once a treatment focus has been established, we suggest adopting a modular approach, selecting information from the rest of this publication (and other sources) that are relevant to the issue(s) that the client has identified.

Four issues that commonly arise for people with BPD are addressed in detail below:

- Recognising and naming emotions;
- Distress tolerance difficulties;
- Emotional dysregulation;
- Interpersonal difficulties and deficits in mentalizing.

This list of difficulties is not exhaustive. Other issues that may be identified include self–loathing, a severely limited sense of self–worth with associated deficits in self–compassion, or issues around identity and sense of self. A module concerning identity and sense of self is not included within the modular structure of this intervention. These issues are too complex to be adequately addressed within the three to four remaining sessions of this brief intervention.

MODULE A: DIFFICULTIES WITH RECOGNISING AND NAMING EMOTIONS

INDICATIONS FOR THIS MODULE

This module should be the focus of treatment when the client has difficulty recognising and naming emotions and a limited emotional vocabulary.
For instance, when the client describes their mood only using words such as "bad", "shitty" or "pissed off", this may suggest a severely restricted ability to identify and name a range of emotions (clinically referred to as alexithymia). Since the other modules assume that the client has some ability to identify and name emotions, completion of Module A should be prioritised if this is not the case.

OBJECTIVES:

- To provide psychoeducation about the role of emotions;
- To begin or work on addressing difficulties with recognising and naming a range of emotions.

NEXT STEPS

Depending on the degree of difficulty the client experiences with identifying and naming emotions, 3 or 4 sessions may not be enough to adequately address all aspects of limited emotional literacy or all difficulties with emotional expression. A longer period of treatment may be needed to address difficulties with emotional understanding and regulation. This may be an indication for referral to one of the specialist treatments for BPD.

MODULE CONTENT

What is an Emotion?

People with BPD may have difficulty recognising and regulating emotions, including distress. It is difficult to consciously regulate emotions, including negative states such as distress, without first being able to recognise and name discrete emotions. It is common for people with BPD to have difficulty recognising and naming emotions. The aim of this initial intervention is to encourage the client to reflect on their emotions. It is important that the client be able to connect physical sensations with emotional experiences; the clinician is encouraged to introduce this concept in the earliest discussion of emotion.

Introducing this topic may be most conversational and effective if the clinician starts with a discussion of how the client conceptualises emotions. The emotions handout can then be introduced.

Possible questions to get the discussion going include:

- How do people feel emotions?
- What would people be like if they didn't have any emotions?
- Is an emotion different from a thought or a physical sensation?
- How do you know what you are feeling at any moment in time?

Benefits and Costs of Emotions

The aim of this part of the module is to encourage a more complex understanding of emotions, including the idea that each of the six basic emotions has benefits but also costs if the experience of the emotion is approached in an inflexible way.

Why Do We Have Emotions? Handout is in Appendix E and Benefits and Costs of Emotions handout is included in Appendix F.

Recognising Emotions

This part of the module focuses on increasing identification and recognition of emotions. In particular it encourages the client to make a connection between a physical experience in the body or facial expression and an emotional experience. Some clients may have difficulty with this process and may need considerable prompting and support. This exercise can take an entire session or longer. Encourage curiosity and reflection and don't rush the process.

Complexity of Emotions

When discussing emotions with clients, it is common for the emotion that is acknowledged to comprise only a part of a more complex emotional experience. For instance, people may report experiencing anger when actually there was a more primary (earlier in time and more appropriate to the trigger) experience of fear or hurt. It is also possible that anger may be mixed with an unacknowledged experience of sadness. Clinicians should be alert to situations involving secondary emotions or mixed emotions and through a collaborative discussion, deconstruct these complex emotional experiences when appropriate.

Emotion Diary

After working through this content, you can encourage the client to complete an emotion diary at home for each day of the remaining weeks. The diary forms the basis of discussion of the client's experience in subsequent sessions. These sessions may be more conversational in nature with less direct psychoeducation. The aim is to encourage a more complex and reflective approach to the experience of emotion. For instance, the client may notice that he or she does not only experience negative emotions as they initially conclude. They may notice complex emotions such as sadness and confusion at the same time. The aim is to encourage a more nuanced understanding of emotions that may enable clients to differentiate, for instance, confusion, frustration and anger, or disgust and disdain. See also note about emotional vocabulary below.

The Emotion Diary handout is available in Appendix G.

Emotional Vocabulary

The Emotional Vocabulary handout can be worked through after completion of the first diary handout. The diary handouts use a simple design to allow for the difficulties some clients may have with complex emotional vocabulary. Nevertheless when discussing the diary handout, the therapist can support the process by encouraging the client to go beyond the six basic emotions.

The Emotional Vocabulary handout is available in Appendix H.

B

MODULE B: DISTRESS TOLERANCE DIFFICULTIES

INDICATIONS FOR THIS MODULE

This module should be prioritised when the client's self–report or presentation includes becoming highly distressed on a regular basis. A key decision for the clinician is whether this module or the emotional regulation module (Module C) is likely to be more useful for a particular client. *We would suggest using this module only when the client has very limited ability to self–calm.* The emphasis in this module is on the use of sensory modulation for self–calming. The therapist may wish to introduce some DBT distress tolerance skills at the end of the module if time permits, refer to Marsha Linehan's DBT Skills Training Manual. The decision about which distress tolerance approaches will be useful is based on assessment of the intensity of distress the client experiences.

OBJECTIVES:

- To provide psychoeducation about the importance of tolerating emotions so that the emotions can pass and tolerance of distress can increase;
- To start the process of supporting the client to tolerate distress with a particular emphasis on sensory modulation.

NEXT STEPS

Further work within a sensory–motor framework may be indicated according to the degree of difficulty the client has with tolerating distress and the progress the client makes with the sensory modulation component of this module. Janina Fisher and Pat Ogden's work may be particularly instructive in this regard (Appendix P).

MODULE CONTENT

Traffic Light Analogy — Levels of Emotional Arousal

At any given time an individual may be under-aroused or even dissociated, at a comfortable level of arousal and well regulated, or over–aroused and emotionally dysregulated. The analogy of the green, amber and red zones within a traffic light is a simple way of introducing the concept of levels of emotional arousal. The Levels of Emotional Arousal handout (Appendix I) can be used during the session to introduce this concept together with discussion of situations where the client felt they were experiencing low or comfortable levels of arousal (green zone), an intermediate level of arousal that's heading for dysregulation (amber zone) or actual dysregulation (red zone). At the same time, the therapist should also ask about situations or examples of when the client was under-aroused or possibly dissociative (black zone).

Under or over–arousal (black or red zone) are generally experienced as aversive. Exploring the client's experience in this regard may serve as a motivating factor for the client to learn new distress tolerance strategies. Alongside this discussion, the client may have some (albeit limited) distress tolerance abilities; identification and discussion of these existing approaches is also recommended.

The Traffic Light Analogy/Levels of Emotional Arousal handout is available in Appendix I.

Examples of Distress Tolerance Strategies

Use the sessions to work through a checklist of distress tolerance activities. Encouraging the client to commit to trying a few of these approaches is generally more effective than commitment to a large number of these skills.

A distress tolerance strategies checklist is available in Appendix J.

