2014-05-02

The Experience of Abandonment Before and After Receiving Dialectical Behaviour Therapy

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The Experience of Abandonment Before and After Receiving Dialectical Behaviour Therapy

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASER OF SCIENCE

Division of Applied Psychology

CALGARY, ALBERTA

April, 2014

Abstract

The objective of this study was to determine whether receiving Dialectical Behaviour Therapy (DBT) influences the perception and experience of abandonment by individuals with Borderline Personality Disorder (BPD). Participant eligibility was primarily defined by a confirmed diagnosis of BPD and completion of the first phase (e.g. skills training) of DBT. Four co-researchers (three female and one male) completed both the biographical questionnaire and the semi-structured interview administered by the primary researcher in one-on-one sessions. Verbatim transcripts of the interviews were analyzed according to the phenomenological existential method. The results indicated that there is a common emotional, cognitive, and behavioural experience of abandonment among the participants both before and after DBT, that the experience of abandonment is indeed different after DBT, and that this difference in experience is attributable to the application of DBT skills and DBT therapist trait of empathy used as an intervention in the form of validation.

Acknowledgements

I would like to express the deepest appreciation to my supervisor Dr. Kevin Alderson who has continually and persuasively conveyed a spirit of adventure in regard to research and scholarship. Without his supervision and help this dissertation would not have been possible.

I would like to acknowledge fellow MSc Counselling Psychology students, Constantine Chondros, Cordelle Neufeld, and Ashley Bishop, for assisting me with the organization of themes and sub-themes. I would also like to thank the staff at Inner Solutions for their assistance with the recruitment of potential participants for the current study. In addition, my appreciation is extended to Donna Hughes, Frank Kelton, Jaime LeBarron, and Dr. Tom Strong for their insightful comments and critique, and their general support of this thesis.

I express my deepest gratitude to the individuals who agreed to participate in this study. Your courage in speaking openly about the experience of abandonment is inspiring and commendable.

I would like to thank my parents, Regula Brunies and Pierre Ménard, for their priceless support during this endeavour and throughout my life. Mama, you have taught me how to be a strong woman in the face of any challenge. Pierre, you have shown me how to appreciate the serenity and wisdom that lives in quiet contemplation and acceptance. I would like to show appreciation to my mother-in-law, Johanne Fraser, for her encouragement and for helping with all the little things that tend to fall by the

wayside when one is deeply entrenched in thesis-writing. I acknowledge Kiara, our energetic and dynamic daughter, for helping me gain perspective on the meaning of abandonment and resilience. Finally, I thank my husband, Devin Rued-Fraser. His unwavering love has been integral in healing my wounds of abandonment. His perseverance in facing the lessons presented in life has helped me have the courage to do the same. There are no words that could adequately describe how much he inspires me to love and grow every single day.

Dedication

Trent O. Meacham Sr.

(b. 16 Jun, 1925 ~ d. 23 Nov, 2004)

For the man who inspired my interest in the subject of abandonment.

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Epigraph

“One response to feeling abandoned is to abandon oneself”

(Millon et al., 2004, p. 500)

CHAPTER 1 - INTRODUCTION

Rationale

The fear of abandonment is one of the primary identifiers of borderline personality disorder (BPD). Research has indicated that subtle interpersonal triggers can be perceived by the IDBPD as abandonment or rejection and initiate intense feelings of anxiety, overwhelming sadness, and self-loathing (Sadikaj, Russell, Moskowitz, & Paris, 2010). Due to affect dysregulation, the onset of these emotions is rapid, the intensity is high, and the duration is longer (Linehan, 1993a; Westen, 1998). Neurological investigation has supported the theory that IDBPDs are more severely impaired emotionally and cognitively by memories of abandonment than individuals without BPD (Schmahl et al., 2003).

