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Strategies Used in the Treatment of Borderline Personality Disorder: A Survey of Practicing Psychologists

Ian R. Sharp, Gregg R. Henriques, Jason E. Chapman, Elizabeth L. Jeglic, Gregory K. Brown, and Aaron T. Beck

One hundred and twenty three practicing psychologists completed surveys regarding the therapeutic techniques they employ for patients with Borderline Personality Disorder (BPD). Participants identified their predominant orientation and rated the frequency with which they used a range of 27 specific strategies. Logistic regression analyses identified an expected relationship between specific techniques and the theoretical orientations to which they are most closely linked. These findings suggest a high level of concordance between self-described theoretical orientation and the specific treatment techniques utilized, but also that some theoretical orientations are comprised of smaller independent clusters of strategies. The implications of these findings are discussed.

KEY WORDS: borderline personality disorder; treatment; therapy; survey.

Borderline Personality Disorder (BPD) is a chronic condition, the symptoms of which often begin to appear in childhood or adolescence (Paris, 2003). Persons with this disorder experience significant impairment in a variety of domains, including instability in interpersonal relationships, self image, and affect (American Psychiatric Association, 1994). BPD is a severe condition that has a long history of being viewed as intractable and difficult to treat. Suicidal behavior, including suicidal threats and gestures, suicide attempts, and completed suicide, is a hallmark feature of BPD (see Black, Blum, Pfohl, & Hale, 2004). Additionally,

Address correspondence to Ian R. Sharp, Ph.D., Psychopathology Research Unit, University of Pennsylvania, 3535 Market Street, Philadelphia, PA, 19104-3309; e-mail: iansharp@mail.med.upenn.edu.

self-injurious behavior without intent to die is also common among persons with this disorder (Shearer, Peters, Quaytman, & Wadman, 1988; Dulit, Fyer, Leon, Brodsky, & Frances, 1994). Because BPD is complicated and difficult to treat, there is significant interest in the approaches psychotherapists tend to use for this disorder.

Several newer treatment protocols have been developed and shown to be effective in reducing a number of symptoms in persons with BPD. For example, Dialectical Behavior Therapy (DBT) has been shown to be effective in reducing self-injury (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) and substance abuse (Linehan et al., 1999) in BPD patients. One randomized controlled trial of Mentalization-Based Therapy, a psychoanalytically oriented treatment done in the context of a partial hospital program, found significant improvement in depressive symptoms, decrease in suicidal and self-mutilatory acts, reduction in-patient days and better social and interpersonal functioning compared to treatment-as-usual (Bateman & Fonagy, 1999). Results from an uncontrolled trial suggest that Beck's Cognitive Therapy (CT) is effective in producing significant reduction in a number of symptoms including suicide ideation, hopelessness, and depression, as well as specific borderline behaviors (Brown, Newman, Charlesworth, Crits-Christoph, & Beck, 2004).

Further, other treatment protocols for BPD have been developed and are in the process of being evaluated including Transference-Focused Psychotherapy (Clarkin, Yeomans, & Kernberg, 1999), Schema Focused Therapy (Young, Klosko, & Weishaar, 2003), Systems Training for Emotional Predictability and Problem Solving (STEPPS), a cognitive-behavioral systems-based group treatment (Blum, Pfohl, St. John, Monahan, & Black, 2002), and Cognitive Analytic Therapy (Ryle, 2004).

In addition to the treatments mentioned above, it is likely that therapists employ a number of other interventions (e.g., humanistic therapy). The majority of previous writings examining the popularity and utilization of psychological treatments have relied solely on broad descriptions of 'theoretical orientation.' This is problematic in that the construct of theoretical orientation can be vague and unreliable. For example, two individuals may report that they are 'Cognitive Behavioral' in orientation with each providing completely different treatment approaches in practice. Additionally, there is some evidence that even in manualized psychotherapy regimens a number of therapists adhere to a therapy process other than the one they are ostensibly delivering. For example, Ablon and Jones (2003) examined data from the NIMH Treatment of Depression Collaborative Research Program and found that interpersonal therapy delivered in the study more closely conformed to the prototype of cognitive-behavior therapy than the prototype of interpersonal therapy. The present study is one of the first to assess practitioners' utilization of specific techniques in the treatment of patients with BPD.

