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TREATMENT OF BORDERLINE PERSONALITY DISORDER: A CHALLENGE FOR COGNITIVE–BEHAVIOURAL THERAPY

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Summary—Patients with so-called Borderline Personality Disorder are generally considered as extremely difficult to treat. Until recently, conceptualizations of this severe disorder on which cognitive–behavioural therapy could be based were underdeveloped. The present paper presents a cognitive formulation based on previous cognitive and behavioural conceptualizations, and on empirical evidence pertaining to the relationship between childhood traumas and Borderline Personality Disorder. It is assumed that chronic traumatic abuse or neglect in childhood has led to the development of almost unshakeable fundamental assumptions about others (dangerous and malignant), about one's own capabilities (powerless and vulnerable) and upon one's value as a person (bad and unacceptable). These are assumed to underlie the complex symptomatic presentation of borderline patients. A treatment protocol is described, which takes 1.5–4 years, and consists of 5 stages: (1) construction of a working relationship; (2) symptom-management (gaining more control over symptoms); (3) correction of thinking errors; (4) emotional processing and cognitive re-evaluation of the childhood trauma and schema changes; and (5) termination. A case example is presented, and a call for research into the efficacy of this approach is made.

INTRODUCTION

Treating borderline problems with cognitive–behavioural therapeutic techniques is quite unusual. In recent years however promising developments have been initiated. Different strategies can be distinguished in this, which only partially overlap. The treatment model described here is an extension of the cognitive treatment of Borderline Personality Disorder as described by Beck, Freeman and Associates (1990), but is also partially based on the approach of Westen (1991) and on the behavioural approach of Linehan (1987a, b, 1993). The most important extension is that the present model integrates previous views with recent findings on chronic sexual and/or violent abuse and/or neglect in childhood, which prove to be specifically related to borderline problems. The treatment described concerns an ambulant psychotherapy with a frequency of 1 or 2 sessions per week and a total duration of 1.5 to 3 or 4 years. On the whole the therapy is based on the assumption that chronic traumatic abuse or neglect in childhood has led to the development of almost unshakeable fundamental assumptions about others (dangerous and malignant), about one's own capabilities (powerless and vulnerable) and upon one's value as a person (bad and unacceptable). These core assumptions were already hypothesized by Beck *et al.* (1990), but the model proposed here aims at clarifying their developmental background and introducing specific techniques for emotional and cognitive processing of the memories of the traumatic events that led to these assumptions. Before this nucleus can be challenged the therapy must pass through a number of phases, during which a working relationship is constructed, better control over symptoms is gained and the patient learns therapeutic skills. Before discussing the treatment, the diagnosis and the formulation of the borderline disorder in cognitive–behavioural terms will be treated.

DIAGNOSIS

The diagnosis of Borderline Personality Disorder is often problematic, because of the quickly fluctuating complaints and symptoms that are generally presented by the patient. Structured instruments might be helpful. As to the diagnosis on Axis-II, questionnaires carry the risk that

Axis-I complaints influence the answers too much, leading to overdiagnosis (Joffe & Regan, 1988; Noyes, Reich, Suelzer & Christiansen, 1991). The clinical interviews seem to function better in this respect, because the clinician must determine the judgement of the functioning apart from Axis-I complaints. One of the available interviews is the Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II; Spitzer, Williams, Gibbon & First, 1990), which has been proven to have good inter-rater reliability (Arntz, van Beijsterveldt, Hoekstra, Hofman, Eussen & Sallaerts, 1992; Renneberg, Chambless, Dowdall, Fauerbach & Gracely, 1992) and good factorial validity (Eussen, Arntz, Hoekstra & Hofman, 1994). The inter-rater agreement concerning the borderline diagnosis is good [$\kappa = 0.79$ (Arntz *et al.*, 1992)].

Generally the diagnosis will not be made with these instruments. In clinical diagnosis good use can be made of the DSM-III-R criteria for the diagnosis of Borderline Personality Disorder, which are concretely defined, as long as they are questioned accurately. The clinician is alarmed by a hazy picture of atypical, quickly fluctuating symptoms, substance abuse, dissociative experiences etc. On further questioning *desperation* proves to be the central theme in the patient's complaints. The patient, for example, who reported with complaints which initially gave the impression of panic disorder proved not to base these complaints upon catastrophic interpretation of physical sensations, as is usual in the Axis-I panic disorder. She only experienced these fears when she was alone in the evening or at night and was overwhelmed by desperate feelings of loneliness. She often had dissociative experiences and commenced automutulation during such 'attacks'.