While working with highly suicidal patients, Marsha Linehan (1993a, 1993b) developed a new form of cognitive therapy, dialectical behaviour therapy (DBT), which has been shown to be highly successful in the treatment of BPD. The definition of successful treatment of BPD has been established by clinical data such as in-patient status duration or rate of symptom relapse (Koerner & Linehan, 2000; Scheel, 2000). To the author's current knowledge, no study has investigated the IDBPD's perspective of whether DBT treatment was helpful in addressing their fear of perceived or actual abandonment, since the concept of abandonment issues, a psychodynamic perspective, is not addressed by DBT, which operates from a cognitive and biosocial perspective (D. Hughes, personal communication, December 9, 2013). The current study thus intends to illuminate what psychoanalytically-oriented theorists consider to be the keystone symptom of BPD: the experience of abandonment.

Statement of Purpose

This study's aim is to promote contribution to the field of BPD research from an insider's perspective rather than the clinician's or researcher's perspective. Its purpose is to understand how IDBPDs experience, perceive, and manage abandonment issues. Specifically, changes in individuals' experience, perceptions, and management skills will be explored through biographical questionnaires and their personal accounts of abandonment reactions before and after receiving dialectical behaviour therapy.

The objective of this study was to determine whether receiving DBT influences IDBPDs' perception and experience of abandonment. The research was guided by the following research questions:

1. Do IDBPDs perceive themselves as affected by abandonment?
2. Is there a common experience of abandonment among IDBPDs?
3. How is abandonment related to the other symptoms of BPD?
4. Do IDBPDs describe a different experience of abandonment after having undergone DBT?

Significance of the Study

This research will give IDBPDs an opportunity to have their side of the story heard. A qualitative study will afford research that represents the participants' data as detailed and in depth as possible. A focused discussion of the ways that DBT may have altered their perception of abandonment may help to affirm positive changes and result in an increased sense of empowerment.

This research aims to elucidate the experience of abandonment and how the fear of abandonment is managed by IDBPDs after having completed DBT. Little to no

empirical research has been conducted on this topic specifically, or the personalized experience of IDBPDs generally. This research is novel and needed to shed additional light on this topic.

BPD is a relatively misunderstood disorder in today's society (Friedel, 2004), despite it having the highest prevalence and severity among the personality disorders (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Among individuals who are aware of BPD, the disorder carries with it a stigma that is even upheld by some practitioners. This study may help remove some of the stigmatization of BPD by lending an honest human voice to the experiences of individuals with the disorder.

Researcher Reflexivity / Bracketing

As the researcher and sole interviewer in this study, the onus was upon me to maintain awareness of the influence of my personality, values, and theoretical standpoint on both the interviewee's responses and my interpretation of them. Pure objectivity is considered by qualitative methodologists to be a lofty and naïve goal, and existential-phenomenologists acknowledge and accept the inherent influence of the researcher on the data (Osborne, 1990). Researchers' preconceptions must thus be considered both in the formulation of research questions, interactions within interviews, and in the subjective interpretation of results. Within phenomenology, researcher reflexivity is maintained through the process of bracketing. According to Starks and Trinidad (2007), a phenomenological researcher:

> must be honest and vigilant about her own perspective, pre-existing thoughts and beliefs, and developing hypotheses. In phenomenology and grounded theory researchers engage in the reflective process of "bracketing," whereby they

> recognize and set aside (but do not abandon) their a priori knowledge and assumptions, with the analytic goal of attending to the participants' accounts with an open mind. (p. 1376).

Expectations of exactly what should be bracketed differs from one theorist to the next (Tufford & Newman, 2010). According to Gearing (2004), bracketing includes the researcher's personal history, knowledge, experience, and theoretical orientation in relation to the phenomenon under investigation. Drew (2004) specified that the researcher's emotions in the context of the investigation need to be bracketed. In the interest of achieving comprehensive bracketing, I will abide by the definition proposed by Starks and Trinidad (2007) and merge the bracketing processes posited by Gearing (2004) and Drew (2004).

My interest in this study's subject matter is of both a personal and intellectual nature. I have had a lifelong personal relationship with the term abandonment because I identified myself as a daughter abandoned by her father since the age of three who was then repeatedly rejected by him when attempting to contact him. As a result, I personally define abandonment to include an emotional aspect rather than just the physical abandonment of a baby on an orphanage's doorstep, for example.

