

8

A Cognitive-Developmental Formulation of BPD

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This chapter presents a cognitive-developmental model for understanding borderline personality disorder (BPD) and describes how it may be used in conceptualizing and treating this disorder. The model represents an extension of standard cognitive and schema-focused models. It is developmental in that it postulates that BPD stems from (1) biological and genetic propensities toward affect dysregulation, (2) deficits in the acquisition of affect regulation skills, and (3) the establishment of maladaptive tacit beliefs about oneself and relationships with others. The cognitive-developmental model is similar, in many respects, to traditional cognitive and schema-focused approaches for understanding and treating personality disorders in that it emphasizes the central role of cognitive and perceptual processes in the development and maintenance of clinical disorders. It differs from them in that it incorporates insights from the developmental psychopathology literature (Cicchetti, 1989, 1990; Garber & Dodge, 1992; Rutter & Garmezy, 1983; Sroufe, 1990) and postulates that personality disorders may usefully be understood from a developmental-systems perspective (Geiger & Crick, 2001).

Variations in symptom patterns over time and across settings can complicate both the diagnostic and treatment process. With this in mind, the cognitive-developmental model focuses upon commonly occurring features of the disorder and directs our attention toward factors associated with their development and maintenance. Borderline personality disorder is characterized by (1) intense and unstable emotions, (2) behavioral impulsivity, (3) a tendency to view others as uncaring

and rejecting, (4) a pattern of intense interpersonal relationships characterized by extremes of idealization and devaluation, and (5) negative self-concept or a lack of a coherent sense of self (Adams, Bernat, & Luscher, 2001; Sperry, 1995). Each of these factors must be addressed in a comprehensive model of BPD and its treatment. Research on emotional and social development may prove useful in illuminating our understanding of BPD in that the biological and social foundations of personality are believed to be present from birth, and emotional characteristics associated with adult personality disorders have been described among children and adolescents (Kernberg, Weiner, & Bardenstein, 2000).

TOWARD AN INTEGRATED COGNITIVE-DEVELOPMENTAL MODEL

The question, then, arises—how does this constellation of risk factors contribute to the emergence of symptoms of BPD? That is to say, what is the mechanism by which early trauma, familial psychopathology, genetic factors, and personality variables interact in contributing to risk? We propose the following:

1. Parents who do not provide a consistent, supportive, nurturant, and responsive home environment, and who do not model and support the development of affect regulation skills, place their children at risk for the development of BPD.
2. Temperamental vulnerabilities, impulsivity, and affective dysregulation interact with parenting style to contribute to the development of a disorganized attachment style.
3. Disorganized attachment style places the individual at risk for the development of maladaptive schema regarding self-worth, abandonment and rejection, and impaired self-efficacy.
4. Maladaptive schema regarding loss, abandonment, and personal worth, when activated by specific life events, serve as proximal risk factors for behavioral and emotional characteristics of this disorder.

Individuals may manifest a biological or genetic vulnerability in that they may be temperamentally impulsive, neurotic, or labile. Inconsistent parenting may exacerbate these difficulties by interfering with the nor-

mative development of affect regulation skills and may contribute to the establishment of maladaptive belief systems and problem-solving styles. Factors associated with vulnerability for BPD are summarized below.

- Behavioral impulsivity
- Neuroticism/negative affectivity
- Emotional lability
- Familial history of depression, impulse control disorder, substance abuse
- Chaotic home environment
- Disorganized attachment
- Severe or chronic abuse/neglect
- Separation/early loss

Cognitive Model

Although the cognitive-developmental model includes a number of concepts and approaches not typically found in standard cognitive behavioral models of psychopathology and psychotherapy, its theoretical assumptions are consistent with these approaches. It is, in a true sense, a cognitive theory. As with other cognitive models, the cognitive-developmental model of BPD assumes that cognitive activity affects behavior, that cognitive activity may be monitored and changed, and that behavioral and emotional change may be affected through modifications in cognitive processes. The model implicitly assumes that cognitive processes are ongoing, active, and adaptive and that emotional, behavioral, and cognitive factors interact in a transactional manner over time. We assume that relationships exist between cognitive contents (i.e., what the individual thinks), cognitive processes (i.e., how he or she uses this information) and the occurrence of specific behavioral and emotional symptoms. The cognitive-developmental model of BPD is mediational; that is, we assume that cognitive factors mediate human adaptation, and we focus on these factors in therapy. In practice, the treatment of patients with BPD involves active attempts to change cognitive contents and processes, to develop affect regulation skills, and to address social behaviors that may be contributing to the individual's distress. Our approach is, like other cognitive behavioral therapies, problem-oriented, active, strategic, and structured.

Developmental Model

The cognitive-developmental model is also, in a true sense, developmental. Its tenets are consistent with those of the developmental psychopathology framework for understanding clinical problems. The model assumes that deviations from normal developmental processes during childhood place individuals at risk for later psychopathology. From this perspective, an understanding of normative development can serve as a foundation for understanding emotional and behavioral disorders. The model also assumes that human development and adaptation are multiply determined. Cognitive, biological, social, behavioral, and environmental factors interact over time in contributing to vulnerability for psychopathology. To fully understand (and treat) a complex disorder, such as BPD, it is necessary to address the full range of etiological and maintaining factors.

Developmentally based models suggest that individuals must address a series of age-related tasks over the course of life (e.g., development of a secure attachment during infancy, language acquisition, affect regulation, development of social skills, autonomy from caregivers, development of self-identity), and that failure to effectively address one or more of these tasks will place an individual at risk for later adaptive difficulties. Three specific domains—attachment security, affect regulation, and self-identity—are implicated in the development of BPD. Finally, developmentally informed models acknowledge that there are “sensitive” or “critical” periods for the acquisition of specific skills. The cognitive-developmental model proposes that early experiences and the development of a disorganized attachment style serve as distal risk factors for adaptive difficulties, including the development of BPD (Carlson, 1998; Carlson & Sroufe, 1995; Dozier, Stovall, & Albus, 1999; Liotti, 2002). Infants who exhibit a disorganized attachment style demonstrate erratic, disorganized, and often conflicting behavioral responses to their caregivers. These behaviors are believed to stem from the lack of a coherent pattern of attachment that, as Carlson (1998) observed, “places the infant in an irresolvable paradox in which the infant can neither approach the caregiver nor flee or shift attention to the environment. The caregiver serves as a source of fear as well as . . . reassurance” (pp. 1107–1108).

In describing the infant with a disorganized attachment style, Liotti (2002) remarked that “the infant is both comforted and frightened by the traumatized attachment figure, either simultaneously or in quick

sequence” (p. 351), leading the infant to turn to the caregiver for safety or to withdraw defensively. This fluctuating pattern of relationships—seeking and even demanding closeness while simultaneously recoiling out of fear—characterizes both youth with disorganized attachment style and the interpersonal relationships of patients with BPD.