METHOD

Participants

Brief surveys were mailed to the 261 members of the Philadelphia Society of Clinical Psychologists. The survey was conducted as one component of the recruitment procedure for a treatment effectiveness study evaluating cognitive therapy for BPD utilizing therapists in the community. Of 261 sampled, 123 (47%) participants returned completed surveys. Surveys were considered complete if participants responded to one or more of the items in the "therapeutic strategies" section of the survey.

Instrumentation

The survey consisted of general demographic information including age, gender, primary clinical setting (e.g., Private Group Practice, Inpatient Setting), and number of years in practice. Questions specific to the treatment of BPD included number of years treating patients with BPD, number of BPD patients treated in the last three years, self-rated expertise vs. non-expertise in treating patients with BPD, and what they would consider to be their predominant theoretical orientation (Psychodynamic, Family Systems, Cognitive-Behavior, Behavioral, Dialectical Behavior Therapy, and/or Humanistic).

Using a 5-point Likert scale from 'Never' to 'Always,' participants were also asked to rate how frequently they use a list of 27 therapeutic strategies when treating BPD patients. Therapeutic strategies were derived from a number of theoretical approaches including *interpretations of unconscious* associated with Psychodynamic Therapy, *cognitive restructuring* associated with Cognitive Therapy, *distress tolerance training* associated with Dialectical Behavior Therapy, and a *nondirective* stance associated with Humanistic Therapy. Selection of the techniques was based on interviews conducted by one of the authors (A.T.B) with several therapists from each of the theoretical orientations to determine which techniques they used in their practice. Cognitive-behavior therapists reported using the largest numbers of techniques, and therefore there was a preponderance of those techniques included in the survey.

RESULTS

Fifty-nine (48.4%) participants were male, 63 (51.6%) were female, and one declined to answer. The mean age of the sample was 54.3 years ($SD = 9.0$; range = 30 to 82). All of the respondents held a doctorate with 93 (75.6%) reporting a Ph.D., 15 (12.2%) reporting a Psy.D., and 15 reporting an Ed.D. (12.2%).

The mean number of years in practice was 22.8 ($SD = 9.5$; range = 3 to 55), the mean number of years treating patients with BPD was 18.2 ($SD = 8.0$; range = 2 to 43). Participants were asked to endorse the number of BPD patients treated in the last three years using provided ranges: 46 (37.7%) participants endorsed treating 1–3 BPD patients, 41 (33.6%) endorsed 4–9 BPD patients, 15 (12.3%) endorsed treating 10–15 BPD patients, 9 (7.3%) endorsed treating 16–25 BPD patients, 9 (7.3%) endorsed treating 25 or more BPD patients, and 2 (1.6%) reported that they had not seen any patients with BPD in the last three years. A majority of participants ($n = 93$, 75.6%) reported working in a solo private practice. Other treatment settings included group private practice ($n = 29$, 23.6%), inpatient setting ($n = 12$, 9.8%), intensive outpatient setting ($n = 9$, 7.3%), rehabilitation ($n = 4$, 3.3%), vocational ($n = 2$, 1.6%), group home ($n = 1$, 0.8%), and other ($n = 9$, 7.3%). Twenty-eight (22.8%) respondents endorsed more than one setting.