I also have a personal relationship with BPD in that I was handed the diagnosis in September, 2010. I debated whether or not to divulge this information in my MSc counselling psychology thesis, given the stigma associated with BPD. One of my goals as a counsellor, however, is to help decrease the stigma associated with this diagnosis among counselling practitioners and the general public. As a result, I have chosen to follow in the footsteps of Dr. Marsha Linehan, founder of DBT, by also disclosing my

identification as a IDBPD (Carey, 2011). I have struggled with some of the symptoms of BPD throughout my adult life and believe that the abandonment issues and rejection sensitivity are at the core of said symptoms. In terms of the theoretical frameworks which attempt to explain the aetiology and organization of BPD symptoms, I ascribe to aspects of both the biosocial developmental model (Crowell, Beauchaine, & Linehan, 2009; Linehan, 1993a) and to Attachment Theory (Fonagy, Target, & Gergely, 2000; Masterson, 1972), two points of view which, by tradition, are diametrically opposite.

Finally, I have a personal relationship with DBT, given my involvement as a client over a period of two years. Based on personal experience, I believe that although DBT fails to address abandonment issues directly, it has the potential of decreasing the severity of the BPD symptoms triggered by abandonment issues by introducing positive coping skills, and increasing clients' self-worth via the counsellor-client relationship. As a result, clients' predilections towards mistakenly perceived abandonment are decreased. I hold these aforementioned beliefs because this is the effect DBT has had on my personal experience of abandonment.

How then, has my personal relationship with the subject matter potentially influenced my choice and formulation of interview questions, my conduct in interviews, and my interpretation of the data? The questions I considered important to include in interviews were influenced by my theoretical orientation. Because I ascribe to aspects of the biosocial model, I consider a holistic account of the experience of abandonment to include cognitive, emotional, and behavioural aspects. Because I also ascribe to aspects of the attachment model of BPD, I also chose to ask about family dynamics and childhood experiences related to abandonment and rejection.

I admit that I hold preconceptions regarding the relationship of abandonment to other BPD symptoms, the relationship between DBT and abandonment, and the understanding of abandonment or abandonment issues. Years of cognitive behavioural therapy to treat depression and anxiety had helped me gain an awareness of the link between my emotions, thoughts, and behaviours. Some exposure to narrative therapy increased my understanding of the effect of my paternal abandonment on my ineffective approach to interpersonal relationships. Treatment for substance abuse issues helped me recognize the destructive nature of impulsive behaviours that I engaged in to numb overwhelming emotions. But it was only when I received the diagnosis of BPD that all these insights coalesced.

Initially horrified by this diagnosis, about which I had only heard defeatist and aversive opinions, I sought comfort from knowledge and devoured research articles and books about borderline personality. Seeing all my symptoms grouped together in descriptions of the diagnostic criteria ironically made me feel normal for the first time in my life. Through self-aware personal analysis of my emotional, cognitive, and behavioural patterns, I came to the conclusion that the manifestation of my BPD symptoms followed a distinct pattern triggered by a perceived threat of abandonment or an interpersonal rejection. I enrolled in a DBT program in which I learned coping skills to regulate my emotions, further reduce my impulsive self-harming behaviours, and improve my effectiveness in interpersonal relationships. My perceptions of invalidations from childhood to adulthood were validated by my therapist, thereby increasing my sense of self-worth, but my abandonment issues were never directly addressed.

To account for my preconceptions, I was intentional in my choice to formulate neutral questions and conduct interviews inductively using the semi-structured interview as a guide. This allowed the interview subject as much freedom as possible in choosing what subjects would be elaborated upon based on their assignment of importance rather than my own.

I chose to disclose my BPD diagnosis and personal experience with DBT to each participant, and explained the purpose of the study as well as what had motivated me to pursue this line of research. In doing so I believe I welcomed participants into what existential phenomenologists call the role of co-researcher (Osborne, 1990), and ideally established an atmosphere of cooperation and equality. It is my hope that, in recognizing a common bond between us, co-researchers felt more at ease in divulging very personal and sometimes painful recollections to me, thereby allowing me greater access to their insider's perspective.