Many of these strategies involve focusing on the senses to modulate distress. Discuss the use of sensory stimulation to manage distressing emotions prior to introducing the concept of sensory modulation.

Sensory Modulation

Sensory modulation is the use of sensory processes to modulate current emotional experience (increase or decrease emotional arousal). The idea of sensory modulation can be introduced in terms of the connection between the body and the mind. If the body calms, distressing thought processes will also change positively.

A first constructive step may be to make a distinction between sensory processes for self–alerting and sensory processes for calming or coping. You can work through the Sensory Menu for Alerting and the Sensory Menu for Calming during the session, emphasising strategies that the client feels would work for him or her. Clarify that this is a personal process; what works for one person may not be so good for another. Encourage the client to create a personalized sensory kit.

The Sensory Menu handouts are available in Appendix K.

A Personalized Sensory Kit

A sensory kit is a collection of everyday or household items that have calming or alerting associations for the person. Refer to the Menu for Alerting and the Menu for Calming for ideas. Also encourage the client to think about where they are going to use the kit. Items for use at home may be different to items used on public transport for instance. The kit may include items with particular smells or tastes; images may also be included.

Recording Emotions for a Week and Associated Distress Tolerance Strategies

A diary for recording emotions and use of distress tolerance strategies is provided in Appendices G and J respectively. Encourage the client to focus on both under–arousal and over-arousal and to use a small range of strategies that they have identified on the check–list to respond to either over– or under–arousal. Also encourage the client to think about a range of sensory modalities such as smell and touch rather than relying on a single modality.

The remaining sessions may be more conversational in nature with less emphasis on psychoeducation. The diary entries can be used as the basis for subsequent in–session discussions.

MODULE C: DIFFICULTIES WITH EMOTIONAL REGULATION

INDICATIONS FOR THIS MODULE

This module should be used when clients express difficulties with understanding their emotions but can name emotions and when intense emotions lead to distorted thinking and unhelpful behaviour. This module is best used when clients are already using basic distress tolerance skills and can generally avoid impulsive behaviours in response to emotions. If a client is struggling to self–calm, it may be better to focus on the distress tolerance module (Module B) as a starting point. This module involves strategies to change responses to emotions and includes a strong cognitive component.

OBJECTIVES:

- Develop an understanding and vocabulary of emotions and how to identify emotions;
- Appreciate that all emotions have adaptive and important functions;
- Help clients to challenge their thinking once their emotional arousal is reduced;
- Identify unhelpful reactions when experiencing intense emotions; identify other ways of acting in these situations.

NEXT STEPS

Given the brief nature of this intervention, further work could be based on DBT emotion regulation skills such as developing problem solving abilities and opposite actions skills (referenced at the end of this module. Linehan, 2015).

MODULE CONTENT

What are emotions?

People with BPD often experience emotions more intensely than other people do. This intensity of emotional experience, combined with limited early life support to regulate emotions, means that people with BPD often find it difficult to cope with emotions and engage in self–defeating behaviours during times of high emotion. People with BPD often find it difficult to label emotions and to know what emotion they are feeling. They can also at times attempt to shut themselves off from emotions, leading to emotional numbing or dissociation.

Possible questions to ask:

- What emotions do you most often experience?
- What is your experience of different emotions?
- How do you know you are experiencing an emotion?
- What body sensations do you notice?

When the person has difficulties noticing or naming emotions, Module A may be more appropriate. The current module may be the most appropriate choice when noticing and naming emotions is not an issue but when there are regulatory difficulties, that is, emotions escalate rapidly.

Discuss each of the basic emotions and ask clients to identify typical times when they experience each of these. Following that, discuss both the benefits and problems of basic emotions. It is important for clients to be able to understand that all emotions are important and can be helpful, as many clients believe that certain emotions are bad and that they should not be experiencing these. We ask that clinicians and clients work through each of the basic emotions and discuss benefits and problems of each.

A handout on benefits and problems of basic emotions is available in Appendix F.

What is emotion regulation?

Emotion regulation is a skill. It involves being able to understand and respond to emotions in a flexible way that is consistent with the person's values and goals. It involves being able to identify their own emotions, identify why these emotions may have occurred and identify an appropriate response for the situation. Discussion about effective and not so effective examples of emotion regulation from the client's experience helps to make the client more aware of their own patterns around responding to emotions.

Thinking errors

The purpose of this section is to assist the client to understand common thinking errors or cognitive distortions and to help them to identify which of these are relevant for them. While it is often relatively easy for clients to identify general thinking styles, having their thinking challenged in relation to a specific situation can be more difficult. This can be managed by developing a balance between validating and challenging the person's cognitions.

Between sessions, clients are asked to identify situations in which they experienced intense emotions and then attempt to identify any cognitive distortions which may have been present for them. The clinician supports the client to identify what action they took as a result of the emotion they were experiencing. The aim here is for clients to be able to identify times of intense emotional experience and learn to respond in a flexible, intentional way in these situations.

A list of thinking styles for this section is available in Appendix L.

Opposite Action

This DBT strategy asks clients to identify the urges associated with each of the basic emotions and to attempt to act the opposite way to their urges (if they can recognise thinking errors). 'Acting opposite' is a good skill to use when:

- Emotions (or their intensity) are not justified by the facts;
- Acting on the urge associated with the emotion is not effective.

See Appendix M for information on this skill

Optional module content

This section is optional; it is likely that you will not have time to complete it unless the client has some prior knowledge of emotion regulation skills. Once clients are familiar with thinking errors and opposite action, we can ask them to practice problem solving.

Problem Solving

The aim of this section is to create a template for understanding how best to understand and solve problems using a stepped approach.

See Appendix N for information on this skill.

MODULE D: INTERPERSONAL DIFFICULTIES AND UNDERSTANDING SELF AND OTHERS (MENTALIZING)

INDICATIONS FOR THIS MODULE

This module is indicated when a client's primary concerns relate to interpersonal difficulties. This module is most relevant when a client has the ability to cope with intense emotions and distress and does not regularly engage in problematic impulsive behaviours. The aim of this module is to help clients to understand their relationships with others and to better understand their own mind and the minds of others. This module is particularly useful for clients who have a history of problematic relationships and difficulty understanding how to manage their relationships.

OBJECTIVES:

- To help clients understand what healthy and unhealthy relationships look like;
- To encourage clients to become curious about their own minds and those of others;
- To encourage clients to consider the perspective that others may have in interpersonal relationships.

NEXT STEPS

This module could be used as an introduction to further treatment where the focus is on healthy relationships. Accessing MBT therapy or other relationship–focused therapies would be beneficial.

MODULE CONTENT

Understanding Relationships

Initially this module focuses on a detailed assessment and understanding of the client's current relationships as well as their previous relationships. This may reveal unhelpful patterns or themes in relationships that may assist clients to better understand themselves. Refer back to your client's formulation and their attachment history during this module as this may provide a context for understanding why the client has difficulties with interpersonal relationships.

Healthy and Unhealthy Relationships?

In many instances, clients will have experienced unhealthy and potentially abusive relationships and may not always be aware of what constitutes a healthy versus an unhealthy relationship. We suggest providing the handout on healthy and unhealthy relationships and discussing this with the client in the context of their own relationships. It is important to note that this may be confronting for some clients as they may not be aware of patterns in their relationships.