The most commonly endorsed "predominant approach" to treating BPD patients was cognitive behavior therapy ($n = 74$, 60.2%) and the second most commonly endorsed was psychodynamic therapy ($n = 48$, 39.0%). Thus, 85.4% of respondents described their approach to treating patients with BPD as cognitive behavioral, psychodynamic, or both ($n = 17$, 13.8%). Other approaches endorsed were family systems therapy ($n = 22$, 17.9%), dialectical behavior therapy ($n = 13$, 10.6%), humanistic therapy ($n = 11$, 8.9%), and behavior therapy ($n = 10$, 8.1%). Forty (32.5%) respondents endorsed more than one approach.

Table I provides the frequency of endorsement for each of the therapeutic strategies. The five most commonly endorsed strategies, determined by the percentage of participants who rated these items as "Often" or "Always" included: Problem-Solving (71.6%), Here and Now Focus (64.2%), Cognitive Restructuring (59.4%), Validation of Experience (58.6%), and Anger Management (52.9%). The five least commonly endorsed strategies determined by the percentage of participants who rated these items as "Never" or "Rarely" included: Interpretations of Unconscious (69.9%), Nondirective (66.7%), Mindfulness Training (62.6%), Socratic Questioning (57.7%), and Schema Focused Work (57.0%).

A principal components analysis (PCA) with Promax rotation was conducted with the 27 strategies. Given the conceptual relationship between factors composed of groups of therapeutic strategies, we selected Promax as an oblique rotation method to allow for the statistical correlation of these factors. The Kaiser-Guttman rule was used to determine the number of factors to extract. The magnitude of the factor loading was the primary determinant in the decision to interpret a particular item on a given factor. The general guideline we used was a factor loading of $>.35$. In addition, we examined the loadings of items across factors, and interpreted these items on the factor in which loadings were greatest and the interpretation made the most theoretical sense.

Initial checks of the adequacy of the correlation matrix suggest that the data were in good condition for factoring, KMO Measure of Sampling

Table I. Frequencies for Therapeutic Approaches Employed among 123 Practicing Psychologists

Therapeutic Approach	Number of Responses (%)				
	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
Interpretations of unconscious	44 (35.8)	42 (34.1)	27 (22.0)	9 (7.3)	1 (0.8)
Facilitating insight	14 (11.4)	11 (8.9)	54 (43.9)	32 (26.0)	12 (9.8)
Working with transference	23 (18.7)	14 (11.4)	44 (35.8)	30 (24.4)	12 (9.8)
Exploration of childhood	9 (7.3)	20 (16.3)	44 (35.8)	33 (26.8)	17 (13.8)
Eliciting expressions of affect	17 (13.8)	20 (16.3)	49 (39.8)	26 (21.1)	11 (8.9)
Client centered	31 (25.2)	25 (20.3)	37 (30.1)	19 (15.4)	11 (8.9)
Nondirective	39 (31.7)	43 (35.0)	31 (25.2)	8 (6.5)	2 (1.6)
Assertiveness training	26 (21.1)	21 (17.1)	47 (38.2)	28 (22.8)	1 (0.8)
Relaxation training	22 (17.9)	25 (20.3)	46 (37.4)	25 (20.3)	5 (4.1)
Anger management	5 (4.1)	3 (2.4)	50 (40.7)	53 (43.1)	12 (9.8)
Monitoring of self-injury	12 (9.8)	14 (11.4)	35 (28.5)	32 (26.0)	30 (24.4)
Mindfulness training	60 (48.8)	17 (13.8)	22 (17.9)	19 (15.4)	5 (4.1)
Validation of experience	15 (12.2)	7 (5.7)	29 (23.6)	50 (40.7)	22 (17.9)
Distress tolerance training	35 (28.5)	9 (7.3)	25 (20.3)	35 (28.5)	19 (15.4)
Crisis management training	27 (22.0)	13 (10.6)	35 (28.5)	30 (24.4)	18 (14.6)
Socratic questioning	48 (39.0)	23 (18.7)	35 (28.5)	10 (8.1)	7 (5.7)
Cognitive restructuring	13 (10.6)	5 (4.1)	32 (26.0)	44 (35.8)	29 (23.6)
Schema focused work	50 (40.7)	20 (16.3)	26 (21.1)	22 (17.9)	5 (4.1)
Problem solving	6 (4.9)	2 (1.6)	27 (22.0)	53 (43.1)	35 (28.5)
Agenda setting	22 (17.9)	12 (9.8)	35 (28.5)	35 (28.5)	19 (15.4)
Here and now focus	10 (8.1)	3 (2.4)	31 (25.2)	46 (37.4)	33 (26.8)
Homework	15 (12.2)	18 (14.6)	42 (34.1)	27 (22.0)	21 (17.1)
Psychoeducation	16 (13.0)	7 (5.7)	51 (41.5)	29 (23.6)	20 (16.3)
Emergency phone contact	19 (15.4)	18 (14.6)	49 (39.8)	18 (14.6)	19 (15.4)
No-suicide contracts	20 (16.3)	12 (9.8)	37 (30.1)	30 (24.4)	24 (19.5)
Couples/family sessions	20 (16.3)	19 (15.4)	67 (54.5)	15 (12.2)	2 (1.6)
Structured interview	38 (30.9)	25 (20.3)	37 (30.1)	14 (11.4)	9 (7.3)