This disorganized working model is believed to serve as a template for relationships that BPD patients have with important individuals in their lives and is postulated to serve as a foundation for the development of dysfunctional attitudes and schema that characterize BPD. The notion that early experiences and attachment styles may contribute to the development of dysfunctional attitudes is supported by recent research on cognitive vulnerability for depression (Reinecke & Rogers, 2001; Roberts, Gotlib, & Kassel, 1996; Whisman & McGarvey, 1995). Experiences during early childhood, as such, are presumed to play a critical role in the development of this disorder.

Like other developmentally based models, however, the cognitive-developmental model views adaptation as mutable. We do not presume, as do psychodynamic models of personality, that BPD stems from the activation of maladaptive defenses or dynamic structures (Roberts, 2000). Rather, an individual’s functioning varies depending upon the nature of the situation and the specific adaptive competencies the individual has acquired. Patients are not, from this perspective, viewed as “flawed” or “impaired” so much as being on a maladaptive developmental trajectory or pathway.

Formulation of Borderline Personality Disorder

As noted, the cognitive-developmental model proposes that borderline personality disorder stems from two factors: a breakdown in the acquisition and use of adaptive emotion regulation skills, and the acquisition, consolidation, and activation of maladaptive schema and information-processing strategies. Maladaptive schema believed to be associated with BPD include (1) a view of the world as threatening or hostile; (2) a belief that others are potentially rejecting, uncaring, or malevolent; (3) and a view of the self as inherently unlovable and incapable of coping effectively with the tasks of day-to-day life. Because BPD patients view the world as fundamentally dangerous or overwhelming and see themselves as incapable, they look to others for support, guidance, and reassurance. They maintain an adaptive propositional belief that “if I

can maintain a close relationship with someone, then I can feel secure in my life.” Because they believe themselves to be inherently unlovable, and others as potentially rejecting, they are at risk for abandonment. Individuals with BPD tend, as a consequence, to be attentive to signs of potential separation or abandonment and respond to them with feelings of anger (reflecting their view of the potential separation as both malicious and threatening) and by making intense efforts to reestablish the relationship. Given their deficits in affect regulation, the accompanying feelings of anger, anxiety, dysphoria, and desperation rapidly escalate and become subjectively severe. Because these individuals lack effective cognitive, behavioral, and social skills for self-soothing, they come to engage in a range of maladaptive behaviors to alleviate their distress. Their angry outbursts, demands for support, and suicidal gestures may be viewed as attempts to reestablish a significant relationship.

The cognitive-developmental model proposes that these variables can, in conjunction, account for the clinical presentation of patients with BPD. These factors are seen as necessary (but not sufficient) distal risk factors for the development of BPD. Negative early experiences with caregivers likely contribute to the establishment of a disorganized attachment. These experiences, in turn, are associated with the development of *specific* maladaptive schema. Disorganized children come to view themselves as unworthy or unlovable and to view relationships as unstable, unpredictable, inconsistent, and potentially dangerous. This is not to say the emotional and social competence during adolescence and adulthood is a direct consequence of early attachment disorganization. Rather, attachment security is viewed as one of several interacting influences on socialization and adjustment. Consistent with cognitive models of psychopathology, it is postulated that these maladaptive beliefs about the self and others are consolidated over the course of development, and that individuals come to selectively attend to and remember events that are consistent with these beliefs. The cognitive-developmental model of BPD is presented in Figure 8.1.

Clinical Implications

The goals in cognitive-development therapy for BPD are threefold: (1) to develop affect regulation skills, (2) to identify and change specific maladaptive beliefs or schema that may be contributing to the individu-

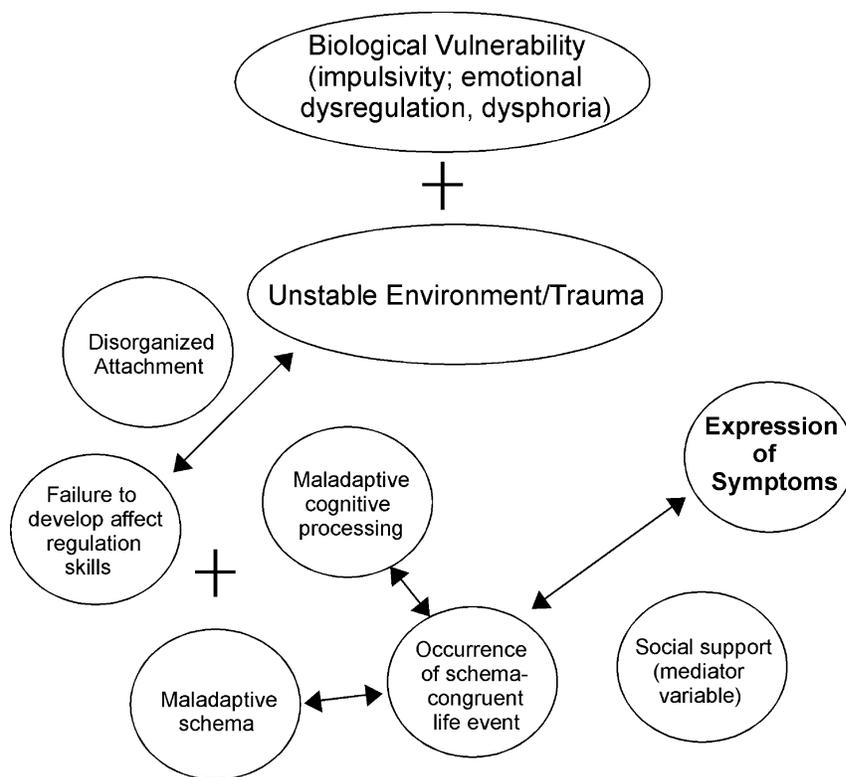


FIGURE 8.1 Cognitive-developmental model of BPD.

al’s distress, and (3) to develop a more coherent, organized, and secure sense of self. This is accomplished through psychoeducation; the introduction of cognitive and behavioral techniques to alleviate feelings of depression, anxiety, and anger; and the use of developmentally informed interventions to address the lack of stable, coherent, and secure systems for understanding oneself and relationships with others.

Central to the cognitive-developmental model are the notions of “scaffolding” and “apprenticeship.” Virtually all adaptive skills—including language, social problem-solving, academic, and social skills—are acquired over the course of development through guided modeling by individuals with a greater expertise than the child. A teacher, coach, or mentor, for example, guides the child in learning basic math, reading, or athletic skills by modeling skilled behavior and by challenging

the child to perform actions that are just beyond his or her current abilities. The acquisition of adaptive skills, as such, is viewed as occurring within a zone of proximal development (Kaye, 1982; Vygotsky, 1962). The child may be viewed, in many ways, as an apprentice, acquiring adaptive skills through guided practice with a skilled instructor—a mentor. The mentor does not simply model and reinforce skilled action but also provides support and reassurance, maintains the child’s motivation, and assists the child by facilitating component skills necessary for the completion of the action. As with the construction of a building, the acquisition of adaptive skills over the course of development is guided by the organizing framework. The scaffold provides a structure for the construction of the building, leading the area of construction. The scaffold bears the weight of the building and is essential for maintaining the form of the edifice during the construction process. A wall that is not supported by scaffolding is at risk of falling should a stressor occur (a gust of wind, for example) before the concrete has set. The development of affect regulation skills during childhood (and in the therapy session) can be viewed in these terms.