The handout on healthy and unhealthy relationships can be found in Appendix O.

Mentalization

Mentalizing refers to an individual's ability to understand their own mental states (what they are thinking and feeling), and how this relates to why they are behaving as they are. It also refers to the ability to understand the mental states of others, and why others behave as they do. People with BPD often have difficulty with mentalizing themselves (understanding their own thoughts, feelings, beliefs and motivations) and others (understanding others' thoughts, feelings, beliefs and motivations). They also often struggle with identifying what information others may need to know about them in order to understand (or mentalize) them. Often people with BPD believe that others should just know how they feel and they can often believe they know what others are thinking or feeling about them.

The aim of this part of the module is to ask clients to become curious about their minds and the minds of others. Often clients get caught in patterns of thinking in which they believe they know how others think about them (usually negative, e.g. they think I'm worthless, I'm disgusting etc.) without checking these assumptions. The hope is that clients will be better able to take a 'not-knowing' stance and be interested in finding out from others how they think and feel rather than being certain that they already know.

This section of the module requires clinicians to take a similar 'not–knowing' stance with clients and to be curious about their client's mind. The clinician should be prepared to be open about their own mind and attempt to let the client know what they are thinking and feeling to help demonstrate this process.

Firstly, we suggest introducing the idea of mentalizing to the client and to explain the basic concepts of the not–knowing stance and curiosity. Through this process the client is asked to start being more curious about their own mind and those of others. The vignette provided below may be used to begin this process. Once the client has had some practice in mentalizing, they can be encouraged to discuss interpersonal situations that they are finding challenging and use these to improve their ability to mentalize. Ask clients to slow down their telling of interpersonal events and discuss in detail their mental states at the time of these events as well as during the retelling in the session.

Vignettes:

1. It is Sarah's birthday. She is planning to celebrate with Mike, her boyfriend, and has invited him home for dinner. She has purchased wine to go with the food and is looking forward to him coming after work. When Mike arrives, he does not have a gift with him, and he says to her "Wow, what a dinner you have made, and on a Tuesday". During dinner Sarah is quiet and drinks most of the wine herself.

2. Jane is texting back and forth with a man (Tom) she met at a party. They have been getting on great and she thinks they have a strong connection. They organise to meet up but when she attempts to confirm he goes quiet and does not respond.

Mentalizing questions:

- What do you think Sarah/Jane are thinking?
- What do you think Sarah/Jane are feeling?
- What might be happening for Mike/Tom?

Use these vignettes to ask the client to generate as many different possibilities as they can as a way of demonstrating that we cannot know what others are thinking. You can then ask your client to recall interpersonal situations they have recently experienced and use these to help clients to mentalize themselves and others. Example questions to stimulate mentalizing in the vignettes and in their life experiences may include:

- What was going through your mind during the interaction?
- How did you feel during the interaction?
- Where there any other emotions you may have been experiencing?
- How do you feel about it now?
- What did you want to have happen?
- What may the other person have been thinking?
- How would you know this (i.e. how did they work out what the other person was thinking)?
- How do you think the other person understood you during the interaction?
- How does it feel discussing this in therapy?
- Are there any alternative perspectives?

The aim in this section is for clients to be able to better understand their own experience — thoughts and feelings — in greater detail. The clinician's role is to promote curiosity in the client and to attempt to encourage a more nuanced understanding of interpersonal interactions and relationships.

Adapted from Bateman and Fonagy 2016

APPENDIX A: ATTACHMENT

Attachment is a normal and essential part of human development and is an observable phenomenon in all mammals. Its purpose is to protect infants against dangers and promote nurturing bonds between infants and parental figures. Our first attachments are with primary caregivers (usually parents) and form our earliest experiences. Often our experience of early life attachments have a large impact on the ways we are able to create attachments in adulthood.

There are four principal patterns of childhood attachment.

1 SECURE ATTACHMENT

Having a secure attachment pattern usually means that caregivers' responses have been attuned to the infant's affect and need. The care–givers' availability to the infant is consistent and predictable. People who experience secure attachment as infants develop an internal belief that they are lovable and worthy of love. They expect that others will be responsive to them and treat them as though they are lovable. As adults, they are able to share their thoughts and feelings with others and feel confident of being heard and understood.

2 INSECURE ATTACHMENT

An individual with an insecure attachment has developed an internal belief that they are not lovable and won't necessarily be responded to positively by others.

There are three types of insecure attachment:

- Anxious avoidant;
- Anxious ambivalent;
- Disorganised (much less common).

2A ANXIOUS AVOIDANT ATTACHMENT:

Children with this kind of attachment cope with their insecurity by withdrawing into themselves and appearing self–contained and not in need of help from their caregivers. These children tend to dismiss their own emotional responses and avoid expressing them as they have learnt that their caregivers are emotionally unavailable to them. As an adult, they may be dismissive of their own needs and not able to tell others when they need support. They may engage in impulsive behaviour when an attachment need is triggered.

2B ANXIOUS AMBIVALENT ATTACHMENT:

Children with this kind of attachment cope with their insecurity by becoming pre-occupied with seeking the attunement of their care–giver. This is because the children's caregivers are inconsistent in the ways that they respond. Children with this kind of parenting are confused and insecure because they do not know what type of treatment to expect. They often feel suspicious and distrustful of their parent but at the same time their behaviour may appear clingy and desperate. As an adult, they may appear overly needy or desperate for another person.

2C

DISORGANISED ATTACHMENT:

Disorganised attachment occurs when a parent or caregiver is simultaneously a source of hoped–for comfort and a source of fear. This attachment pattern arises when a parent or caregiver is abusive to the child in some way and/or suffering from their own unresolved loss or trauma. This can result in their being emotionally unavailable or angry in relation to the child's distress or need for comfort. The child is caught in a terrible dilemma: his/her survival instincts are telling him/her to flee to safety; however safety is represented by the person who is a source of fear. The attachment figure is the source of the child's distress. The child may be observed to simultaneously move towards and away from their attachment figure. As an adult, the person may attempt to get close to others but do so in unhealthy or odd ways. They are likely to push them away if the other person attempts to respond to them.

As noted, attachment styles that develop during childhood can often impact on patterns of adult attachment, observable in the ways in which people behave in adult relationships.

3

EARNED SECURE ATTACHMENT

Securely attached children usually go on to become securely attached adults within intimate relationships. This outcome is less true with the other attachment styles. But this doesn't have to be the case. 'Earned secure attachment' was coined to describe changes in insecure attachment styles occurring between childhood and adulthood. Earned secure attachment may be facilitated by experiencing a supportive, compassionate relationship with a friend, family member or therapist. Attachment behaviour is a style or 'flavour' that we bring to relationships; it is not set–in–stone and its expression can vary from one relationship to another.

APPENDIX B: MINDFULNESS EXAMPLES FOR USE WITH CLIENTS WITH BPD

STRETCHING, HALF SMILE

Purpose: To introduce mindfulness without referring to it as mindfulness. Clients may have heard the word 'mindfulness' and have a range of preconceptions. The aim is to introduce the practice of mindfulness as simply as possible without suggesting that it is a 'special' practice. A secondary aim is to allow participants to engage in a mindfulness practice which is guided and strongly supported.