Note. $N = 123$. Five mostly commonly endorsed items are in bold.

Adequacy = .826 and Bartlett's Test of Sphericity were significant, $\chi^2\ (351) = 1447.23$, $p < .0001$. The rotated factor solution converged in nine iterations. Seven components with Eigenvalues greater than 1 were extracted, accounting for 64% of the variance in strategies endorsed. The factor pattern matrix is presented in Table II. The seven factors were defined as follows: I. Cognitive-Behavior Therapy Techniques (A), II. Psychodynamic Therapy, III. Cognitive-Behavior Therapy Techniques (B), IV. Adjunctive Procedures, V. Dialectical Behavior Therapy specific, VI. Cognitive-Behavior Therapy Techniques (C), and VII. Humanistic Therapy-specific. The naming of the factors was conducted by a committee of researchers involved with the project and was based on examination of the factor pattern matrix loadings, independent naming of factors, and group discussion and consensus among the members.

Based on the results of the PCA, there appears to be three distinct subcomponents of treatment techniques (Factors I, III, and VI) that comprise the traditional category of cognitive behavior therapy. Examination of the content of the items

Table II. Factor Pattern Matrix Loadings of Therapeutic Techniques

Items	Components						
	I	II	III	IV	V	VI	VII
Problem solving	**.78**	−.03	.15	−.19	.14	−.02	.07
Cognitive restructuring	**.67**	−.01	.07	.03	−.10	.26	.07
Monitoring of self-injury	**.66**	.13	−.07	.25	.14	−.19	−.15
Anger management	**.55**	−.06	.54	−.25	.06	.02	−.09
Facilitating insight	.06	**.74**	−.21	.16	−.14	.16	.22
Working with transference	−.16	**.73**	−.02	<.01	.27	.06	−.09
Exploration of childhood	.21	**.72**	.04	−.04	−.05	−.03	−.03
Interpretation of unconscious	−.08	**.71**	−.23	−.03	.10	.11	.21
Eliciting expressions of affect	−.10	**.52**	.38	.35	−.37	−.02	−.10
Relaxation training	−.05	−.09	**.75**	.08	.09	−.06	.16
Assertiveness training	.26	−.02	**.70**	−.21	−.11	.18	.05
Here and now focus	−.03	−.08	**.64**	.05	.23	−.05	.09
Homework	.03	−.27	**.50**	.40	−.05	.14	<.01
Couples/family sessions	−.10	.09	−.05	**.76**	<.01	−.06	−.01
Agenda setting	.31	−.23	<.01	**.52**	.13	−.02	.10
Structured interview	.41	−.12	−.21	**.49**	−.04	.15	.15
Psychoeducation	−.08	.13	.17	**.45**	.18	.27	−.07
Emergency phone contact	.03	.27	.02	**.43**	.24	.06	.02
No-suicide contracts	.33	.25	.19	**.36**	<.01	−.08	−.07
Mindfulness training	−.17	−.24	.16	.13	**.67**	.27	.06
Distress tolerance training	.36	.08	−.09	<.01	**.67**	.09	−.11
Validation of experience	<.01	.35	.32	−.06	**.56**	−.16	.07
Crisis management training	.42	.06	−.09	.10	**.52**	−.06	<.01
Socratic questioning	.06	.18	.06	−.15	.08	**.84**	−.06
Schema-focused work	−.04	.02	<.01	.27	.08	**.70**	−.12
Client centered	.01	−.02	.17	.27	<.01	−.27	**.82**
Nondirective	<.01	.30	.12	−.29	<.01	.12	**.73**