Organization of the Thesis

This thesis is comprised of five chapters including the current one. Chapter 2 consists of a review of the literature pertaining to different perspectives of abandonment, BPD, and how both abandonment issues and BPD can be treated. Chapter 3 presents the research questions and relevant hypotheses, followed by a comprehensive description of the methodology employed in the collection and analysis of qualitative data to address the research questions. In Chapter 4, each participant's experience of abandonment issues and BPD is presented in the form of four case studies. Description of individual experiences is then followed by the results of the phenomenological analysis which are organized into major categories, including themes and subthemes. Each thematic level is

supported with direct quotes from interviews and reference to information gathered from the biographical questionnaires. Chapter 5 discusses the current findings in light of the existing literature and further discusses the potential implications of the findings for clinical practice and future research. The limitations of the current study are also addressed.

CHAPTER 2 - LITERATURE REVIEW

There are several perspectives of the aetiology, symptom structure, development, and underlying mechanisms of borderline personality disorder (BPD). I focus here on the formulations provided by attachment theory and biosocial theory. The BPD symptom of fear of abandonment will be discussed in terms of its theoretical meaning and its relation to the other symptoms of BPD. Research findings regarding the fear of abandonment in BPD will be presented. Finally, dialectical behaviour therapy (DBT), which is the BPD treatment with the most empirical support, will be explained and I will postulate whether or not it directly or indirectly affects the experience of abandonment lived by individuals with a diagnosis of BPD (IDBPD[s]).

Borderline Personality Disorder

> Increasing evidence points to borderline personality disorder as a valid diagnosis with relatively specific genetic antecedents, biologic susceptibilities, psychosocial antecedents, treatment response, and characteristic outcomes. The signature of borderline personality disorder is the exquisite sensitivity to the vicissitudes of interpersonal relationships, including profound feelings of abandonment upon disruption of these relationships. (Goodman, Hazlett, New, Koenigsberg, & Siever, 2009, p. 525)

Understanding Borderline Personality Disorder

BPD was first recognized by the American Psychiatric Association (APA) as a diagnosis in 1980 when it was included in their third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association

[APA], 1980). The following sections provide a brief history of what we know about this perplexing disorder.

Between the borders of neurosis and psychosis. The first observations of IDBPDs as a separate group of patients who did not fit diagnostic categories are in the clinical observations of the psychoanalyst, Adolph Stern (1938). Stern (1938) described these patients as bordering neurotic classification, and qualified borderline as a wastebasket diagnosis. A wastebasket diagnosis is of little psychiatric value according to Rosenhan (1975), since it is achieved as a last resort, when no other diagnoses are deemed appropriate. Knight (1953) agreed with Stern's (1938) wastebasket qualification but added that the IDBPD bordered not just on the neurotic classification, but on the psychotic classification as well.

The next major advancement in the understanding and description of the IDBPD came with Kernberg's (1967) definition of *borderline personality organization*. Kernberg stated that the borderline patient's identity formation was compromised and characterized the ego defenses as primitive. He further postulated that when affected by stress, the IDBPD failed to differentiate between internal and external realities, a state that is now referred to as dissociation.

Empirical research and diagnostic criteria. The first empirical study of IDBPDs was conducted by Grinker, Werble, and Drye (1968). The research resulted in a comprehensive description of the *borderline syndrome* and the identification of four diagnostic criteria for BPD. Gunderson and Links (2008) succinctly summarized the four criteria; "1) failures of self-identity, 2) anaclitic relationships, 3) depression based on loneliness, and 4) the predominance of expressed anger" (p. 4). Anaclitic relationships

are characterized by *dependent* or *anaclitic depression*, which consists of feelings of hopelessness, a sense of emptiness, and a fear of abandonment (Blatt, 1974). Recognition of BPD as a valid diagnosis resulted from the identification and description of distinct traits that allowed for differentiation from the schizophrenia spectrum (Gunderson & Kolb, 1978), and the development of the Diagnostic Interview for Borderline Patients ([DIB]; Gunderson, Kolb, & Austin, 1981).