It is wise to enquire into traumatic experiences in childhood accurately in the intake phase. As will become apparent, there is a strong relationship between childhood traumas and borderline problems, and it helps the therapist to view the symptoms in the right context. For the decision for ambulant behavioural therapy it is of importance to ascertain whether the patient has any areas of relatively stable functioning (e.g. work or some social contacts). Therapists should ascertain for themselves whether they have the desire *and* the possibility to enter into a long, difficult therapy, in which the frequency of the sessions will have to be increased in difficult periods. Explanation is given to patients about the treatment: it concerns a relatively long (1.5–4 year) therapy, with difficult periods, whereby exercises which patients must perform themselves will be scheduled. It is recommended to predict that there will be periods during which the patient will despair of the lack of progression and will perhaps desire an admission. The pros and cons of a(n) (temporary) admission must be discussed. In our (limited) experience borderlines have a strong desire for admission in difficult periods. An admission however frequently offers little consolation, because upon discharge, returned to the everyday situation, the relapse is often great.

FORMULATION

A clear formulation of what exactly a borderline disorder is, is not only impeded by the baffling presentation of problems by the patients themselves. According to Beck *et al.* (1990), one source of confusion stems from the tradition of using the term borderline to indicate borderline cases of 'neurosis' and 'psychosis'. Though borderlines (diagnosis according to DSM-III-R) can experience brief reactive psychotic experiences, a 'real' psychosis rarely occurs. A second source of confusion has developed because psychoanalytics have a different understanding of the term borderline than the DSM-III-R. Psychoanalytics use the term for a certain personality *structure*, whilst the term is used in the DSM-III-R to indicate a certain extreme personality type, defined by observable characteristics. Theory apart, the empirical similarity between the DSM-III-R and the psychoanalytical diagnosis is also limited (Beck *et al.*, 1990).

In the DSM-III-R criteria the central issues are the instability of mood, interpersonal relationships and identity. This instability, which also occurs in the complaints which the borderline patient presents, initially impeded a cognitive–behavioural formulation, for cognitive–behavioural therapy is best suited to the treatment of relatively stable complaints, such as Axis-I anxiety and mood disorders. In recent cognitive therapy however, the emphasis has been increasingly on the formulation of core schemas, which offers the possibility of gaining more grip therapeutically on the treatment of patients with a complicated and varying manifestation of symptoms. In cognitive therapy the term 'schema' refers to a theoretical construct, which is assumed to encompass an organized collection of information in the memory. These knowledge structures have developed

through (interpretations of) experiences, and once formed, they are assumed to fulfil a regulatory role in the processing of information. Based on these schemas, incoming information is filtered (only a small part of the available information is processed further) and is given meaning (Neisser, 1976; Nisbett & Ross, 1980; Brewin, 1988). Formed schemas are resistant to change and the information processing in established schemas has acquired an automatic, 'unconscious' character. Moreover, self-confirmatory selection and interpretation of information and the resulting behaviour, and the consequences thereof, lead to the persistence of previously formed schemas. The final goal of cognitive therapy is to change the schemas that lie at the root of the mental problems. As the schema is a theoretical construct, and therefore cannot be visualized directly, the therapist (together with the patient) must formulate hypotheses upon the core of the underlying schemas. This occurs in the form of so-called assumptions, fundamental suppositions that the patient has about himself, others and the world.

What, in general, are the contents of the characteristic assumptions of borderline patients? These seem to centre on three themes (cf. Beck *et al.*, 1990). Firstly, the idea that others are dangerous and malignant figures. Secondly, the idea of being powerless and vulnerable is central. Finally, the idea of being inherently bad and unacceptable to both the self and to others plays a role. With this the borderline patient displays a combination of fundamental assumptions which occur separately in other Axis-I disorders. But the specific combination causes a surplus of problems: dependent personalities, for example, also think they are powerless and vulnerable, but also think that others can offer reliable support. Due to this, the dependent person can solve this problem relatively easily as long as strong helpers are available. Because the borderline patient is convinced that others cannot be trusted, and that they themselves are unacceptable to others, the patient does not dare to trust others. Also, the fundament upon which the paranoid patient can rely is absent in the borderline patient: paranoid persons see themselves as strong and good, borderline persons see themselves as bad and unacceptable. In other words, borderline patients oscillate between the various positions because in a dangerous world they cannot trust themselves, and neither can they trust others. It is this oscillation which is central to the despair and instability which characterizes these patients. The borderline patient is like a child who has been left alone in a hostile world, in which no-one can be trusted.

This constellation of assumptions has a background. A biological vulnerability has been presumed, which would be responsible for emotional overreacting and impulsivity (Linehan, 1987a, b, 1993; Millon, 1981). In addition, a specific learning history of borderlines has been suggested, which would be characterized by rejecting and punitive reactions of significant others to emotional experiences and expressions of the child and the demand for a non-problematic 'positive attitude' (Linehan, 1987a, b, 1993). The child learns different things in this manner: (1) to present a façade of competence, whatever the person's own feelings are; (2) that the expression of feelings and opinions is punished (usually the child fears final rejection); (3) from the reactions of the educators it derives that there is no basis for its own opinions and feelings; and (4) the child does not learn in what way opinions and feelings can be expressed adequately. The façade of competence therefore hides a great degree of insecurity. Because the capacity to express emotions adequately has not been learned, the façade of being problem-free is shattered in periods of strong emotional upset by inadequately strong emotional expressions. The expectation that others will dismiss the person's own feelings amplifies the despair and therewith the inadequacy of the expression.