Note. $N = 123$. I. Cognitive-Behavior Therapy Techniques (A) II. Psychodynamic Therapy, III. Cognitive-Behavior Therapy Techniques (B), IV. Adjunctive Procedures, V. Dialectical Behavior Therapy-specific, VI. Cognitive Behavior Therapy-specific(C), and VII. Humanistic Therapy specific.

comprising each of these three components revealed that the first CB component may be best defined as a *directive cognitive*, the second as *behavioral*, and the third as a *non-directive cognitive*.

Next, factor total scores were created by summing the scores on each of the items that loaded significantly on that factor. For example, the factor score for Factor VII (Humanistic Therapy) was the sum of the scores of the two items that comprise the factor (i.e., 'client-centered' and 'non-directive'). Given that all items were scored using a 5-point Likert scale ranging from 0–4, the possible range would be 0 to 8 for this factor. To examine the relation between the components derived from the PCA and participants' self-reported predominant approach, single covariate logistic regression analyses were conducted.

A number of the composite scores predicted dichotomous endorsement of theoretical orientation. Logistic regression analyses identified a logical relation

between specific techniques and the theoretical orientations to which they are most closely linked. Participants who endorsed psychodynamic strategies were significantly more likely to endorse the psychodynamic theoretical orientation, Wald's $\chi^2(1, N = 123) = 19.05$, $p < .001$ (odds ratio [OR] = .91, 95% confidence interval [CI] = 1.16–1.49). Conversely, participants who endorsed items from the third cognitive behavior therapy component, CBT(C), were significantly less likely to endorse a dynamic orientation, Wald's $\chi^2(1, N = 123) = 4.97$, $p = .026$ (odds ratio [OR] = .82, 95% confidence interval [CI] = .68–.98). Participants who endorsed items from the first and second cognitive behavior components, CBT (A) and (B), were significantly more likely to endorse a cognitive behavior orientation, Wald's $\chi^2(1, N = 123) = 10.66$, $p < .001$ (odds ratio [OR] = 1.22, 95% confidence interval [CI] = 1.08–1.38) and Wald's $\chi^2(1, N = 123) = 5.85$, $p = .016$ (odds ratio [OR] = 1.14, 95% confidence interval [CI] = 1.03–1.27), respectively, and significantly less likely to endorse a psychodynamic orientation, Wald's $\chi^2(1, N = 123) = 8.29$, $p < .01$ (odds ratio [OR] = .86, 95% confidence interval [CI] = .78–.95). Participants who endorsed items from the dialectical behavior therapy component were significantly more likely to endorse a dialectical behavior therapy orientation, Wald's $\chi^2(1, N = 123) = 12.53$, $p < .001$ (odds ratio [OR] = 1.52, 95% confidence interval [CI] = 1.20–1.91). Lastly, participants who endorsed items from the humanistic component were significantly more likely to endorse a humanistic orientation, Wald's $\chi^2(1, N = 123) = 11.26$, $p < .001$ (odds ratio [OR] = 2.21, 95% confidence interval [CI] = 1.39–3.52).