Several advancements in the understanding of BPD have occurred since its original inclusion in the *DSM-III* (APA, 1980) and thanks to the publication of the DIB (Gunderson et al., 1981). These developments allowed for an increase in diagnostic validity and reliability (Gunderson & Links, 2008), and for research to be conducted and compared across "reasonably homogeneous population[s] of borderline patients" (Friedel, 2004, p. 56). Research has supported the high rate of comorbidity of BPD with DSM Axis I mental health disorders and other Axis II personality disorders. The highest incidence of comorbidity for BPD appears to be with major depressive disorder and dysthymia (Gunderson & Phillips, 1991), followed by substance and alcohol abuse (Trull, Sher, Minks-Brown, Durbin, & Burr, 2000), post-traumatic stress disorder, obsessive-compulsive disorder, eating disorders, somatization, bipolar I and II (Zanarini et al., 1998a; Zimmerman & Mattia, 1999), narcissistic personality disorder, and antisocial personality disorder (Zanarini et al., 1998b). The validity of BPD as a diagnosis continued to be questioned, however, with many still referring to it as the wastebasket diagnosis (Friedel, 2004). To challenge the dismissive regard towards BPD as a diagnosis, nearly 30 longitudinal studies demonstrated that the course of BPD is similar across individuals with the diagnosis (Grilo, McGlashan, & Oldham, 1998), and genetic

heritability has been established (Distel et al., 2008; Kendler, Myers, & Reichborn-Kjennerud, 2011; Torgersen, Kringlen, & Cramer, 2001).

The diagnostic criteria for BPD have remained relatively unchanged since its original inclusion in the *DSM-III*. In May, 2013, the APA published its most recent version of the DSM, the *Diagnostic and Statistical Manual – 5th edition* (APA, 2013a). The most substantial change from former editions is the removal of the multi-axial system of diagnosis. Although not accepted in the current edition, major revisions were suggested for the diagnosis of personality disorders and included in Section III of the *DSM-5*. This included multilevel criteria for each disorder, and trait-specific assessment:

> For the general criteria for personality disorder presented in Section III, a revised personality functioning criterion (Criterion A) has been developed based on a literature review of reliable clinical measures of core impairments central to personality pathology. (APA, 2013b, p. 17)

This alternative approach was not accepted based on feedback from the research community that the proposed method was "too complex for clinical practice" (APA, 2013c, p. 2). The proposed revisions are included in Appendix A. As such the diagnostic criteria for BPD remain unchanged from the *DSM-IV* (APA, 2000). The currently valid diagnostic criteria for BPD, according to the *DSM-5,* are:

> Five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment.
>
> 2. Pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

6. Affective instability due to a marked reactivity of mood.

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger or difficulty controlling anger.

9. Transient, stress-related paranoid ideation or severe dissociative symptoms. (APA, 2013a, p. 663)

The World Health Organization ([WHO], 2010), in its diagnostic manual, the *International Classification of Disease – 10th Edition* (*ICD-10*) described the borderline personality in a manner similar to the APA, but categorized it as an "emotionally unstable personality disorder", the description of which is as follows:

> Personality disorder characterized by a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious. There is a liability to outbursts of emotion and an incapacity to control the behavioural explosions. There is a tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored. Two types may be distinguished: the impulsive type, characterized predominantly by emotional instability and lack of impulse control, and the borderline type, characterized in addition by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable

> interpersonal relationships, and by a tendency to self-destructive behaviour, including suicide gestures and attempts. (WHO, 2010, section F60.3)

While diagnosis of BPD requires evidence of at least five of the nine criteria defined in the *DSM-5* (APA, 2013a), any combination of five criteria suffices. As such, the presentation of BPD may vary from one IDBPD to the next. Most IDBPDs do, however, exhibited disturbances in each of the following four categories, as described by Friedel (2004): poorly regulated emotions, impulsivity, impaired perception and reasoning, markedly disturbed relationships (p. 2). These categories represent groupings of common borderline symptoms, an elaboration of which is presented in Appendix B.