Recent research has made it clear that the majority of borderline patients have experienced a traumatic episode before puberty, characterized by chronic sexual abuse and/or violent behaviour by relatives (Bryer, Nelson, Miller & Krol, 1987; Coons, Bowman, Pellow & Schneider, 1989; Herman, Perry & van der Kolk, 1989; Ogata, Silk, Goodrich, Lohr, Westen & Hil, 1990; Stone, 1981). The frequency, determined in controlled research with the help of structured interviews, of sexual or violent abuse varies in borderlines from 71 to 81%, whilst in most psychiatric control groups the frequency varies between 22–35%.* The other Axis-II disorders do not display a specific relationship with such abuse (Bryer *et al.*, 1987; Herman *et al.*, 1989). Only the relationship of

*Methodologically less sound research characterized by indirect data collection (file research, interviews with therapists) produces lower frequencies of sexual and violent child abuse in borderlines, but still a specific relationship between child abuse and borderline diagnosis is found.

childhood trauma with serious dissociative disorders seems to be stronger (Coons *et al.*, 1989). In addition, in borderlines often there has been long-lasting and multiple abuse. However, sexual or violent abuse is not found in every borderline. There are other forms of chronic traumatic experiences which can be related to borderline problems. They all seem to be related to the intimates of the child. Examples thereof are: frequently witnessing violence between other family members; losing one of the parents before puberty; emotional unavailability of the parents; serious conflicts between the parents and between the child and the parents etc (Coons *et al.*, 1989; Herman *et al.*, 1989; Soloff & Millward, 1983).* In this article the assumption prevails that every borderline has experienced chronic traumas in childhood.

These findings lead to the hypothesis that the borderline disturbance is a consequence of long-lasting traumas during development, which have interfered intensely with the forming of schemas concerning the self and (intimate) others. Moreover, the combination of traumatic experiences and the (perceived) lack of safe others upon which one might fall back seems to lead to a stagnation in the development of abilities to experience and understand emotions and in identity development: the child learns early on that there is no external validation for his/her feelings pertaining to the traumatic occurrences and therefore cannot integrate these in the image that it (thinks it) must maintain towards significant others. In other words, it is assumed that Borderline Personality Disorder is not just a post-traumatic disorder, because the traumatic experiences had more fundamental effects on the development of the personality of the child than is generally the case in post-traumatic stress disorder.† The borderline characteristic of dichotomous (black-and-white) thinking is also explainable from this developmental stagnation hypothesis, for the child possesses incompletely developed cognitive powers. One-dimensional thinking and black-and-white evaluation are characteristic of childish thinking, whilst adult thinking is characterized more by multidimensional and nuanced thinking. In the areas related to pathology black-and-white thinking will dominate in the borderline patient.‡ According to the cognitive hypothesis this is directly connected to the characteristic sudden turnarounds in the evaluation of self and others.

The symptoms, the style of thinking and the assumptions of the borderline seem to be explicable through the trauma hypothesis. The emotional oversensitivity also does not necessarily have to be biologically determined. It can also be the result of unprocessed traumas such as we also see in adult post-traumatic stress disorder and other post-traumatic disorders (Rachman, 1980; van der Kolk, 1987). With this trauma hypothesis it is not contended that childhood traumas are the *cause* of the borderline disorder. But the manner in which the chronic childhood traumas were processed are thought to be causally related to the borderline disorder: it is the conclusions that the child has drawn from what has happened which causes the later problems. The therapy is aimed at adjusting these conclusions.

THE TREATMENT

The treatment can be divided into 5 overlapping stages: (1) the construction of a working relationship; (2) symptom management; (3) correction of thinking errors; (4) trauma processing and schema change; and (5) termination. These stages are discussed in order.

The Working Relationship

Constructing a working relationship is problematic in borderlines. A strong ambivalence dominates the contact: on the one hand, there is a desire for help and acceptance, on the other there is fear of hurt and rejection. Due to the nature of the borderline disorder a task-directed

*As with the findings on sexual and violent abuse in childhood, these findings are based on retrospective research with adequate psychiatric control groups. Due to the retrospective character it cannot be excluded that there are distortions in the reports specific to borderlines. On the other hand, there are reasons to believe that true traumatic memories have certain characteristics that distinguish them from distorted memories (Ensink, 1992). Prognostic research will have to produce further clarity.