Script: Now we are going to take a bit of a break and encourage you to stand up and stretch. But I will ask you to do this is a particular way. Start by stretching and noticing what you are feeling. [Pause]. Just noticing. Now we will ask you to focus on your face. Start by relaxing your face from the top of your head down to your chin and jaw. Let each facial muscle relax (forehead, eyes and brow, cheeks, mouth with teeth slightly apart). If this is hard, try tensing your facial muscles and then let go.
Now let both corners of your lips go slightly up, just so you can feel them. It is not necessary for other people to be able to see this. We are aiming for a half–smile with slightly upturned lips with a relaxed face. Try to adopt a serene facial expression.
Now briefly to notice how you are feeling. Just noticing.

[Pause for a few seconds]

Reflection: Ask the client what that was like. Encourage reflection on any changes that the person may have experienced.

Observation: Note that the client has now experienced a mindfulness practice. You have just stretched mindfully. Two things you just experimented with were mindful: Firstly you focused your attention and then you noticed your experience in the present moment. Mindfulness uses both these principles.

STRETCHING, WILLING HANDS

Purpose: To reinforce the idea from the previous half smile practice that mindfulness is not a 'special' practice but something that can be incorporated into everyday life.

Script: Now I am going to ask you to stretch in a similar but slightly different way to last week. Encourage your client to stand up and stretch. Start by focusing on how you are feeling. What is happening for you right now? Just notice those sensations. Now, drop your arms down from your shoulders keeping them straight or slightly bent at the elbows. With your hands unclenched turn your hands outwards with thumbs out to your sides, palms up and fingers relaxed. Notice that your hands communicate to your brain and your body connects to your mind.
Now briefly notice how you are feeling. Remember to just notice.

[Pause for a few seconds]

Reflection: Ask client what that was like. Encourage reflection on any changes that the person may have experienced.

Observation: Reinforce the message that clients have experienced doing something mindfully. Open up a discussion about using mindfulness in everyday life. Also ask about practising this out of sessions. Does this seem possible?

OBSERVING (GROUNDING)

Purpose: The purpose of this practice is to introduce one specific aspect of a mindfulness practice: observing. Similar to the practices in the first two sessions, a focus on the part of the body will be used with slight extension: the client will be asked to focus on one particular sensation in their body.

Script: Notice that you observe the world outside of yourself through your five senses: seeing, hearing, smelling, tasting and touching. You also observe the world inside yourself thorough sensing your thoughts, emotions and internal bodily sensations. So I am going to ask you to stand, arms relaxed at your sides, feet comfortably apart. Focus your attention on how your feet feel connecting with the floor. [Pause]. Without moving your feet, find a position where you feel most balanced over your feet.

[Pause].

Reflection: Ask the client to share their experience of the practice. Is this something you would try at home?

Observation: Note that what you sense depends on where you focus your attention. Ultimately you will want to be able to observe events occurring within your mind and body (i.e. thoughts, sensations, emotions, images) and events outside your body. Ask the client about their out–of–session practice.

SAFE PLACE

Purpose: The aim of this practice is to develop the self–soothing aspects of mindfulness by focusing on self–soothing by imagining a safe place.

Observation: The aim of today's practice is to imagine a safe place for yourself. Try not to choose your home or bed but rather imagine another place that is safe for you. Also remember that imagining is more than just seeing. Think about the other senses that you can engage; what do you hear, touch, taste, for instance?

Script: Find a comfortable position sitting attentively but also comfortably. Close your eyes or fix on a spot on the floor or wall that is not distracting.
Imagine a place where you feel calm, peaceful and safe. It may be a place you have been before, somewhere you've dreamed about going to, or somewhere you've seen in a picture, or a peaceful place you imagine in your mind's eye.
Look around you in that place, noticing the colours and shapes. What else do you notice?
Notice any sounds that are around you, or perhaps the silence; sounds far from you and those nearer to you; those that are more noticeable and those that are more subtle.
Think about what you can smell.
Then focus on any skin sensations – the earth beneath you or whatever else is supporting you in that place, the temperature, any air movement or breeze, anything else you can touch.
Notice the pleasant sensations in your body as you enjoy this safe place.
Now while you are in your peaceful and safe place, you might choose to give it a name, whether one word or a phrase that you can use to bring this image back, anytime you need to.
You may choose to linger in your safe place for a while; just enjoying the peacefulness and serenity.

[Pause]

When you are ready, bring your awareness back to the room.

Reflection: Ask the client what it was like to image a safe place without necessarily describing that place.

Based on Linehan, 2015

APPENDIX C: CRISIS PLAN

CLIENT CRISIS PLAN

Name: _____

What are my warning signs of a potential crisis?

What does it look like for me when I'm in a crisis?

What are my coping strategies?

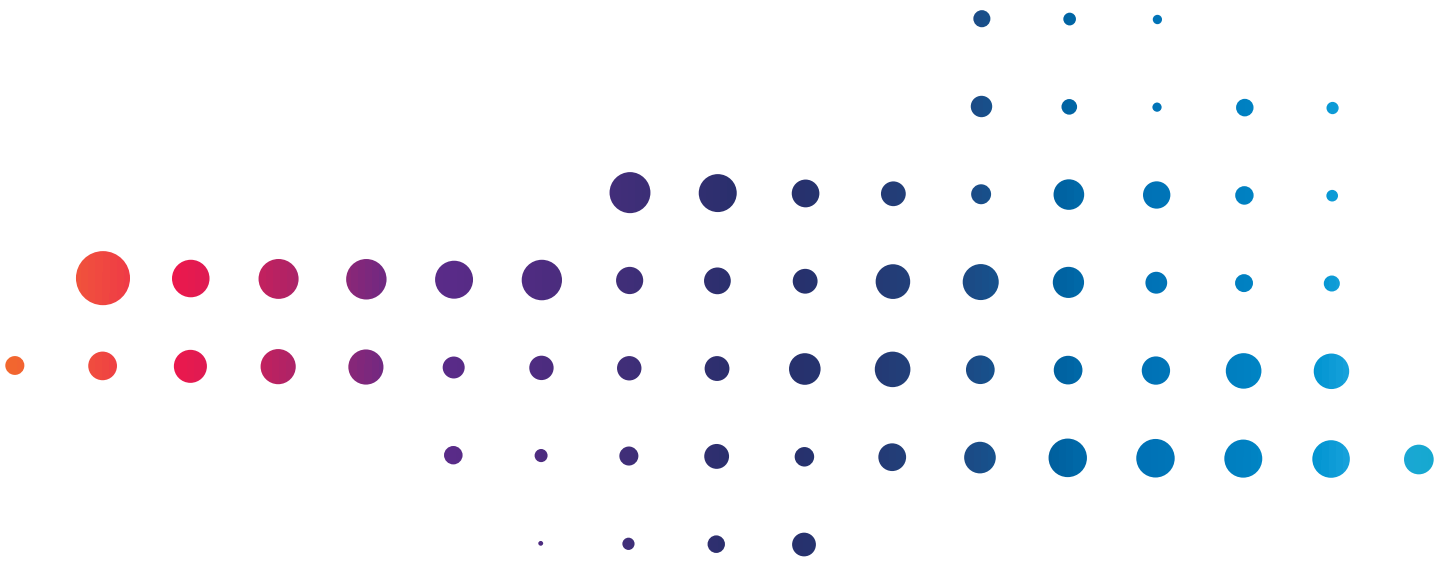
Who are my supports?