The Development of Affect Regulation

As noted, the cognitive-developmental model posits that change processes in psychotherapy are essentially similar to those in normative development. The cognitive-developmental therapist, as such, serves as the scaffold, guiding and supporting the patient’s development of affect regulation skills by providing support, serving as a resource to “buffer” the patient from the effects of potentially traumatic life events, and guiding the development of more sophisticated emotion regulation skills through modeling and guided practice.

The unstable, intense, and volatile emotions that characterize individuals with BPD contribute to their risk for impulsive behavior (Eisenberg & Fabes, 1998) and may lead the individuals to view themselves as flawed, damaged, or unlovable. A reciprocal relationship may exist, as such, between deficits in affect regulation and the development of negative beliefs about the self. Strategic cognitive behavioral techniques, such as rational responding and a developmental review of evidence, are used to counter negative views about the self. It also can be helpful to use experiences within the therapeutic relationship to challenge negative beliefs about the self.

TREATMENT MODEL

Linda manifests many symptoms of BPD, including depression, anxiety, outbursts of anger, feelings of emptiness, unstable relationships, reactivity to perceived abandonment, dissociation, and impulsive suicidality. These difficulties are long-standing in nature and are subjectively quite severe. The cognitive-developmental treatment program for Linda would be designed to address cognitive, social, and behavioral variables that maintain these difficulties. Specifically, the therapist would attempt to help Linda (1) develop more effective emotion regulation skills; (2) change maladaptive schema that may contribute to feelings of depression, emptiness, anxiety, and anger; (3) improve her social skills; and (4) reduce suicidal and self-destructive behavior.

CLINICAL SKILLS OR ATTRIBUTES

An essential clinical skill is patience. It is quite likely that Linda will become suicidal, furiously angry, sexually promiscuous, or highly depressed over the course of therapy. Her difficulties are long-standing in nature and are firmly entrenched. The beliefs that maintain them are well learned, and the maladaptive coping strategies she uses in response to stressful life events are well rehearsed. It is not likely that she will change quickly. Given the severity of her difficulties, the therapist will likely feel compelled to quickly do something to rectify the situation. Short-term actions (e.g., providing support, encouraging expression of affect, and placing limits on specific behaviors) will provide only short-term relief. A more effective way of addressing concerns as they arise is to patiently, calmly, and objectively review the nature of the events that triggered her crisis, the thoughts and feelings she experienced at the time, how these thoughts and feelings are related to broader tacit beliefs or expectations, and how she can more effectively regulate her affect in this situation. As in standard cognitive behavioral therapy, teaching patients with BPD to reflect upon their experiences, to identify precipitants, to label emotions, and to identify specific upsetting thoughts will serve as a foundation for the introduction of techniques for developing affect regulation skills. Working with Linda to develop a clear and parsimonious formulation of what precipitated the crisis or outburst will allow her to see that these experiences are neither unpredictable nor inscrutable and will give her a clear sense of what might be done to prevent them from occurring again in the future.

A second therapeutic attribute is radical neutrality—the ability to maintain an even, calm, observant, and objective demeanor at all times. The therapist should not be drawn into becoming overly supportive, warm, or reassuring (lest this lead Linda to become dependent and to perceive that she will be abandoned when the therapist comes to know her flaws and imperfections) but also should not be cool, rigid, and formulaic. Patients with BPD can be exquisitely sensitive to others' behaviors. Note, for example, how Linda became enraged when her husband was 15 minutes late for dinner and interpreted this as evidence he was leaving her. Patients with BPD may react strongly to such subtle behaviors as the therapist leaning back in his or her chair or glancing away (indicating indifference or rejection) or leaning forward (which may be suggestive of emotional closeness or sexual interest). It is important, as a consequence, for the therapist to remain neutral and to be sensitive to the moment-to-moment fluctuations in the patient's mood.

THERAPEUTIC GOALS

Therapeutic goals should be collaboratively defined with the patient and should be explicitly stated. It may be helpful to have Linda write them out and note how she and the therapist will know when they have been accomplished. Reasonable primary goals would include (1) reducing the frequency and severity of Linda's suicidal gestures and self-destructive behavior; (2) reducing her feelings of depression, anxiety, and anger; (3) increasing the number and quality of her friendships; (4) reducing the frequency of her outbursts or mood swings; and (5) reducing the frequency of her dissociative episodes.

Secondary goals for treatment might be to develop Linda's affect regulation skills, identify and change maladaptive schema and interpersonal working models, develop social problem-solving skills, encourage cognitive flexibility, and increase adaptive interpersonal functioning. The primary goals include discrete behavioral and emotional targets, whereas secondary goals center on underlying mechanisms, mediating variables, and more diffuse behavioral objectives.

FURTHER INFORMATION NEEDED

Based on the cognitive-developmental model, the therapist will want to assess and rectify a number of factors that may contribute to Linda's

distress. As noted in Figure 8.1, a range of factors may play a role in the etiology and maintenance of BPD, and the therapists will want to sensitively evaluate each of these domains. Both objective and subjective approaches may be used in assessing these factors. Therapeutically, the goal is to maintain an objective stance and to reliably evaluate each of these factors. The therapist should balance this with a phenomenological approach, seeking to understand each of these factors from Linda's perspective. Variables to be evaluated are listed below:

1. Biological vulnerability
 - Family history of psychiatric illness
 - Early temperament and social relatedness
2. Unstable environment/trauma
 - History of trauma, neglect, or physical or sexual abuse
 - Modeling of maladaptive coping and beliefs by caregivers
 - Parental availability, reliability, responsiveness, nurturance
3. Disorganized attachment
 - Relationships with parents
 - Current relationships (including romantic attachments)
4. Impulsivity
5. Emotional dysregulation
6. Maladaptive cognitive processes
 - Impaired social problem solving
 - Cognitive bias (dichotomized thinking)
7. Maladaptive schema
 - Negative self-concept; self-loathing (view of self as incapable, unlovable, fundamentally flawed, incompetent)
 - World as dangerous, threatening
 - Others as rejecting, uncaring, malicious
 - Low self-efficacy, perceptions of control
 - Heightened dependency, need for support
8. Life events
 - Schema-congruent negative life events (e.g., perceived abandonment, rejection, loss)
 - Social stressors

9. Moderator variables
 - Adaptive cognitive and behavioral coping skills
 - Social supports
10. Symptoms
 - Depression
 - Anxiety
 - Anger
 - Suicidality
 - Self-destructive behavior
 - Maladaptive social behavior

The goal in gathering additional information is to clarify the potential role of each of these variables and to develop strategies for addressing them. Those most amenable to change include security of attachment in current relationships, maladaptive beliefs (including negative automatic thoughts, attributions assumptions, expectations schema, and self-assessments), problematic information processing (including cognitive biases and social problem solving), affect regulation skills, and social supports.