†Moreover, many borderlines do not have the DSM-III-R symptoms of post-traumatic stress disorder.

‡It would be interesting to investigate whether dichotomous thinking in borderline patients is restricted to schema-related issues, or is a general characteristic.

relationship, other than in 'normal' cognitive–behavioural therapy, in which there is a stable consensus upon the goals and methods of therapy, cannot develop swiftly. In crisis periods, the claim upon the therapist for immediate relief of despair can be astoundingly large. The typical borderline mistrusts others so strongly, that much of the help-offering that the therapist lets himself be drawn into, is rejected or undone. Therapists feel themselves standing before an impossible task and can easily let themselves be provoked into rejecting reactions. The therapist must realize, however, that the behaviour of the patient is directly related to the core of the borderline problem, which cannot be treated before a certain trusting relationship has been built. Trust cannot be enforced, and manoeuvres such as trying to convince and discussions are discouraged. It is better to take your time, acknowledge the problem with trust and react empathetically. Consistent and congruent behaviour by the therapist are important. Intimacy, physical proximity, confrontation (telling the patient "you don't want to change") and lack of clarity (e.g. long silence, or no answer to the question of the meaning of the therapy, but returning the question) increase the level of fear and are not indicated. However, attempts to offer clarity, consistency and a foothold by prescribing strict standard programs or through an authoritarian-directive approach by the therapist will not meet with success because the patient does not dare relinquish control.

It is good to give the patient as much control as possible. A number of possibilities exist for this. (1) Each session of the therapy begins with the determining of the agenda for the following hour. The patient is given a lot of influence upon this. (2) If the patient is desperate it is better to assign the first 15 min for this, rather than to engage in a meaningless power struggle, even if the subject has no bearing on the line set out by the therapist. In order not to lose the line of the therapy it is recommended that the therapist should not intervene in this period. (3) Also, patients themselves choose, possibly from the offer of the therapist, which therapeutic method will be tried. (4) The patient can terminate the discussion of difficult subjects that are too frightening by giving a signal defined previously, e.g. raising a finger. This means that the therapist must change the subject and that as a distraction the concrete characteristics of a painting in the room, for example, are discussed. It is recommended to practice the giving of this signal beforehand, because otherwise the patient will not trust this procedure.

Though the patient is given considerable control, the therapist must assign boundaries. It is better to frustrate the patient sometimes in not being able to offer extra help and to prove to be reliable in what help can be offered, than to concede too much and to dismiss the patient out of irritation. Reliability can also be increased by clarifying and removing misunderstandings, which lie at the root of the sometimes exorbitant emotional expressions in therapy; by emphasizing that the discussion of feelings and impulses (also towards the therapist) will never lead to cessation of the therapy; and by admitting errors.

Symptom Management

The goal of this phase of the therapy is not the banishing of symptoms by a symptom-directed approach, but making life more bearable and thereby evening the path towards the next phases of therapy. Roughly 2 groups of symptoms can be distinguished: the first occurs chiefly during crises, the second has a more chronic character. The following applies to both.

Crises, self-mutilating and self-threatening behaviour should be taken seriously, and not be minimalized (which often occurs by the patient's family). The therapist resists the inclination to see every crisis or new symptom as an emergency and to respond as such. It is better to identify the common denominator in the varying problems. The therapist tries to elucidate the background of the problem with the patient, but in the first instance avoids intervening in this background (depth, intimacy and confrontation are still too threatening). Mostly the motive concerns a form of despair, with severe feelings of fear or aggression, which are escaped from or expressed by problematic behaviour. Thereupon a search is made, together with the patient, for less damaging alternative behaviour. Self-multilating behaviour can, for instance, be replaced by harmless vehement experiences, such as placing the hands in ice, dancing to music, cold showers etc. (Linehan, 1978b; Leibenluft, Gardner & Cowdry, 1987). Frequently the misunderstanding occurs that the patient thinks the therapist has told them they *must* behave differently. The goal of therapy, however, is to increase the *freedom* of choice pertaining to the expression of emotions.

The patient therefore chooses an alternative, the therapist does not prescribe this. The goals are limited, every small improvement is advantageous in this phase.

In the long term, the goal is to cope with emotions in a more adequate fashion: gradually the focus in the therapy is removed from the problem behaviour to the motive. The therapist explains that this is beneficial to the therapy and confirms every approach of avoided feelings and thoughts by taking these seriously. It might be dangerous to explicitly praise patients in this phase: this may induce fear. If there is some progression at symptom level, or increased trust, the following phase can be considered.