Who else can I call?

NAME	NUMBER
Psych Triage	
Lifeline	131 114
Suicide Callback	1300 659 467

Client signature: _____ Date: _____

Clinician signature: _____ Date: _____



APPENDIX D: WHAT IS BPD?

Making a diagnosis of BPD is a step–wise process. The DSM 5 defines personality disorder as, “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment”. It is important to obtain an adequate history and understanding of the person’s functioning in order to determine whether functioning across situations and in relation to his or her history meets this criterion.

The DSM 5 lists nine criteria for the diagnosis of BPD. In order to be diagnosed with BPD, an individual’s functioning (across situations and over time) must meet five (or more) of these criteria:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self–mutilating behavior covered in Criterion 5).
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self–image or sense of self.
4. Impulsivity in at least two areas that are potentially self–damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self–mutilating behavior covered in Criterion 5).
5. Recurrent suicidal behavior, gestures, or threats, or self–mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress–related paranoid ideation or severe dissociative symptoms.

The DSM 5 criteria can be shared with interested clients. As noted previously, the language may be perceived as overly technical; we suggest using lay language in your explanation, taking care to relate different criteria to the person’s experience.

Often it can be valuable to discuss BPD with clients in terms of four main areas of difficulty rather than using the diagnostic criteria.

1. EMOTIONS AND STRONG OVERWHELMING FEELINGS

People with BPD describe experiencing overwhelming, almost constant emotional pain. Strong emotions are easily triggered. Some people have also learned to cope with this by putting a lid on most emotions. Their need to dampen down emotions can result in feelings of deadness, unreality and boredom. Problems experiencing and managing anger are common and may include feeling angry a lot of the time, with the possibility of violent or aggressive behaviour when angry.

2. RELATIONSHIPS

People can experience strong and changeable feelings of love and hate, alongside great sensitivity to signs of rejection or criticism. They also have a tendency not to trust people and have difficulty coping with losses and separations. It is common to have problems with interpersonal dependency, either feeling very dependent or trying to avoid dependency or closeness.

3. IMPULSIVE, OFTEN SELF–DESTRUCTIVE BEHAVIOUR

A frequent feature of BPD is deliberate NSSI or suicide attempts when a person feels emotionally overwhelmed. NSSI can provide short–term relief from suffering; however it has negative long term consequences. Abuse of drugs or alcohol, binge eating and problem gambling may also be viewed as attempts at coping with intense feelings.

4. FRAGILE SENSE OF SELF

This may be evident when a person has problems identifying or maintaining a consistent sense of self or identity. Maintaining a clear sense of one's own feelings and thoughts can be difficult. When particularly stressed, some people can withdraw from engagement with others, leaving them feeling vulnerable and alone. At times like this, it is common to experience feelings of paranoia. This usually passes when the level of stress reduces.

Prognosis and course

- BPD is present in 1–2 % of the Australian population. Nearly 75% of people diagnosed with BPD are women, but recent research suggests that men may be almost as frequently affected by BPD. BPD in men can sometimes be overlooked; men with BPD are also likely to be diagnosed with Antisocial Personality Disorder and Substance Use Disorder.

- Borderline Personality Disorder usually manifests in early adulthood, however its symptoms (e.g., NSSI, disordered eating) can often be seen in early adolescence. As individuals with BPD age, the expression of their symptoms and/or the severity of the illness may change and/or diminish. Late–onset BPD may also be observed. This is particularly likely when a support that formerly provided stability is taken away (e.g. marriage breakdown, loss of job, death in family).

- Studies of the course of BPD have indicated that the first year of treatment is usually the most crisis–ridden. With treatment engagement, the need for psychiatric care (e.g. inpatient admissions, emergency service utilisation) gradually diminishes and transitions to briefer, less intensive interventions.

APPENDIX E: WHY WE HAVE EMOTIONS

1 AS A WAY OF KNOWING

Our feelings about people and events give us information about the situation. They can be a signal or alarm that something is happening that we need to pay attention to.

2 EMOTIONS LINK US TO OTHERS

Facial expressions communicate our thoughts faster than words can. We connect with others via our tendency to 'catch' emotions from each other. This is the basis of empathy and a prompt for compassion.

3 TO GUIDE ACTION

Emotions can drive us to get out of danger quickly and to help each other.

4 TO ENERGIZE AND HELP OVERCOME OBSTACLES

Strong emotions give us the energy to overcome obstacles — in our mind and in our actions in the world.

5 TO HELP US SURVIVE

Emotions connect us to others, remind us of danger and are what keep us supported, safe and alive.

6 TO FEEL GOOD

Pleasant emotions provide hope and an appreciation of life and other people.

7 TO GUIDE US THROUGH THE JOURNEY OF EXPERIENCE

Emotions provide a prompt to tell us that we need to work on difficult past experiences, such as trauma, loss, grief.

Adapted from Linehan (1993)

APPENDIX F: BENEFITS AND COSTS OF BASIC EMOTIONS

Below are six different types of basic emotion. The exercise is for you to work out the *positive* ways we associate with these feelings, and then the *negative* ways we can sometimes behave when we feel them.

JOY

How is **joy** valuable and important?

What actions inspired by **joyfulness** can sometimes be a problem?

ANGER

How is **anger** valuable and important?

What actions inspired by **anger** can sometimes be a problem?

SADNESS

How is **sadness** valuable and important?

What actions inspired by **sadness** can sometimes be a problem?

FEAR

How is **fear** valuable and important?

What actions inspired by **fear** can sometimes be a problem?

APPENDIX G: EMOTIONS DAILY DIARY

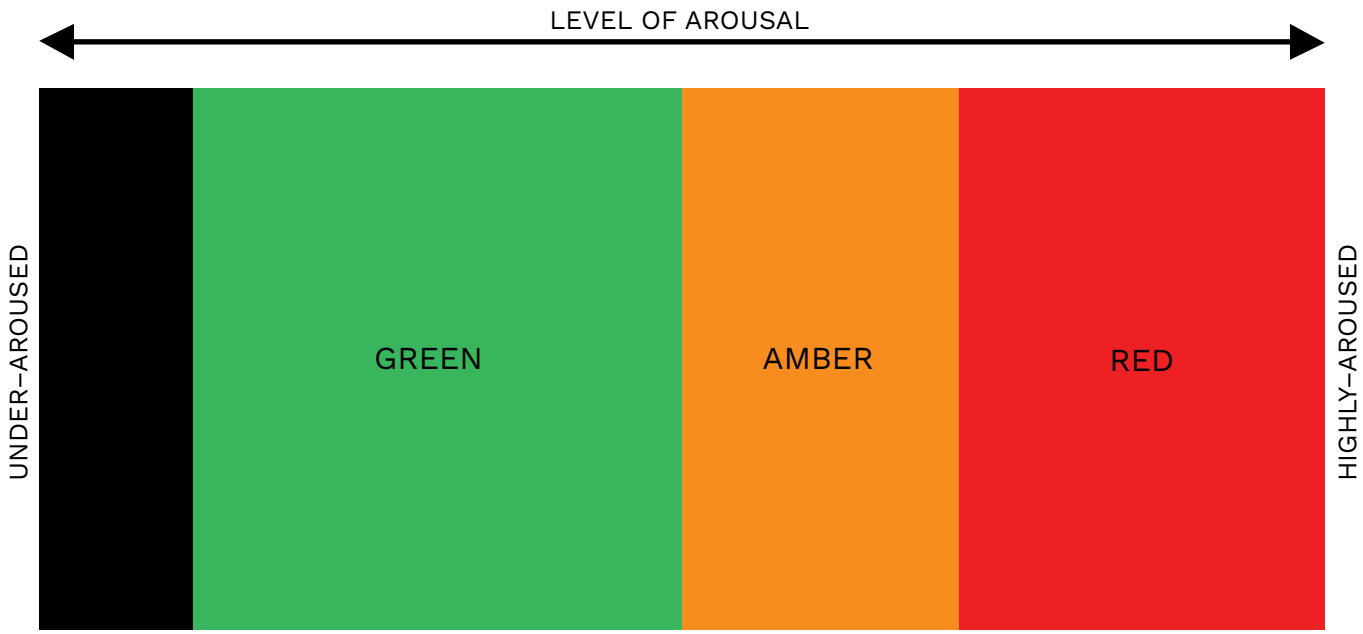
From the list below circle the emotions you experienced today.