Studies indicate that many individuals with BPD have a history of childhood sexual abuse (Bryer, Nelson, Miller, & Kroll, 1987; Paris, 1994, 1997). Although not reported in the case study, the possibility exists that Linda may have been physically or sexually abused. Fugue episodes can accompany both BPD and post-traumatic stress disorder (PTSD) and are often associated with more severe forms of early trauma. Linda was an attractive eldest daughter and was cast into an adult role as a caretaker when her mother was away at work. She grew up in a home with an impulsive father who abused alcohol and admonished her to “learn how to accept sex.” It is not implausible, with this in mind, that there may have been an abusive relationship at home. Careful evaluation of this possibility is warranted.

Assessment Tools

Although Linda meets the diagnostic criteria for BPD, she also appears to manifest symptoms of other psychiatric disorders, including major depression, PTSD, and bulimia nervosa. Insofar as a significant percentage of patients with BPD also meet the criteria for a comorbid Axis I

(Farmer & Nelson-Gray, 1990; Widiger & Frances, 1989) or Axis II (Zittel & Westen, 1998) disorder, it may be helpful to complete a comprehensive, objective diagnostic evaluation. Structured and semi-structured instruments, such as the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1995) and the Personality Disorder Interview-IV (PDI-IV; Widiger, Mangine, Corbitt, Ellis, & Thomas, 1995) can be quite useful in this regard. The Structured Clinical Interview for DSM Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997) and the Diagnostic Interview for Borderlines-Revised (DIB-R; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989) are psychometrically strong instruments that can be used to clarify the diagnosis. Clinician interviews such as these can be augmented with patient self-report measures such as the Personality Diagnostic Questionnaire-IV (PDQ-IV; Hyler, 1994) or the Personality Assessment Inventory (PAI; Morey, 1991).

The cognitive-developmental model of BPD directs our attention to understanding Linda's early developmental history; the nature and quality of her early relationships with her parents, siblings, and peers; and whether she demonstrated a secure attachment to her caregivers. It is important, as well, to assess her temperamental style during her early childhood, for example, was she shy or inhibited as a toddler? Was she a withdrawn or angry child? Was she difficult to soothe, "slow to warm up," or a "difficult" temperament type? To be sure, it can be difficult to gather reliable and valid information on a patient's early developmental history. If available, however, such information can be quite helpful in developing a case formulation to guide treatment.

An objective assessment of mood can be important in beginning work with patients with BPD. In addition to understanding the patient's subjective experience of their difficulties, it can be helpful to have them complete brief, objective measures of their mood. Several excellent self-report measures are available, including the Beck Depression Inventory (BDI; Beck & Steer, 1987), Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988), Hopelessness Scale (HS; Beck, Weissman, Lester, & Trexler, 1974), the Profile of Mood States (POMS; McNair, Lorr, & Droppleman, 1971), and the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977).

It is quite important when working with patients with BPD to attend to the occurrence of suicidal thoughts. Like a fast-moving thunderstorm, these often appear with furious intensity, wreaking damage, then pass as quickly. A number of measures, including the Scale for Suicide

Ideations (SSI; Beck, Kovacs, & Weissman, 1979) and the Suicide Ideations Questionnaire (SIQ; Reynolds, 1987) can be used to assess acute risk of suicide. The therapist can augment questionnaires and interviews, such as these, with a careful discussion of Linda's motivations for considering suicide. Is it because she views her problems as unsolvable? She feels hopeless about her future? That she wants attention or revenge because someone has abandoned or offended her? That she wants others to pay attention to her, to recognize her distress, and come back to her?

The cognitive-developmental model of BPD emphasizes understanding patients' maladaptive schema, affect regulation capacities, and the attachment working models on which they are based. Information on these factors can be gained both through clinical interviews and with the aid of objective rating scales. The Young-Brown Schema Questionnaire (YBSQ; Young, 1999) can be of assistance in identifying maladaptive beliefs and attitudes that may contribute to Linda's distress. This can be complemented with information provided by the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996), a semi-structured, hour-long research interview that provides information about relationships with caregivers, early losses and separations, and experiences of rejection and abuse. The results of the AAI can be used to classify individuals into one of four attachment types (secure-autonomous, dismissing, preoccupied, unresolved-disorganized). Given the length of this instrument (as well as difficulties with scoring), it may not be practical to use the AAI in clinical settings. However, several self-report scales are available that can provide useful information about early experiences and attachment style.

The Parental Bonding Inventory (PBI; Parker, Tupling, & Brown, 1979) is a brief, objective self-report scale assessing recollections of parenting on two dimensions—caring and protection—whereas the Attachment Questionnaire (AQ; West & Sheldon, 1988) can be used to classify current attachment relationships into categories that are consistent with Bowlby's formulation. The Adult Attachment Scale-Revised (AAS-R; Collins & Read, 1990) is an 18-item self-report scale developed to assess three dimensions of adult attachment—fears of being rejected or abandoned (anxiety dimension), comfort with closeness to others (close dimension), and perceived dependability of others (depend dimension). Although designed as research instruments to assess representational working models of attachment, these scales can be used clinically as a means of clarifying patients' thoughts and feelings

about relationships and their experiences with their parents during their childhood. They can be used both to provide a focus for therapeutic discussion and to monitor changes over time in variables believed to underlie their distress.

Controversy exists regarding the construct validity of measures of adult attachment style and their relationships to early experiences and attachment security during childhood. With this in mind, scores on scales, such as the AAS-R, might best be viewed as measures of current perceptions of attachment security. This said, the authors have found that information provided on this scale can provide a useful focus for discussions of feelings of insecurity, fears of abandonment, and views about the reliability of others in current relationships

CONCEPTUALIZATION OF PATIENT

A number of factors appear to contribute to Linda's current distress. Although we know little of Linda's early developmental or social history, it appears that biological (and perhaps temperamental) factors were present that served as a foundation for her current difficulties. Both of Linda's parents were affectively labile, and her father had a history of alcohol abuse. It is likely, then, that there is a familial history of undiagnosed psychopathology. Linda's mother was critical and perfectionistic, and her father demanding and explosive. It is not likely, then, that she experienced her parents as responsive, reliable, nurturant, and nonpunitive, or that she would have been able to develop a secure attachment to them. Rather, one can postulate that she developed an insecure-disorganized attachment style and that this served as a template or "working model" for relationships with others throughout her life. Research indicates that relations between attachment security and mood may be mediated by the establishment of maladaptive beliefs or schema (Roberts, Gotlib, & Kassel, 1996; Reinecke & Rogers, 2001).

For Linda, experiences during her childhood and her consequent disorganized attachment style may have led to the development of a range of negative beliefs, attitudes, attributions, and expectations. In Linda's case, it is hypothesized that she came to view herself as flawed, incapable, and unlovable, to anticipate that others would be abusive or rejecting, and to view herself as being unable to control important outcomes. Her lack of remorse regarding the auto accident and her offhand comment that it is "kind of like the lottery" are telling. Several

pundits have recently noted that the growing popularity of lotteries and the legalization of casinos may reflect a fundamental change in American culture, in that success is now attributed more to chance than to diligent effort. The traditional American work ethic has been compromised. Linda's view that people "are just trying to get away with making money . . . like the lottery" may reflect a tacit belief that others are uncaring and malicious, and that important outcomes in life are due to happenstance.