Modifying Thinking Errors

Whereas the emphasis in the beginning lies on concrete behaviour, if some progression has been made, or if at least the patient's trust in the therapist has grown, then cognitive diaries (Beck, Rush, Shaw & Emery, 1980) can be introduced. With this the misinterpretations that lie at the root of the symptoms are traced. Dichotomous (black-and-white) thinking is the most characteristic thinking error which borderlines make (Beck *et al.*, 1990). Dichotomous thinking is, according to the theory of Jean Piaget, characteristic of children, and distinguishes itself from more adult thinking, which is multidimensional and more nuanced (Beck *et al.*, 1980). There, where more nuanced judgements are obvious, borderlines see themselves as only bad, and others as totally trustworthy, or totally not. Dichotomous thinking is hypothesized to underlie the strongly varying emotions and judgements. In the therapy, the patient learns to correct dichotomous thinking with structured methods, as used in cognitive therapy of depression (Beck *et al.*, 1980).

Other thinking errors are also made frequently (Westen, 1991). For example *personalization*, the tendency to excessively relate external occurrences to oneself. Borderlines have the tendency to blame themselves excessively for what goes wrong in their environment. Moreover, they use a *double standard*: the strict rules which they judge themselves by do not apply to others. The thinking in this is *egocentric*, which does not mean egoistic, but denotes the inability to distinguish between one's own interpretations or wishes and those of another. Borderlines have difficulty *differentiating* between another's wishes and demands (in the therapy for example, a wish of the therapist is easily experienced as an order), and fear great catastrophes if they do not fulfil others' wishes (*catastrophizing*). These cognitive patterns can be approached with the help of the standard cognitive techniques (Beck *et al.*, 1980). Often this will not be enough. Intellectually the patient does understand the arbitrary character of his/her thinking, but claims that "it just simply feels this way". The lack of a definite effect of the standard cognitive procedures should then be acknowledged and can be used to motivate the patient for the next phase of the therapy.

Trauma Processing and Schema Change

The changing of thinking errors is not easy in borderlines: the core schemas are deeply anchored. Moreover, the patients fear the consequences of letting these assumptions go. Clinical findings indicate that it is necessary to modify the patient's representation of the traumatic childhood experiences which led to the development of these assumptions in the therapy. The therapist is discouraged from being *too* cautious in touching on this subject, even if the patient displays a lot of resistance against it and/or dissociates in the discussion thereof. Borderlines seek therapy amongst others for support in dealing with their traumatic experiences, even if they do not dare to broach the subject (Perry, Herman, van der Kolk & Hohe, 1990). After therapy their judgement is that the emotional processing of the traumatic experiences has helped them considerably (Perry *et al.*, 1990). What must happen? In the first place, the traumatic experiences and their context are clarified. This process must occur in such a way that concurrently a certain extinction of fear for these memories occurs: the exposure to the traumatic memories and the emotions thereby incurred must proceed slowly, gradually and predictably, and must be controlled by the patient. Secondly, it is of importance that the previous childlike interpretations, which lie at the root of the problematic assumptions, are reconstructed. This can make it clear to the patient that the assumptions were reasonable then, but do not necessarily apply to the present situation. Mostly, however, more is needed: the change has to take place at the child-level, so to speak; thereto, use can be made of imagination techniques (Edwards, 1990), or of psychodrama.

In a psychodrama the childlike interpretations which have led to the development of the underlying schema are modified. A typical interaction between the patient as a child and (for example) the parent can be replayed in a role-play, in which the therapist or a *stand-in* plays the role of the parent. The childlike interpretations are traced by letting patients play themselves as a child; by changing roles a different perspective is offered, which breaks open the childlike (egocentric) interpretations and leads to the formulation of alternative interpretations (the patient can now use adult insights and cognitive powers which he/she did not have as a child); finally, the role-playing model is repeated, in which patients now base their role on their newly acquired insights.

An example: Mrs G. had been in treatment for quite a while, in which initially the (many) presenting complaints were entered into: binge-eatings interspersed with anorexic periods, somatoform complaints, and periodical episodes with severe fears and alcohol and drug abuse. Interpersonal problems at work, with family members and friends, as well as the extraordinary negative self-evaluation of the patient were added to this. The patient fulfilled the DSM-III-R criteria for Borderline Personality Disorder. Incest in the past, besides many other traumatic experiences in childhood, were known, but could not be modified initially: the patient resisted this and dissociated during attempts to bring it up in conversation anyway. Progression proved to be difficult to achieve because the patient refuted any positive action of herself as not suiting her: she saw herself as 'bad'. When the patient finally did try it became apparent that not only the incest experience itself, but mainly the manner in which mother had responded in her eyes to the revealing thereof, had contributed to her idea of being guilty and bad herself. The typical guilty, bad feeling which the patient experienced if something in her environment had gone wrong proved to correspond to the feelings she had experienced as a child during the moment that mother had wanted to talk to her about what had occurred.