Elated	Depressed	Furious	Terrified	Remorseful
Excited	Alone	Enraged	Horrified	Worthless
Overjoyed	Hurt	Outraged	Fearful	Disgraced
Thrilled	Hopeless	Defended	Shocked	Unworthy
Cheerful	Miserable	Frustrated	Apprehensive	Guilty
Passionate	Lost	Agitated	Threatened	Embarrassed
Satisfied	Unhappy	Annoyed	Uneasy	Ridiculous
Glowing	Moody	Resistant	Cautious	Uncomfortable
Glad	Blue	Irritated	Nervous	Regretful
Contented	Upset	Touchy	Anxious	Silly
Pleasant	Disappointed	Uptight	Worried	Pitied

APPENDIX H: EMOTIONAL VOCABULARY

INTENSITY OF FEELING	HAPPY 	SAD 	AFRAID 	ANGRY 	ASHAMED 
HIGH	Elated Excited Overjoyed Thrilled Exuberant Ecstatic Fired up Passionate	Depressed Agonised Alone Hurt Dejected Hopeless Heartbroken Miserable	Terrified Horrified Scared stiff Petrified Panicky Frantic Shocked	Furious Enraged Outraged Boiling Seething Loathing Betrayed	Remorseful Defamed Worthless Disgraced Dishonoured Mortified
MEDIUM	Cheerful Gratified Good Relieved Satisfied Glowing	Sombre Lost Distressed Let down Melancholic Sorrowful	Apprehensive Frightened Threatened Insecure Uneasy Intimidated Fearful	Upset Mad Frustrated Agitated Disgusted Irate	Apologetic Unworthy Guilty Embarrassed Secretive Admonished
LOW	Glad Pleasant Tender Pleased Mellow	Unhappy Moody Blue Upset Disappointed Dissatisfied	Cautious Nervous Worried Timid Unsure Anxious	Perturbed Annoyed Uptight Resistant Irritated Touchy	Bashful Ridiculous Regretful Uncomfortable Embarrassed Silly

APPENDIX I: LEVELS OF EMOTIONAL AROUSAL



When your level of arousal is in the red or the high amber "zone", you are likely to receive the most benefit from regulation skills. Their purpose is to bring down your level of arousal and thereby enable you to contain distressing emotions and impulses. Examples of these skills are STOP, TIP and IMPROVE skills which we cover together. The aim is to help you to tolerate your intense feelings and, most importantly, **not make the situation worse.** Your mood may not feel much better after using these skills, however you will feel less out of control and be less likely to react to urges. This will help you to **survive the moment** without creating further suffering for you and/or others.

When you are in the green or low amber "zone", your level of arousal is more likely to be within the optimal arousal range. This is a time that you can engage in and practice skills that build your emotion resilience. Building your **emotion resilience** will help you cope better with your emotions on an everyday basis.

APPENDIX J: DISTRESS TOLERANCE CHECKLIST

Adapted from Linehan (1993); and Champagne (2003b)
See also Williams & Shellenberger (1996); www.AlertProgram.com

The following is a checklist of things people may use or do in order to help decrease and/or prevent distress. Please take a moment to check off those things that seem to be helpful for you. Each of these activities employs all or most of the five senses. They are categorized to help you identify some of the specific sensorimotor qualities you may want to focus on.

MOVEMENT

- ☐ Riding a bicycle
- ☐ Running or jogging
- ☐ Walking or hiking
- ☐ Aerobics
- ☐ Playing an instrument
- ☐ Sketching or doodling
- ☐ Rearranging furniture
- ☐ Jumping on a trampoline
- ☐ Rocking in a rocker
- ☐ Rocking yourself
- ☐ Building things
- ☐ Shaking your hands
- ☐ Lifting weights
- ☐ Washing the car
- ☐ Skiing
- ☐ Gardening
- ☐ Shopping
- ☐ Cleaning
- ☐ Driving
- ☐ Stretching
- ☐ Yoga or tai chi
- ☐ Swimming
- ☐ Skating

DIFFERENT TYPES OF TOUCH AND TEMPERATURE

- ☐ Blanket wraps
- ☐ Fidgeting with something
- ☐ Soaking in a hot bath
- ☐ Getting a manicure
- ☐ Washing your hair
- ☐ Cooking or baking
- ☐ Warm/cold cloth
- ☐ Sewing
- ☐ Using a stress ball
- ☐ Holding ice
- ☐ A weighted blanket
- ☐ Getting a pedicure
- ☐ Pottery/clay work
- ☐ Holding a pet
- ☐ Knitting or crocheting
- ☐ Using a hand lotion
- ☐ Getting a massage
- ☐ Twirling your hair
- ☐ Using arts/craft supplies
- ☐ Feel of sunshine
- ☐ Patting a pet
- ☐ Feel of different fabrics
- ☐ Hot/cold shower
- ☐ Washing the dishes

APPENDIX J: DISTRESS TOLERANCE CHECKLIST

AUDITORY/LISTENING

- ☐ Enjoying the quiet
- ☐ Sound of a fountain
- ☐ A live concert
- ☐ Radio shows
- ☐ Music Box
- ☐ Wind chimes
- ☐ Humming
- ☐ Whistling
- ☐ Personal audio system
- ☐ Listening to music
- ☐ Rain
- ☐ Birdsong
- ☐ A cat purring
- ☐ Sound of a fan
- ☐ People talking
- ☐ Ocean sounds
- ☐ Relaxation CDs
- ☐ Singing

VISION/LOOKING

- ☐ Photos
- ☐ Sunset or sunrise
- ☐ Snow falling
- ☐ Rain showers
- ☐ Fish in a tank
- ☐ Ocean waves
- ☐ A fire
- ☐ Movies
- ☐ Bubble lamp
- ☐ A mobile
- ☐ A waterfall
- ☐ Watching clouds
- ☐ Stars in the sky
- ☐ Coloured glass
- ☐ Watching sports
- ☐ Animal watching
- ☐ Window shopping
- ☐ Photography
- ☐ Reading
- ☐ Autumn foliage
- ☐ Art
- ☐ A fireplace

FACTORY/SMELLING

- ☐ Scented candles
- ☐ Essential oils
- ☐ Citrus fruit
- ☐ Herbs/spices
- ☐ Chopped wood
- ☐ Freshly cut grass
- ☐ Flowers
- ☐ Scented lotions
- ☐ Incense
- ☐ Herbal tea
- ☐ Fresh, clean washing
- ☐ Cologne/perfume
- ☐ Baking/cooking
- ☐ Coffee

GUSTATORY/TASTING

- ☐ Chewing gum
- ☐ Biting into a lemon
- ☐ Eating a lollipop
- ☐ A thick milkshake
- ☐ Deep breathing
- ☐ Chewing carrot sticks
- ☐ Spicy foods
- ☐ Carbonated drink
- ☐ Crunchy food
- ☐ Sour Food
- ☐ Chewing ice
- ☐ Strong mints

ADDITIONAL QUESTIONS:

What kind of music is calming to you?