Linda's affect regulation skills appear to be quite poorly developed. Her mood is labile and her behavior often self-destructive and impulsive. Like her mother, Linda appears to be critical and demanding, with high, rigidly held standards for performance. It does not appear that either of her parents served as models for adaptive coping or effective problem solving. The "explosive" home environment appears to have been characterized by high levels of expressed emotion.

In sum, it is hypothesized that genetic or biological factors and adverse early life experiences have contributed to Linda developing an insecure-disorganized attachment style that, in turn, has led to the establishment and consolidation of maladaptive tacit beliefs about the self and others. Effective problem-solving, social, and affect regulation skills were not modeled or reinforced. When confronted with schema-congruent life events, such as criticism or a separation, Linda becomes vulnerable to rapid mood swings and begins to use a range of dysfunctional coping strategies (including withdrawal, shopping, promiscuous sex, suicidal gestures) both to ameliorate her negative feelings and to reestablish a sense of connection or attachment with others.

POTENTIAL PITFALLS

Substantial evidence indicates that reciprocal relations exist between cognition and mood. Not only do the ways we think about things influence our emotional reactions, but our emotional state can influence perception, attention, memory, problem-solving, and appraisal processes. It is possible, as such, that Linda's rapidly fluctuating moods will influence her recollection of events and the ways in which she interprets her experiences. A potential pitfall exists in therapists' natural tendency to empathize with their patients' experiences. When working with patients with BPD, however, therapists do not want to be pulled into accepting the validity of their patients' perspectives. Care must be taken

to validate the legitimacy of Linda's emotional experience, and so have her feel understood, while at the same time remaining agnostic as to the reliability of her reports of events and questioning of the adaptiveness of her ways of coping with them. Linda was referred for treatment, for example, after angrily rear-ending an elderly couple in traffic. The therapist can attempt to understand and validate her feelings of frustration, while at the same time challenging her way of coping with them (it really isn't acceptable to bump others with your car) and supporting the development of more effective ways of managing feelings of anger.

A second potential pitfall stems from therapists' natural tendency to attempt to address immediate concerns. As in standard cognitive therapy, cognitive-developmental psychotherapy focuses on current problems and would attempt to assist Linda to manage them more effectively. Many patients with BPD present their therapists with crises that must be addressed. As important, however, will be to identify how current behavioral and emotional reactions derive from past relationship working models (attachment insecurity and schema), how they may be seen as attempts to reestablish a relationship, and how they reflect deficits in affect regulation. It is important to maintain the long view and to attend to underlying mechanisms while addressing crises that Linda presents.

A final potential pitfall may be Linda's tendency to become dependent on the therapist. This is a natural reaction, in that the therapist will likely be more attentive, empathic, understanding, acceptant, consistent, and reliably supportive than others in her life. This dependency can be used, at least initially, to encourage Linda to actively complete therapeutic activities. In the long run, however, it can be problematic. Given her low feelings of efficacy, it is possible she will attribute improvement to the therapist or to changes in her environment. It will be important, from the outset, to encourage autonomy and to help her to see how her efforts are responsible for bringing about change in her life.

PROGNOSIS

It can be very difficult to predict long-term outcome, and the authors hesitate to make predictions about Linda's progress without knowing her better. To be sure, a good deal of sophisticated research in recent years has examined predictors of response to treatment. Characteristics

of the clinician and the patient, nonspecific relationship factors (including warmth, empathy, positive regard, collaborative rapport, feeling understood), motivation and readiness to change, compliance, understanding and acceptance of the therapeutic rationale, therapeutic activity and problem focus, environmental variables (e.g., socioeconomic status and availability of social support), and technical factors in the therapy all appear to play a role. That said, it is challenging to predict the response of individual patients to a treatment program. Perhaps the best that can be done is to attend to each of these predictor variables and, whenever possible, work to maximize them.

Linda's long-term prognosis for adaptive change depends on how she and her therapist define "adaptive change." With regular attendance and diligent effort, the likelihood that Linda will make notable gains is reasonably good. It should be possible to provide her with techniques that will reduce her feelings of depression, anxiety, and anger, and that will reduce the frequency of suicidal gestures and attempts. The underlying factors that maintain her distress, however, are long-standing in nature and will likely prove difficult to change. Whereas it should be possible to provide Linda with techniques to more effectively regulate her mood, it may prove difficult to identify and change maladaptive schema. Linda appears to view herself as fundamentally flawed, unlovable, and incapable, and she views others as unreliable and rejecting. Transforming her into a confident, warm, and resilient woman who is tolerant of others' shortcomings and acceptant of the vagaries of close relationships is a tall order. Reconstruction of schema is difficult under the best of circumstances. If the goal, however, is more modest—to modify her most malignant beliefs and provide her with techniques for coping with emotional reactions that they elicit—progress might be made.

To paraphrase Sigmund Freud, the defining feature of clinically significant improvement is whether the individual is able to love and to work. Linda's functioning in both of these domains is quite poor. Moreover, it is not clear that she is motivated to develop close, empathic, and reciprocal romantic relationships or whether she views her work as problematic. She appears to attribute her difficulties to external factors (e.g., "I get overwhelmed a lot by the things that I do") rather than to personal characteristics. She is, in terms of her readiness to address these difficulties, in the "precontemplation stage" (Prochaska, DiClemente, & Norcross, 1992). She appears to be unaware of her social and work problems and may not yet be motivated to change. A first

step, then, may be to discuss these problems with her and to encourage her to identify specific problems in these domains that can be addressed during therapy sessions.

TIMELINE

The time frame for therapy can vary depending on a number of factors, including Linda's motivation and readiness to change, specific goals, level of distress, psychological mindedness, comorbid conditions, and expectations for change. Cognitive-developmental psychotherapy, like standard cognitive behavior therapy, is problem oriented, active, and strategic. For patients with severe BPD, sessions are typically held once a week for approximately 12 months. Sessions are held more frequently if there is an emergency or if the patient is experiencing acute distress.

SPECIFIC TECHNIQUES

Many of the techniques used in cognitive-developmental psychotherapy are essentially similar to those used in standard cognitive therapy (A. Beck, Freeman, & Associates, 1990; J. Beck, 1995; Sperry, 1999) and in schema-focused cognitive therapy (Young, 1999). After the therapist develops a case formulation and shares it with her, a problem list would be prepared. Initial interventions would be directed toward improving Linda's support system and encouraging her to engage in activities that provide her with a sense of accomplishment. Linda noted that her "life is empty" and that "there is nothing in her life." It would be worthwhile to explore these statements with her and to determine if there have been activities she has enjoyed or gained a sense of accomplishment from in the past. Did she, for example, feel a sense of meaning or accomplishment when she completed her master's degree? How does she feel when she trims a bonsai tree to perfection? Does she have goals for the future?