The interaction with her mother, upon which the patient based the conviction of being bad was then replayed in a role-play. This concerned a situation in which the mother, who has just learned something vaguely, wants to talk to her daughter about what exactly has happened. In the role-play it became apparent that the patient as a child was so afraid of the expected reaction of her mother, that she did not dare to talk with her mother: she feared that everything that she would say about what had happened would result in a total rejection by her mother (those who had committed the incest had told her that her mother would send her away for ever if she found out what had happened). Thereafter, the patient interpreted the ending of the conversation by her mother as proof of the rejection by her mother and of her own 'badness'. After the role-play this interpretation was made explicit and role-swapping was applied: the patient played the mother role, and the stand-in (because the therapist was a man, a female stand-in was used) played the daughter. Playing the role of the mother the patient experienced not being able to get the daughter to speak. This gave her the opportunity of formulating an alternative interpretation. Whilst her original interpretation was that her mother's cool behaviour and the termination of the conversation were proof of her mother's rejection, the alternative interpretation entailed that there was a reciprocity between the mother and daughter, in which the daughter did not dare tell and thereby did not test her fear of being rejected by her mother, whilst the mother did not succeed in breaking through the silence of her daughter, could not handle this and did not talk of it further. Therefore, the mother did not reject her daughter, but did not know how to respond otherwise.

In a third round the patient was given the opportunity to experiment with the alternative interpretation: by telling her mother what had happened and explicitly asking for her mother's judgement she could test her fear and correct her judgement. It was thereby important, of course, that the mother's reactions were accurately played according to the patient's directions. By applying extra role-swapping the catastrophic expectation of being rejected could be tested accurately: even if the patient played her mother as accurately as possible, she did not reject her daughter. After a number of variations the patient finally became convinced that her childlike conclusion had not been correct, which was further confirmed by then discussing what had happened with her (real) mother. The final result of this role-play was that patient could nuance her self-image as inherently bad. The patient now could allow successes in her life, and did not always see herself as guilty of everything.

In this technique frequent role-swapping and variations are often necessary, before a clear new insight develops. In theory this technique may seem simple, in practice it often proves to be accompanied by strong emotions in the patient. The patient must not be fearful of this in order to bring the whole psychodrama to a satisfactory conclusion. It should be stressed that the purpose of such reinterpretation techniques is not to undo what has happened in reality, and to make things better than they were, so to speak. The purpose is to investigate the conclusions that the patient has drawn from the traumatic experiences and to correct them if this seems appropriate.

It remains necessary to consolidate the obtained insight in the present life. To this end, the patient can now express the feelings and opinions towards those involved with the trauma, which he/she did not dare to or could not express as a child. With this, catastrophic expectations which are linked to this can be tested ("if I say what I thought of his behaviour, then ..."). The generalized expectations also should be modified in the present. The expectation of the above-mentioned patient of being deserted by others if she were to express anger towards them was tested with behavioural experiments: the planned expression of irritation or criticism and accurate determination of what the reactions of others were.

After the emotional processing and the reinterpretation of the trauma, a 'working-through phase' follows in the therapy, in which the three fundamental assumptions (others are dangerous and malignant; I am powerless and vulnerable; I am inherently bad and unacceptable) are modified with challenges and behavioural experiments. Thereby it is important to repeatedly draw the relationship between previous traumatic experiences and present expectations, and to each time let the patient examine to what degree the expectations are well-founded. In the therapeutic relationship, too, such catastrophic expectations will have an influence: the patient expects, for example, that the therapist will terminate the treatment if she does not do her homework perfectly. It is of importance to bring these expectations to light and modify them with cognitive techniques. Finally, it can be necessary to treat certain symptoms in a complaint-directed manner, even if this failed in a previous phase. The progress concerning fundamental schemata now gives more opportunity for symptom-directed treatment: the patient now can enter into a task-directed relationship and can allow both disappointments and progress.

Termination of the Treatment

Once the changes have been consolidated reasonably one can work towards termination of treatment. Good indications of this are, for example, the reduction of symptoms, better control over emotions, bigger and more realistic trust in the therapist and in others, and being able to independently apply skills acquired during therapy. Termination of treatment must be discussed far in advance, and if the patient agrees a plan is made for the last phase. The patient is invited to make an overview of what still has to be done. The therapist emphasizes that the goal is not to become a totally different person, but to learn skills (such as being able to distinguish between one's own and other's wishes, being able to express one's own opinion, being able to independently apply cognitive techniques such as challenging and performing experiments) with which the initially automatic reactions can be corrected. It may be of importance to offer the patient the opportunity to return anytime for *booster* sessions. This certainty alone seems to have a therapeutic effect (A. T. Beck, personal communication).