Understanding the Psychological Mechanisms of BPD

Attachment theory and BPD. Attachment theory was developed by John Bowlby (1969, 1973, 1977, 1979, 1980, 1988), and Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978; Ainsworth & Eichberg, 1991). Bowlby's immersion in the study of attachment was influenced by three separate contexts. Firstly, Bowlby's studies in ethology led him to understand animal as well as human behaviour and social organization from a biological and evolutionary point of view (Shemmings & Shemmings, 2011). He drew his primary inspiration from his colleague, Harry Harlow, who published his infamous research with infant macaques whose need for maternal comfort superseded the need for food (Harlow, 1958; Seat, Hansen, & Harlow, 1962). Secondly, Bowlby's studies of child evacuees during the Second World War, informed his view of the importance of a supportive caregiving environment to a child's well-being (Bretherton, 1992). Finally, Bowlby's case studies of maladjusted adolescents and their

personal accounts of their parental relationship in childhood further set the stage for the development of attachment theory (Bowlby, 1944).

Bowlby (1969) posited that attachment behaviours are biologically-based and naturally selected for. During his career, he further elaborated that human infants instinctually bond with their primary caregivers, and that a set of attachment behaviours evolved to ensure the emotional, physical, and psychological survival of the dependent infant by maintaining proximity with primary caregivers (Bowlby, 1969, 1973, 1980). Attachment theory postulates that the attachment bond between infant and caregiver forms during the first year of life and signifies the differentiation of the primary caregivers from all other individuals by the infant (Ainsworth & Bowlby, 1991; Rholes & Simpson, 2004).

The attachment relationship developed by an infant is dependent on the caregiver's reaction to said infant's attachment behaviours (Ainsworth et al., 1978). In fact, the caregiver's degree and type of responsivity to the infant's attachment-specific behaviour could be the keystone for the type of attachment organization that will develop (Cassidy et al., 2005; George & Solomon, 2008). This attachment relationship, formed in early infancy, is considered the foundational working model upon which the developing individual will construct beliefs about self, other, and the relationship between self and other (Bowlby, 1988). The internal social cognitive schema becomes self-perpetuating and generalized to encompass intimate relationships in adulthood (Fraley, 2002; Shaver & Mikulincer, 2005).

In ideal circumstances, both the infant's attachment system and the primary caregiver's caregiving system are initiated in response to each other's cues, "with both

child and carer sensing the need for proximity" (Prior & Glaser, 2006, p. 39). There are situations, however, in which there is a lack of synchronicity in the initiation of these ideally complementary systems due to differences in the perception of need for proximity, which could result in persistent distress on the part of the infant (George & Solomon, 2008).

Ainsworth et al. (1978) described the different attachment relationships between infants and caregivers based on their observations during the Strange Situation research protocol. It should be noted that these are attachment *relationships*, and not attachment styles as people commonly and erroneously designate them. The Strange Situation research protocol consisted of an experimental manipulation in which infants between the ages of 12 and 18 months were monitored for their reactions when their mothers left them with a stranger in an unfamiliar environment and then returned to them. The researchers described three types of attachment relationships based on their results: secure, anxious-ambivalent, and avoidant (the latter two being categorized as insecure attachment relationships). The secure infant-mother relationships were characterized by infants that adapted in a positive manner to changes in their mother's proximity and also actively sought out and accepted interaction with their mother or the proxy adult during the mother's absence. The anxious-ambivalent infant-mother relationships were characterized by infants who reacted extremely negatively to the mother's departure, did not easily return to baseline levels after her departure, in conjunction with an inability on the part of the infant to benefit from the mother's return and her subsequent attention-giving behaviours. Infant-mother relationships that were categorized as avoidant were characterized by infants who engaged in minimal interaction with their mother and gave

the appearance of being unmindful of her departure, absence, or return. Ainsworth et al. (1978) continued to observe the mothers' behaviours when interacting with their infants in their home environment and compared these observations to their categorizations of the infants in one of the three attachment relationships. Their findings indicated that the mothers of infants of both types of insecure relationships were significantly less responsive to their baby's cries and were both less attentive to and less gentle with their baby than the mothers of infants categorized as in a secure attachment relationship.