Initial interventions might also be directed toward reducing Linda's self-destructive behavior (Reinecke, 2000). She might, for example, be encouraged to identify situations where she is likely to experience suicidal thoughts and to prepare a list of strategies she can use should these feelings arise. These strategies might include reminding herself that she has "been through this before" and that "these feelings don't

last; they will be gone tomorrow.” She might carry a list of supportive people (and emergency resources) she can call and a list of activities that would distract her from thoughts of self-injury. Particular attention should be paid to “releasing cognitions,” which are beliefs that give the individual permission to engage in self-destructive behavior.

Linda’s compulsive shopping is of interest in that research indicates that impulsive and excessive shopping is associated with two beliefs—that material possessions are a source of identity and success and that purchasing goods will bolster self-concept by reducing discrepancies between how the person views him- or herself (perceived or actual self) and how the person wishes to be (ideal self). Excessive buying can serve as a temporary means of coping with feelings of anxiety or depression. Linda’s excessive purchasing may serve to provide social status (McCracken, 1990), help her to regulate her emotions (Elliott, 1994), and serve as an indicator of who she would like to be (Dittmar, 1992; Dittmar & Drury, 2000). With this in mind, it may be helpful to discuss her thoughts and feelings as she anticipates heading to the store to shop, the triggers for these emotions, the meanings attached to the objects she has selected (compulsive shoppers consistently select high-prestige items, such as clothes and jewelry, rather than functional items such as food or utensils), and how she would feel if she resisted making the purchase. A discussion of Linda’s shopping, then, may provide access to a range of negative beliefs about the self, her desirability to others, and her ways of coping with negative moods.

The development of affect regulation skills plays a central role in cognitive-developmental psychotherapy. Affect regulation may be viewed as a skill and, like other adaptive skills, is influenced by both environmental and biological constraints. Affect regulation comprises an integrated set of component skills that allows an individual to maintain a level of affective arousal that is appropriate for effective coping with stressful situations. These component skills include mood monitoring, cue identification, and implementation of cognitive and behavioral regulation strategies. If an individual is able to maintain a stable level of arousal when confronted with a stressful event, he or she will be better able to use more sophisticated skills, such as rational problem solving, assertive communication, and the like, to resolve the problem.

The first step in assisting Linda to more effectively regulate her emotions is for her to recognize that affective lability is, in fact, a problem. Like many individuals, Linda will likely view her reactions to her coworkers, ex-husband, fellow motorists, and neighbors as reason-

able and appropriate. The first task, as such, will be to encourage her to describe a recent event that elicited a strong emotional reaction and to ask about her “feelings about the feeling.” The question is not “Was your reaction justified?” but “Was it proportionate to the event, or was it stronger than it needed to be?” Insofar as strong feelings of depression, anxiety, and anger are uncomfortable, the therapist would guide her to reflect upon these emotions and to explicitly acknowledge that a goal of therapy is to reduce them.

A second step is to teach Linda to monitor her moods. As Roth and Fonagy (1996) observed, the ability to reflect upon one’s feelings and their relations to events is a strong predictor of therapeutic change. Teaching Linda this skill will be no small task. Although cognitive behavioral procedures (such as thought records, emotion rating scales, and mood diaries) can be quite helpful, they require that patients have the prerequisite ability to discriminate and label internal states and that they be motivated to do so. Given the strength of Linda’s emotional “surges,” it is not likely she will wish to reflect on them outside of therapy. These skills can, however, be developed during the therapy session. An empathic, tolerant therapeutic stance that encourages the development of perceptions of personal control or self-efficacy will facilitate the development of this skill. It is important for Linda to see that the therapist can tolerate (and even encourage) the expression and labeling of frighteningly strong emotions during the therapy session. When Linda becomes able to comfortably use mood monitoring techniques during the session, she can begin to practice them at home.

As Linda becomes better able to identify and monitor emotions during the week, she will be asked to rate their severity or strength on a 0–100 scale. Most individuals find this task fairly easy. Quite often, individuals with BPD will rate the majority of their experiences as having been extreme (i.e., in the 95–100 range). This is not problematic because the emphasis is not so much on the ratings of severity as on the identification of triggering events. Once Linda is able to identify situations that were associated with strong feelings of depression, anxiety, and anger, the therapist will ask her to identify physiological, cognitive, or behavioral cues that led her to realize her mood was escalating into the extreme range. She might note that she began, for example, to experience feelings of tension, to swear internally, or to speak more loudly or quickly. The activity teaches her to identify internal cues that she is about to lose control rather than external triggers or precipitating events. If available, family members and partners can be quite helpful in pointing out to patients when their moods are beginning to escalate.

Once Linda has learned to identify internal indicators that her mood is beginning to change, she will be asked to identify the “inflection point”—the point at which her feelings of depression, anxiety, or anger escalate such that she does not perceive that she can control them. The next goal will be to collaboratively develop a set of cognitive and behavioral strategies she can use before she reaches this inflection point. These may include leaving the situation or turning away, relaxing, reviewing a list of adaptive self-statements or counter-thoughts, completing a cognitive-behavioral thought record (see J. Beck, 1995), writing in a diary or journal, talking with a friend, distraction, guided imagery, or engaging in a pleasant activity.

Finally, Linda might be encouraged to identify scenarios that would lead her to experience a surge of negative affect and to develop plans for how she might manage them. It is likely, for example, that Linda will become frustrated by a parent or delayed in traffic at some time in the near future. As these events are predictable, fairly detailed plans for how she will manage them should be developed and practiced in session. The therapist can teach, model, and role-play these skills with Linda; offer recommendations to her; and reinforce her efforts to cope effectively with stressful events.

Attachment security is based on the belief that others will reliably and consistently support and nurture her. Given the nature of her relationships with her parents, siblings, former husband, and romantic partners, it is not surprising that she has come to view herself as defective and unlovable, to feel that she cannot count on others to reliably meet her emotional needs, and to believe that she is not capable of managing life’s challenges effectively. Unfortunately, her behavior appears to contribute to these relationship difficulties. Her critical demandingness, emotional neediness, and affective lability lead others to withdraw from her. This, in turn, exacerbates her feelings of isolation and depression, leading to further demands for emotional closeness. Changing these beliefs, expectations, and social templates will require a patient, focused approach. Linda might be encouraged, for example, to recount experiences in her past when she did feel close to someone, when she was able to empathize with another’s feelings, and when she felt nurtured, supported, and understood. She might then be asked to consider what she would, in the best of all worlds, want her current relationships to be like. The therapist would, in short, be attempting to identify memories of relationships where she felt a bit secure, and to use them as a possible template for future relationships. Feelings of security in current relation-

ships (including the therapy relationship) are discussed, and the fact that she may be capable of developing a trusting rapport with some persons would be explored. This would be followed by a practical discussion of ways in which trusting relationships can be facilitated, and skills for accomplishing this would be practiced in session. As in schema-focused cognitive therapy (Young, 1999; Guidano & Liotti, 1983), a developmental analysis of experiences contributing to maladaptive schema regarding herself and her relationships with others would be completed.

SPECIAL CAUTIONS

Linda's behavior is frequently a provocative, in the sense that it stimulates, excites, and provokes others to take action. The question then becomes, what is the action she desires, and does her behavior accomplish its intended goal? When Linda sends inflammatory notes to parents, calls the wife of her colleague, or destroys her husband's diploma she is seeking (maladaptively) to express her feelings to them and to accomplish specific goals. It will be important to focus not only on controlling these behaviors but also on understanding what her unstated goals are and how these reflect her tacit beliefs and expectations.