_____

What kind of music is alerting to you?

_____

Do you prefer bright or dim lighting when feeling distressed?

_____

Are there other things that are not listed that you think might help?
List them here:

_____

_____

_____

Reviewing all of the activities you have checked off and listed, what are the top five things that are the most helpful when you are feeling distressed?

1. _____

2. _____

3. _____

4. _____

5. _____

APPENDIX K: SENSORY MENU

SENSORY MENU FOR ALERTING

- Holding Ice
- Chewing Gum
- Spicy Food
- Crunchy Snacks
- Cold Drink
- Sour Lollies
- Snapping Elastic Band on Wrist
- Cool Room
- Bright Colours
- Fresh Air
- Brisk Walk
- Bright Light
- Loud or Lively Music
- Dancing to Music
- Stamping Feet Hard
- Sketching or Drawing
- Snapping Fingers
- Yawning
- Loud Clapping
- Whistling
- Tapping Fingers
- Fidget Toys
- Hopping/Skipping
- Wake up Stretch
- Vigorous Exercise
- Cool Shower
- Fiddling with Hair or Jewellery
- Sucking on an Icy Pole
- Eating Crushed Ice

SENSORY MENU FOR COPING AND CALMING

- Routines
- Familiarity
- Low Demands
- Scented Candle
- Hand Massage
- Body Massage
- Warmth
- Soft Slow Rhythmic Music
- Rocking Self Back and Forth
- Swinging
- Tuck Sheets in Tightly at Bedtime
- Blanket Wraps
- Soft Voices
- Apply Gentle Pressure to Shoulders
- Heavy Stuffed Animal on Lap
- Stroking an Animal
- Watching an Aquarium
- Rhythmic Sound of a Fan
- Sound of Ocean Waves
- Hugs and Self Hugs
- Sleep in Sleeping Bag
- Warm Bath
- Slow Dancing
- Watch Flickering Fire
- Rhythmic Bouncing of Ball
- Colour In or Paint
- Work with Clay or Play Dough
- Foam Roller
- Taking Time Out for Quiet
- Deep Breathing
- Yoga
- Meditation
- Humming or Singing Quietly
- Head Rolls
- Walking Slowly
- Ride in a Car
- Sit in the Sun
- Sit on Hands or Legs
- Relaxation Tapes
- Chewing Gum
- Squeezing a Stress Ball
- Sucking on a Lollipop or Something Sweet
- Slow Stroking on Back
- Warm Drink
- Dim Light

APPENDIX L: THINKING STYLES & COGNITIVE STRATEGIES

1. CATASTROPHISING

When your thoughts are ruminating about the worst possible scenario, even though it's unlikely.

Example:

You've had a headache for 3 days

You think..."I've got a brain tumour!!!!"

You feel fear, panic, & are pre-occupied.

2. JUMPING TO CONCLUSIONS

When you come to a conclusion about something despite an ambiguous, or unclear situation.

Example:

Your neighbour has a removal van outside their house.

You think... "They're moving out without even saying goodbye"

You feel... rejected, bad about yourself.

3. MIND–READING

You think you know what someone else is thinking even though you haven't checked it out.

Example:

A friend doesn't say hello to you at a party.

You think..."She's ignoring me, she doesn't like me anymore"

You feel... rejected, depressed.

4. BLACK & WHITE THINKING

When your thoughts go to one extreme or the other, without allowing for the possibility of the "grey", or middle option.

Example:

You fail your driving test.

You think... "If I fail one thing, I'm a total failure as a person"

5. "SHOULD" THINKING

When you tell yourself that something must or must not happen, or must happen in a certain way.

Example:

Your case manager is late for your appointment.

You think... "Professionals should always be on time"

You feel... Angry, frustrated, offended.

6. DISQUALIFYING THE POSITIVE

When you always downplay the things you achieve, and never notice them.

Example:

You go 100 days without NSSI, then self-injure on the 101st day.

You think... "Those 100 days of no NSSI mean nothing now"

You feel... Depressed, ashamed, angry with self.

7. PERSONALISATION

When you take something personally when it is not meant that way.

Example:

You're talking about your weekend to a group of friends, when one of them gets up and walks away

You think... "She left because I'm so boring"

Adapted from Linehan (2015)

APPENDIX M: OPPOSITE ACTION

HOW TO DO OPPOSITE ACTION: STEP BY STEP

1. **STEP 1.** **Identify and name the emotion** you want to change.

2. **Step 2.** **Check the facts (are you doing any of the cognitive distortions?)** — to see if your emotion **(intensity and the duration)** is justified by the facts
E.g.: 'Irritation' fits the facts when someone cuts in front of your car; "road rage" does not fit the facts.

3. **STEP 3.** **Identify and describe your action urges.**
If your emotion does not fit the facts or if acting on your emotion is not likely to be effective.

4. **STEP 4.** **Identify the opposite action** to your urges.

5. **STEP 5.** **Act opposite all the way** to your action urges.

6. **STEP 6.** **Repeat acting opposite** to your action urges until your emotions change.

USING OPPOSITE ACTION

FEAR

The action urge is to .....
Run, hide, freeze, look away.

Opposite Action would be to...
Do what you are afraid of doing... OVER & OVER; approach what you are afraid of; do things that give you a sense of control and mastery; do things in small gradual steps.

NOTE: Opposite Action for Fear should only be used when you are not in real danger.

ANGER

The action urge is to .....
Lash out, get revenge, attack, fight, refuse to talk, or sometimes to submit and give up.

Opposite Action would be to...
Gently avoid the person if you think you will attack them, or approach them willingly to resolve the issue; do something nice rather than mean or attacking; imagine sympathy, empathy & compassion for the other person rather than blame; take a time out.

GUILT & SHAME

The action urge is to .....
Avoid the person or situation, hide, be defensive.

Opposite Action would be to...
If justified... accept your mistake; approach the person or situation; apologise; do something nice for the person; commit to avoiding the mistake in the future; accept the consequences, then let it go.
If unjustified... do what makes you feel ashamed...OVER & OVER, approach, don't avoid.

DEPRESSION & SADNESS

The action urge is to .....
Withdraw, stay in bed, ruminate, be inactive, avoid doing things that you're good at, avoid other people.

Opposite Action would be to...
Get out of bed; get active; exercise; do things that give you a sense of mastery and competence; approach, don't avoid.