An additional attachment system was added several years later, namely disorganized-disoriented (Ainsworth & Eichberg, 1991; Hesse & Main, 2000; Main & Solomon, 1986, 1990). This was considered a secondary attachment pattern and assigned only in conjunction with one of the three primary attachment patterns. The behaviours displayed by an infant with this assignation were, as the name suggests, disorganized and belied a loss of orientation, what Levy (2005) described as "a temporary collapse of a behavioral strategy" (p. 962).

It was Bowlby's (1988) original contention that internal working models of attachment span the entire life of an individual, and longitudinal studies of attachment have supported this position (Holmes, 1996; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). The study of attachment in adults was finally made possible in 1984 by George, Kaplan, and Main (as cited in Slade, 2008) with the development of the Adult Attachment Interview (AAI), a semi-structured interview that explores the adult's recollection of parental-bonds in childhood. Administration of the AAI and analysis of the personal narratives of participants yielded three primary adult attachment classifications (Hesse, 2008; Main, Goldwyn, & Hesse, 2003; Main, Kaplan, & Cassidy,

1985) and a secondary disorganized pattern (Main & Solomon, 1990), which paralleled the infant classifications in the following manner: "secure-autonomous (analogous to the secure infant classification), dismissing (avoidant infant classification), preoccupied (resistant infant classification), and unresolved (disorganized/disoriented infant classification)" (Slade, 2008, p. 764).

In the book *Understanding Disorganized Attachment: Theory and Practice for Working with Children and Adults,* Shemmings and Shemmings (2011) noted that research has failed to find a direct link between disorganized attachment and various mental disorders such as depression, anxiety disorders, eating disorders, or schizophrenia. The authors affirmed, however, that research has been able to demonstrate a firm association between dissociative disorders and disorganized attachment (Carlson, 1998; Liotti, 2004; Sroufe, Egeland, Carlson, & Collins, 2005). In addition to the dissociative symptoms found in BPD (APA, 2000), Shemmings and Shemmings (2011) postulated that:

> BPD is recognized by negative emotion and symptom exaggeration. Consequently, there are correlations with infant and early childhood DA [Disorganized Attachment], which may possibly reflect more of the externalizing form in which DA becomes transformed as children get older when they need to inject predictability into their experience of being parented. (p. 64)

Scott, Levy, and Pincus (2009) hypothesized that adult attachment patterns could be defined based on the individual's location along two axes: attachment anxiety and attachment avoidance. Mikulincer (1998) described attachment anxiety as a negative self-concept activated by distress caused by potential rejection, isolation, and/or

abandonment. Attachment avoidance was described by Brennan, Clark, and Shaver (1998) as an aversion to emotional intimacy and close relationships, with little to no effect of rejection or abandonment on their self-concept. In fact, individuals high on the attachment avoidance scale tend to have a negative view of others rather than themselves.

Attachment theory thus lends itself to understanding the development of borderline personality traits such as the fear of negative feelings triggered by perceived rejection or abandonment, unstable interpersonal relationships, and a fluctuating sense of self. Levy (2005) summarized the usefulness of attachment theory with regard to BPD by stating that:

> Attachment theory, and the subsequent research it generated, provides a comprehensive developmental perspective for conceptualizing and understanding BPD. Attachment theory offers a cogent theory regarding the development and maintenance of the interpersonal difficulties and adaptations that characterize personality pathology, while simultaneously explaining the concomitant development of self-concept and the problems of self-definition and self-regulation. (p. 960)