Linda appears, for example, to hold rigid beliefs about how others should behave and feels threatened when these expectations are violated. She does not appear to tolerate well the shortcomings of her fellow man. It would be interesting to know her thoughts and feelings about the parents of the children in her class. What thoughts occur as she sees that they have not assisted them with their homework as she would like? Her strong reaction suggests that this resonates for her in an important way. She remarked, for example, that "the kids will suffer, but that's their choice." Does she feel that she suffered as a child? Does she believe that she was, in some way, damaged by her experiences growing up? Does she believe that her parents, like those of the children in her class, made choices that were not in her best interest? Particular caution should be exercised should Linda begin to show displeasure with her therapist. Her thoughts and feelings about therapy and how these concerns are related to tacit beliefs and feelings of insecurity in relationships should be actively explored and resolved lest she leave treatment prematurely.

Although the concepts of transference and countertransference do not play a central role in cognitive therapy, the cognitive-developmental

model explicitly acknowledges the critical role of early experiences for forming working models of interpersonal relationships. The therapeutic relationship can be used as a means of understanding Linda's thoughts and behaviors outside of the therapy session and as a tool for therapeutic change. Moreover, the therapist's thoughts and feelings in response to Linda's actions can yield important information about her effects on others.

The cognitive-developmental model presumes that relationships with significant others in one's past have important, enduring effects on the nature and quality of current relationships. This simple notion—that past relationships may influence emotional and behavioral responses in current relationships—has important practical implications. Whereas transference is understood from a psychodynamic perspective as reflecting the expression of drives or the recapitulation of representations of subjective interactive experiences, cognitively based models conceptualize transference effects from a social learning perspective (Reinecke, 2002). Put simply, all of us draw inferences about new people based on past experiences with similar individuals. Transference, from a cognitive perspective, occurs not only in therapy but also in a wide range of social relationships. Inasmuch as relationships can be complex and require rapid assessment and evaluation of a great deal of nonverbal information, transference-based processing—using past experiences in similar situations to make sense of a novel social situation—can be both efficient and adaptive. When applied in a rigid or inappropriate manner, however, difficulties can arise. It will be important when working with Linda for the therapist to be attentive to his or her emotional reactions during therapy sessions and to encourage Linda to describe her thoughts and emotional reactions about the therapist. Her reactions to the therapy relationship may offer important insights into her beliefs about relationships, feelings of insecurity, fears of abandonment and rejection, and desires for support and understanding.

AREAS TO AVOID

There are no specific issues that, if raised by Linda, would not be appropriate for discussion. However, certain clinical difficulties may be better addressed through other forms of treatment. If, for example, Linda reported experiencing difficulties with alcohol or substance abuse, a referral for a consultation with a specialist in substance abuse

and dependence would be appropriate. Similarly, if she met the criteria for an eating disorder (e.g., bulimia nervosa), a referral for an empirically supported treatment (LeGrange, 2003) would be in order. The ways in which difficulties with alcohol abuse or eating disorders may be related to her affect regulation deficits, disorganized attachment style, negative self-concept, maladaptive schema, and ineffective problem solving would, of course, be discussed.

MEDICATIONS

Medications can play an important role in treating of BPD (Silk, 1996). Antidepressant, anxiolytic, neuroleptic, and mood stabilizing medications have all been used (Dimeff, McDavid, & Linehan, 1999) and can be effective in reducing dysphoria, anxiety, anger, and affective lability. It is worth noting, however, that effect sizes in controlled outcome studies tend to be modest and that the long-term effectiveness of medications with patients seen in community settings is not known. Moreover, risk of overdose remains an important concern. Given Linda's history of suicidal gestures, it will be important to monitor her mood carefully and select an agent with a relatively low toxicity. Tricyclic antidepressants and monoamine oxidase inhibitors might not, then, be first-line treatments. Medications might best be viewed as complementing psychotherapy as part of a broad, multidimensional treatment program.

PATIENT STRENGTHS

Linda has a number of strengths and resources that may be used in developing a treatment plan. It can be useful to think of strengths and resources as existing both within the individual and within the environment. These would include adaptive coping strategies and skills, cognitive skills, social skills, social supports, and community resources. Linda appears to be reasonably intelligent and is able to function effectively in predictable, stable settings. She was able to work while completing her graduate studies, suggesting that she can be resourceful and may be able to organize herself to complete challenging tasks. The process of therapy will be arduous. It will be helpful for Linda to see that she is capable of mastering difficult tasks and of acquiring new skills. The case study describes a range of maladaptive cognitive and

behavioral coping strategies. It would be helpful to identify adaptive coping strategies that Linda has developed. How does she cope with stressful events in her life? Are there things she does to calm or soothe herself? Does she, for example, find gardening or watching television relaxing? Is she able to approach problems in a thoughtful, rational manner? In a similar manner, it will be helpful to identify social and community supports. Does she have any friends or relatives she can turn to for support? Is she able to turn to her physicians and therapists when she is distressed? Has she ever participated in community activities or been a member of a group? It was noted that she was raised in the Lutheran tradition. Does she find attending church services or talking with a minister helpful? Developing a network of social and community supports may be helpful to Linda in stabilizing her moods and in reducing the risk of self-destructive behavior.

SETTING LIMITS

All things in development appear on the stage of life twice—first in the intersychic and then in the intrapsychic. The concept that skills are acquired in a social context has important implications for understanding processes of change over the course of development and in psychotherapy. As noted, failures to develop affect regulation skills play a central role in BPD. By setting limits and boundaries, the therapist serves as a model for how one can manage stressful situations. The rules, boundaries, strategies, and guidelines that the therapist places on the therapeutic relationship—limit setting—are openly discussed with the patient and, over time, internalized. If, for example, Linda was to become upset that her therapist would not allow their session to run long (perhaps demonstrating to her that the therapist was uncaring and rejecting), this would become an explicit focus of discussion during the following session. Her thoughts and feelings about the time limit, the relationship to beliefs she holds about other important relationships, and how she is able to manage the emotions that are triggered by these thoughts would all be examined. Linda might come to recognize, for example, that ending the session on time need not mean her therapist is uncaring. It would also serve to demonstrate how her demands that the session continue may be related to her “need to have contact” with her colleague at school. Both are based on her belief that she must have an emotionally close relationship in order to alleviate her feelings

of depression and anxiety. Setting appropriate limits and boundaries makes the therapeutic relationship a venue for developing affect regulation skills and for changing maladaptive beliefs. As noted earlier, the therapeutic relationship and the structure of the therapy session can be viewed as framework that guides and directs the process of treatment. Therapeutic limits and boundaries are an important part of this framework that serves not only to develop cognitive-developmental skills but also to help Linda recognize internal motivations and experiences she reacts to by engaging in maladaptive behavior (Green, 1988).