BODY POSTURE IS IMPORTANT FOR ALL TYPES OF EMOTIONS.

Fear — Keep your head and eyes up, shoulders back but relaxed.

Anger — Unclench hands and teeth, pace your breathing by breathing in deeply and breathing out slowly, relax muscle groups.

Guilt and shame — Maintain eye contact, Lift up your head, keep your tone of voice steady and clear.

Depression and sadness — Increase physical activities.

WITH ANY URGE TO ACT MINDLESSLY OR IMPULSIVELY....

Opposite Action would be to...

STOP. DO NOTHING. BE MINDFUL. Ride the wave of emotion.

APPENDIX N: PROBLEM SOLVING

STEP 1: DEFINE THE PROBLEM

Be as specific as possible. Use numbers whenever possible. For example **"I've been late for work four days this week."**

STEP 2: NEXT, ANALYSE THE PROBLEM

Is it in your power to solve the problem? If not, then consider other options such as trying to minimise your exposure to it. If yes, then continue to analyse the problem. **What are the reasons you've been late? Is the reason always the same? Does it depend on your mood or what time you went to bed? Does it depend on what tasks you have to do at work? Who you work with? Where you went the night before? Consider the 'who, what, when and where' of the behaviour you want to change.**

STEP 3: IDENTIFY WHAT YOU WANT TO ACHIEVE IN SOLVING THE PROBLEM

For example, is your goal to avoid getting a warning from your boss? Or do you want to feel less stressed and rushed at work? Knowing what your goal is will help you choose the best course of action.

STEP 4: CONSIDER POSSIBLE SOLUTIONS

Think of various solutions that could solve the problem. Evaluate the solutions carefully to determine which might work best for you.

- What are the pros and cons of different actions?
- What could go wrong?
- What can you do to make the solution more likely to work?
- Which solution is most in keeping with your goal?

For example, if you decide to set your alarm clock earlier, are you likely just to turn it off and roll over. Do you also have to make sure you get to bed earlier? Can you change your tasks at work so you start off with easier ones? Do you need to reframe how you feel about your work?

STEP 5: PUT THE SOLUTION INTO PRACTICE AND EVALUATE THE CONSEQUENCES

A key thing to bear in mind is how difficult it is to make changes in behaviour. Having a strong commitment to change is important. Be specific in stating the change you want to make. Be willing to make small changes at first.

Adapted From:
https://www.psychologytoday.com/blog/pieces-mind/201202/got-problem-the-good-news-is-you-only-have-four-options

APPENDIX O: HEALTHY AND UNHEALTHY RELATIONSHIPS

What makes a healthy relationship?

- Mutual respect;
- Trust;
- Honesty;
- Support;
- Fairness/equality;
- Maintaining separate identities;
- Good communication;
- Clear boundaries;
- A sense of playfulness/fondness.

All of these things take work. Each relationship is most likely a combination of both healthy and unhealthy characteristics. Relationships need to be maintained and healthy relationships take work. This applies to all relationships; work relationships, friendships, family, and romantic relationships.

What are signs of a healthy relationship?

A healthy relationship should bring more happiness than stress into your life. Every relationship will have stress at times, but you want to prevent prolonged mental stress on either member of the relationship.

When in a healthy relationship you:

- Take care of yourself and have good self-esteem, independent of your relationship.
- Maintain and respect each other's individuality.
- Maintain relationships with friends and family.
- Have activities apart from one another.
- Are able to express yourselves to one another without fear of consequences.
- Are able to feel secure and comfortable.
- Allow and encourage other relationships.
- Take interest in one another's activities.
- Do not have to worry about violence in the relationship.
- Trust each other and be honest with each other.
- Have the option of privacy.
- Have respect for sexual boundaries.

- Are honest about sexual activity if it is a sexual relationship.
- Accept influence from others. Relationships are give and take; allowing your partner to influence you is important; this can be especially difficult for some people.
- Resolve conflict fairly: Disagreement is part of healthy relationships; the difference is how the conflict is handled. Fighting fairly is an important skill which will help you have healthier relationships.

What are the signs of an unhealthy relationship?

At times all relationships will have some of the characteristics listed below. However, unhealthy relationships will exhibit these characteristics more frequently and cause you stress and pressure that is hard to avoid. This tension is unhealthy for both members of the relationship and may lead to problems in other areas of your life.

While in an unhealthy relationship you:

- Put one person before the other by neglecting yourself or your partner;
- Feel pressure to change who you are for the other person;
- Feel worried when you disagree with the other person;
- Feel pressure to quit activities you usually/used to enjoy;
- Pressure the other person into agreeing with you or changing to suit you better;
- Notice one of you has to justify your actions (e.g., where you go, who you see;)
- Notice one partner feels obligated to have sex or has been forced;
- Have a lack of privacy, and may be forced to share everything with the other person;
- You or your partner refuse to use safer sex methods;
- Notice arguments are not settled fairly;
- Experience yelling or physical violence during an argument;
- Attempt to control or manipulate each other;
- Notice your partner attempts to control how you dress and criticises your behaviours;
- Do not make time to spend with one another;
- Have no common friends, or have a lack of respect for each other's friends and family;
- Notice an unequal control of resources (e.g., food, money, home, car, etc;)
- Experience a lack of fairness and equality.

If some of your relationships have some of these characteristics, it does not necessarily mean the end of that relationship. By recognising how these characteristics affect you, you can begin to work on improving the negative aspects of your relationships to benefit both of you.

Adapted from http://depts.washington.edu/hhpccweb/health-resource/healthy-vs-unhealthy-relationships/

APPENDIX P: KEY RESOURCES

RECOMMENDED READING

Bateman, A.W. & Krawitz, R. (2013). *Borderline personality disorder: An evidence–based guide for generalist mental health professionals.* Oxford: Oxford University Press.

Beatson, J., Rao, S., & Watson, C. (2010). *Borderline personality disorder towards effective treatment.* Fitzroy, AUS: Australian Postgraduate Medicine.

Linehan, M.M. (2015). *DBT skills training manual.* New York/London: The Guildford Press.

Livesley, J. (2017). Integrated treatment for borderline personality disorder: *A practical guide to combining effective treatment methods.* Cambridge UK: Cambridge University Press.

National Health and Medical Research Council. (NHMRC) (2012). *Clinical practice guidelines for the management of borderline personality disorder.* Canberra: National Health and Medical Research Council.

Paris. J. (2017). *Stepped Care for Borderline Personality Disorder.* London: Academic Press.

Bateman, A.W. & Fonagy, P. (2016). *Mentalization–Based Treatment for Personality Disorders: A Practical Guide.* Oxford: Oxford University Press.

FURTHER READING

Ogden, P. & Fisher, J. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment.* New York/London: Norton & Company.

Boon, S., Steele, K., & Van Derhart, O. (2011). *Coping with trauma-related dissociation.* New York: Norton & Company.

Tryon, G.S., & Winograd, G. (2011). *Goal consensus and collaboration.* Psychotherapy, 48, 50-57.

ADDITIONAL RESOURCES

https://bpdfoundation.org.au/

https://www.spectrumbpd.com.au/

https://www.yourhealthinmind.org/mental-illnesses-disorders/bpd

https://projectairstrategy.org/index.html