Interestingly, despite a large number of practitioners endorsing the cognitive behavior and psychodynamic orientations, several of the major techniques associated with these orientations were not highly endorsed. For example, 60% of respondents reported cognitive behavior therapy as a predominant approach, yet only approximately 14% of respondents endorsed using Socratic Questioning 'often' or 'always' with their BPD patients. Although 39% of respondents endorsed a psychodynamic orientation, only approximately 8% of respondents reported using Interpretations of Unconscious 'often' or 'always.'

DISCUSSION

The present study examined the popularity of a variety of treatment techniques with a sample of psychologists who treat persons with BPD. Over half of the sample (60%) endorsed cognitive behavioral therapy as a predominant approach in treating their patients with BPD and 39% of respondents endorsed psychodynamic therapy as a predominant approach. Approximately 11% of respondents reported DBT as a predominant approach.

Problem-Solving, Here and Now Focus, Cognitive Restructuring, Validation of Experience, and Anger Management were the five most commonly endorsed strategies and Interpretations of Unconscious, Nondirective, Mindfulness

Training, Socratic Questioning, and Schema Focused Work were the five least commonly endorsed strategies. The components derived from the PCA suggest that practitioners provide several statistically distinct treatments for their patients with BPD. For example, psychologists who utilize psychodynamic techniques are less likely to use cognitive behavioral techniques, and in turn, psychologists who utilize cognitive behavioral techniques are less likely to use psychodynamic techniques.

The present study found a high level of concordance between self-described theoretical orientation and the specific treatment techniques utilized. However, a number of respondents reported multiple orientations. Additionally, many practitioners identified using techniques outside of their predominant approach. This is not surprising as many clinicians describe themselves as eclectic in orientation and treatment delivery. Therefore, for research investigating theoretical orientation or the utilization of specific treatments, it is suggested that participants be provided lists of treatments or treatment packages (e.g., exposure exercises) rather than solely relying upon the broad categories typically used (e.g., CBT, psychodynamic therapy).

The findings of the present study are in-line with recent research suggesting an increase in the utilization of cognitive behavioral therapy (e.g., Norcross, Hedges, & Castle, 2002). However, considering the support for its efficacy, it is surprising that only 13 participants (10.6%) endorsed DBT as a predominant approach in the treatment of their BPD patients. One potential explanation for the low number of practitioners that endorsed using DBT is that it is designed to be an intensive treatment program that requires both individual and group therapy and specialized training for the therapist. With 75% of our sample reporting working in a solo private practice, these factors may deter many psychologists from utilizing DBT with their patients. Further, future research needs to assess the role of empirical support vs. other factors in clinicians' choice of therapeutic techniques.

Study Limitations

The current study was carried out as part of the recruitment procedure for an effectiveness study evaluating cognitive therapy for BPD as provided by practicing psychologists in the community. The sample for this study was comprised of members of the Philadelphia Society of Clinical Psychologists, which may limit the generalizability of the findings to this specific sample. Although the 47% response rate is lower than desired, it is actually higher than other recent surveys of psychologists (e.g., 27.3% in Becker, Zayfert, & Anderson, 2004; and 30% in Addis & Krasnow, 2000). However, because the study was conducted in the context of therapist recruitment for a cognitive therapy clinical trial, it is possible that the results reflect an over-sampling of cognitive therapists.

The present study is preliminary and relied on participants' self-report of what strategies they use with BPD patients. A large scale follow-up study that involves obtaining evidence of participants' *actual* clinical practices, and whether this differs significantly from self report, is needed. Future studies looking at specific treatment usage would be improved by additional objective assessment of clinical practices. Because most therapists are not psychologists, future research is also needed to assess the popularity of therapies in a broader range of mental health professionals, including bachelor and master's level clinicians and psychiatrists. Additionally, further assessment of factors that contribute to practitioners' choice of therapeutic techniques (e.g., predominant approach in training programs or work setting, empirical support) is suggested.

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