CASE EXAMPLE

When Mrs G. was referred for cognitive–behavioural treatment she had broken off 4 previous therapies, including a Gestalt therapy and a psychoanalytic therapy. In all these therapies she had experienced increasing feelings of guilt and badness because she did not progress. She claimed that she could not trust her therapists enough to talk about these feelings, and broke off the therapies to prevent the rejection she expected by the therapist. Mrs G. was 27 years old and had had no intimate relationship since she was 16, when a teacher had sexually abused her during a relationship which they had started after he had given her emotional support after a suicide attempt. During her youth Mrs G. had experienced various (chronic) traumatic experiences, including the loss of her father when she was 6, years of separation from the family in a boarding school during the period when her mother had to recover, and sexual abuse by her brother. When she finally could

return to her mother it appeared that her mother could not manage the family and that her mother was no longer emotionally available (due to brain damage caused by an accident). The sexual abuse by her brother continued. Her brother told her that her mother would reject her and send her away if she disclosed what had happened. Meanwhile, her mother had remarried with an alcoholic who was frequently very aggressive towards his wife. From the age of 7 onwards, the patient felt that she was an intrinsically bad person, that nobody could be trusted and that the only way to survive was to deny her own opinions and emotions and to behave according to the wishes of others. Not being able to do so would cause rejection by the other person.

Mrs G. presented many complaints, but there was one that she demanded to get rid of: her frequent binge-eating. In addition to bulimia nervosa, there were dysthymia, somatoform complaints, alcohol abuse, frequent periods with extreme fears, mistrust of other people and severe interpersonal problems, sleeping problems and automutilation. The patient had also attempted suicide several times. Mrs G. had an extremely low self-esteem and an intense conviction of being a bad person. In the first year of treatment she remained extremely distrustful of the therapist, often did not turn up for scheduled sessions, spent a lot of time during the session discussing that she could better break off the therapy, and dissociated when the topics addressed in the session became too threatening. Virtually all behavioural and cognitive techniques for treating bulimia nervosa were tried during the initial phase of the therapy. Though the patient made good progress with respect to establishing a normal eating pattern, she could not get rid of her binge-eating. Exploration of the function of this binge-eating led to the hypothesis that it served as a way to avoid painful feelings and thoughts about loneliness and worthlessness. By means of cognitive therapy and self-control techniques she achieved some control over interpersonal problems and her emotions. Only after all cognitive and behavioural techniques had been tried and had failed with respect to the binges (and the alcohol abuse), and she had still not been dismissed by the therapist, it was possible to motivate the patient to explore and treat the traumatic experiences in her youth.

It took more than a year for the patient to clarify precisely what traumatic events had happened during her youth: her memories were incomplete and vague. By a gradual approach and with help of guided imagery and role-plays the important aspects were reconstructed. The essential step which increased patient's self-esteem and freed her from her feelings of guilt was the role-play sketched above as an example. After this, the patient was helped to redefine her relationships with those who committed the incest and with mother. To generalize and consolidate the progress cognitive–behavioural techniques were subsequently directed at manifestations of the patient's assumptions in present problems and in therapy. Following this, the patient wanted to try to decrease her binge-eating, and was now much more successful than before the processing of her traumatic memories. The patient made a plan of what she still wanted to achieve and learn in therapy. After most was done, therapy could be terminated. Though the patient was invited to ask for booster sessions if she wanted them, until 1.5 years after the termination of therapy she did not ask for them. At termination she claimed that for the first time in her life she could be satisfied with herself and she started to experiment with intimate relations which were based upon reciprocity. Most of the initial complaints had disappeared, though she still had occasional binge-eatings.

Figure 1 shows the scores of Mrs G. on the Dutch SCL-90 Depression subscale and on the Total SCL-90 (Arrindell & Ettema, 1986), on the Neuroticism and Self-esteem subscales of the Dutch Personality Inventory (Luteijn, Staren & van Dijk, 1985) and on mean binge-eating frequency. As can be seen, progress was very modest until the traumatic memories were addressed in therapy (that was after the mid-test). This brought about the essential change on most variables. At end of therapy Mrs G.'s scores were in the normal range, as determined by the *c* criterion (that is the point half-way between the clinical and the normal distributions) of Jacobson and Truax (1991). At post-test the patient still engaged in binge-eating, but she experienced much more control over it and no longer demanded its complete disappearance.

CONCLUSION

Little is known as yet about the effectiveness of a cognitive–behavioural treatment of Borderline Personality Disorder. Clinical impressions are very positive (A. T. Beck, personal communication; C. Padesky, personal communication). Linehan, Armstrong, Suarez, Allmon & Heard (1991)

report beneficial results of relatively brief interventions in suicidal borderlines. Turner (1989), in a number of case studies, reports positive results in 3 out of 4 patients. Controlled studies are still lacking. The time seems ripe for these. An interesting option would be the comparison between cognitive–behavioural therapy and other methods, e.g. a psychoanalytical or social-psychiatric approach. In addition, it is as yet unclear which ingredients of the total package are essential. Specific research into this is desirable. One of the theoretically interesting issues is whether the