INCLUSION OF SIGNIFICANT OTHERS

It can be quite helpful to include family members in the therapy process. Care must be taken, however, to determine the role that family members may have played in the development of disorder. A history of severe abuse or neglect can complicate the treatment process. If, for example, Linda had been sexually abused by her father, encouraging his participation in therapy sessions could exacerbate her feelings of depression, anxiety, and anger. Similarly, if Linda's relationship with her mother continues to be characterized by criticism and perfectionistic demands, including her in the therapy process could prove challenging. A considerable body of evidence indicates that families that are characterized by high levels of expressed emotion (i.e., conflictual, critical, and demanding and/or obsequiously caring and controlling) tend to exacerbate feelings of depression, anxiety, and agitation among chronically ill patients. It would be useful to include Linda's parents or siblings in therapy sessions only if it appears they could actively support the treatment process and if there was the possibility of improving the quality of their relationship with her. As noted in the case study, Linda is divorced and lives alone. If she had a significant other, he or she could, with her permission, be invited to participate in her treatment.

HOMEWORK

As in other forms of cognitive therapy, homework plays an important role in cognitive-developmental psychotherapy for BPD. Every session should conclude with the collaborative development of a homework task, typically based on a skill discussed during the session, which can

be practiced during the week. Commonly used homework assignments include (1) preparing a list of specific treatment goals; (2) mood monitoring; (3) participation in social activities; (4) rational problem solving; (5) identifying maladaptive thoughts and cognitive distortions; (6) formulating adaptive counter-thoughts; (7) preparing a journal of experiences that are consistent and inconsistent with maladaptive expectations or schema; (8) affect regulation exercises; (9) attachment-based exercises; (10) assertive communication skills; (11) relaxation training; (12) preparing a journal of expectations for relationships, the positive and negative consequences of maintaining these expectations, and the probability that others will meet them; and (13) practicing negotiation and compromise. Whenever possible, homework assignments are practiced during the session, and factors that may interfere with successful completion are discussed. A wide range of cognitive factors (e.g., Linda doesn't believe the task will be helpful or believes she is being coerced into attempting it), behavioral (e.g., Linda lacks the skill to attempt it), and environmental (e.g., Linda won't have the opportunity to attempt the assignment during the week due to her work schedule), can arise that may subvert the treatment process. These should be carefully examined and resolved. If at all possible, Linda should leave the session with a clear sense of what the homework assignment is and how it may be helpful to her, and confident in her ability to accomplish it.

TERMINATION ISSUES

Because patients with BPD have problems with abandonment, loss, and rejection, their reactions to an impending termination may range from heightened dependency and helplessness to cool indifference to anger and dismissive scorn. Dependent neediness and a desire to please the therapist (often by bringing gifts or offering compliments) are quite common. These patients may view the therapist as an essential source of support and guidance and may doubt their own abilities to manage events as they arise. An approaching termination may, as such, activate schemas that play a central role in BPD. The patient's thoughts and feelings about termination, as such, become a critical component of the treatment itself and should be openly discussed.

Dependent, indifferent, and dismissive reactions by the patient can elicit a range of emotional reactions in the therapist, including anger, irritation, frustration, avoidance, guilt, feelings of inadequacy, or a de-

sire to redouble efforts to help the patient. Once again, an attitude of “radical neutrality” may be beneficial. Therapists will want to carefully monitor their thoughts and feelings in reaction to the patient and inquire, “What is it about the patient’s behavior that is eliciting this reaction in me? How might these behaviors be adaptive or maladaptive to the patient? Do these behaviors occur in other relationships? Is there anything I’ve said or done to elicit this reaction?” The therapist and the patient can then work together to understand the patient’s thoughts and feelings about the impending termination, how this may be related to schema and early attachment experiences, and how affect regulation skills learned earlier in treatment can be used to reduce these feelings.

Contemporary psychodynamic and cognitive behavioral theories of BPD frequently emphasize the central importance of abandonment and object loss as dynamics in the condition. Less frequently noted, however, are the notions of responsiveness and reliability. Individuals with attachment-based disorders such as BPD frequently expect and need others to be entirely responsive, nurturant, and reliable. Given their underlying disorganized attachment style, they look to family members, romantic partners, and therapists to be completely responsive and reliable (100% of the time, 24/7), and they react strongly to violations of this expectation (note, for example, how individuals with BPD react to unexpected changes in the date or time of their therapy session). Perfect reliability, of course, is not possible. Family members, partners, and therapists are not automatons. An explicit goal of therapy is to assist the patient with BPD to accept the unreliability of their fellow man, and to recognize that changes occur in relationships as individuals develop. Losses and changes need not be viewed as abandonment or a rejection. With this in mind, the termination process can become an opportunity for important therapeutic growth.

That said, termination is often quite difficult for patients with BPD. It can be useful, then, to taper sessions slowly, to offer the patient booster sessions as needed, to reinforce the skills learned, and to recommend that medications be maintained after psychotherapy has been completed.

RELAPSE PREVENTION

It may, in some ways, be inappropriate to think about relapse prevention when working with patients suffering from BPD. Based on a medical

model, relapse refers to reemergence of symptoms of a disorder that has been cured. Extant treatments for BPD, however, do not offer the possibility of cure, only of management. Given the possibility that Linda will experience episodes of depression, anxiety, and anger in the future, it is essential to help her to prepare for them. Linda might be encouraged to identify situations that are likely to trigger the reemergence of symptoms. If these situations can be predicted, Linda can prepare for them in therapy. Linda would then be assisted in developing a list of strategies and techniques that have been most effective for regulating her mood. The ways these might be used in coping with high-risk situations would then be practiced. It is important, as well, to distinguish a lapse from a relapse. Feelings of anxiety, depression, and anger are a normal part of the human experience. Their reappearance need not mean that therapy has been ineffective. Rather, they indicate that it may be helpful to seek support and to use those techniques that have been helpful in the past. The goal is to prepare Linda for the disappointments and losses of life by instilling a sense of efficacy and hope.

MECHANISMS OF CHANGE

Cognitive-developmental psychotherapy is believed to promote behavioral and emotional change by rectifying affect regulation deficits, changing maladaptive schema, improving social problem solving, and developing a more secure adult attachment style.

CONCLUSION

Treating patients with borderline personality disorder can be at the same time challenging and fulfilling. A well-considered, developmentally based formulation that attends to the full range of factors implicated in the etiology and maintenance of the disorder is important if therapists are to help these patients overcome the long-standing and very debilitating emotional and behavioral patterns that characterize this disorder. The cognitive-developmental model of psychotherapy emphasizes identifying and changing maladaptive schema and social interaction patterns. Therapists endeavor to help patients develop affect regulation skills, improve social problem-solving abilities, and develop a more secure adult attachment style. They build on patients' strengths

and recognize that individuals function in social contexts. Developing social supports and understanding the ways in which adverse early experiences may have served as templates or models for current relationships become an important focus of treatment. Cognitive-developmental models are quite new and sit at the interface of the cognitive-behavior therapy and developmental psychopathology literatures. Although promising, a great deal of work remains to be done. Research is necessary to refine and test these models, and controlled outcome studies are needed before we can have confidence in the efficacy and effectiveness of the procedures proposed.

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