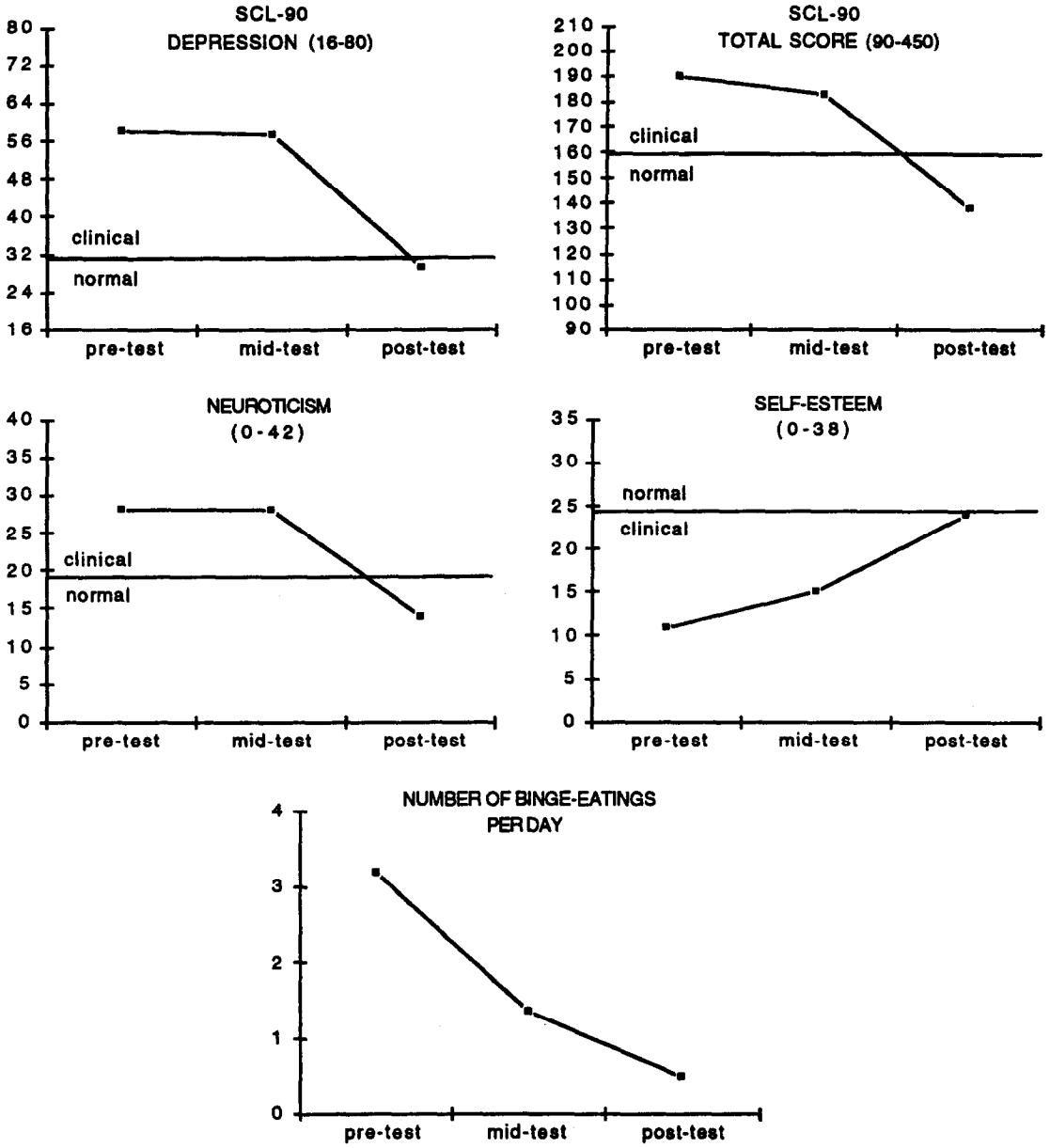

Fig. 1. Mrs G.'s scores on the Depressive Complaints subscale and the Total scale of the SCL-90, on the Neuroticism and the Self-esteem subscales of the Dutch Personality Inventory, and mean binge-eating frequency during 2-week periods at pre-test, mid-test and post-test. As can be seen, the changes were nil to modest during the first half of the therapy [though some progress was achieved in binge-eating frequency, normal eating pattern and self-mutilating behaviour (not depicted)]. Substantial progress was made after traumatic experiences in the patient's youth were addressed during the second half of the therapy. The patient's scores on the questionnaires can be compared with the clinical norms, defined by the point half-way between the normal and the clinical (psychiatric) populations (Jacobson & Truax, 1991) and depicted in the figures.

treatment of the traumatic memories can be restricted to purely emotional processing of what happened (e.g. by imaginal exposure to the traumatic memories), or whether cognitive reinterpretation of the experiences is necessary for progress.

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