It is the work of Margaret Mahler (1986) that provided the link between mother-child attachment relationships and the subsequent development of identity diffusion, a typical borderline trait, wherein the individual cannot differentiate their own identity from that of one on whom they are emotionally dependent (O'Boyle, 2002; Mahler, Pine, & Bergman, 1970, 2000). Mahler hypothesized that separation anxieties and borderline traits developed in the "rapprochement" phase of the child's separation-individuation process, between the ages of 15 and 24 months. She described maternal behaviours

indicating hurt and/or anger upon a child's return after separation, and maternal efforts to stifle a child's attempts towards autonomy, as contributing towards the development of a child's separation guilt and emotional dependence (Mahler, 1986; Mahler, et al., 1970). Separation guilt is defined as "the pathogenic belief that if a person separates from loved ones, or differs from loved ones in some way, loved ones will suffer as a consequence" (O'Connor, Berry, Weiss, & Gilbert, 2002, p. 22).

Biosocial theory and BPD. Theodore Millon (1981, 1987) was one of the first personality theorists to attempt to explain BPD from a biosocial perspective. Millon (1981, 1987, 1999) diverged from other personality theorists with his proposition that numerous equally valid routes exist via which BPD could develop, rather than just one route. He was also the first to suggest that the core traits of the disorder are instability in both mood and behaviour, the cause of which is a combination of biological and social learning influences.

Linehan (1993a, 1993b), whose theory of BPD is also based upon biosocial theory, agreed with the contention that mood instability is at the core of the disorder, but referred to this as emotional dysregulation. She explained that, according to the biosocial theory, a child with affective instability (also referred to as emotional vulnerability) in an invalidating environment will interact with and be affected by said environment in such a way that emotional dysregulation will develop. The hallmark instabilities of BPD (behavioural, interpersonal, self, and cognitive) are the IDBPD's attempts to regulate intense affect, usually with the negative and undesired result of increasing affective instability, invalidation by the self or another, and behavioural dysregulation (Linehan, 1993a, 1993b). Donna Hughes, founder of Inner Solutions, a private DBT clinic in

Calgary, Alberta, echoes the arguments of Millon and Linehan regarding a diverse borderline aetiology in the following statement:

> There are many pathways to borderline symptomology. If we take emotional reactivity, some people are very biologically reactive, as seen in early childhood symptoms, and some people lived in very invalidating environments which manifested biological symptoms such as dissociation. So, the highly anxious child has a lower threshold before having dissociative symptoms than a child with average resiliency that was exposed to high and chronic (it has to be both) levels of invalidating environments before exhibiting dissociative symptoms. (D. Hughes, personal communication, December 9, 2013)

Research conducted by Herr, Rosenthal, Geiger, and Erikson (2012) endorsed the importance of emotional dysregulation in the organization of BPD symptoms. The researchers studied 124 IDBPDs using the emotional dysregulation centric model of BPD. They observed that, without fail, emotional dysregulation was the mediating symptom between the severity of the individuals' other BPD symptoms and the individuals' degree of interpersonal difficulties.

Linehan (1993a, 1993b) further agreed with Millon (1981, 1987, 1999) that heightened emotional vulnerability may be a trait that the IDBPD is born with, and stipulated that this may be due to either genetic predisposition or trauma to the central nervous system experienced during the perinatal phase of development (Chapman & Gratz, 2007). Linehan (1993a) specifically proposes, however, that increased reactivity within the limbic system may be the cause for emotional dysregulation.

Research investigating the activation threshold of limbic structures in IDBPDs supports Linehan's (1993a) proposition (Cowdry, Pickar, & Davies, 1985). Further exploration of the biological aetiology of BPD yielded research on the possibility of a genetic aspect to BPD. Results have been mixed, however. Several researchers have published findings of greater prevalence of affective disorders or BPD among the immediate relatives of IDBPDs (Baron, Gruen, Asnis, & Lord, 1985; Links, Steiner, & Huxley, 1988; Loranger, Oldham, & Tullis, 1982; Pope, Jonas, Hudson, Cohen, & Gunderson, 1983). Others have failed to find such associations (Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1988). Some have proposed instead that BPD is most likely brought about by environmental factors (e.g., the invalidating environment) rather than heritability (Torgersen, 1984). Research within the last ten years has found some evidence of genetic involvement in the aetiology of BPD (Lis, Greenfield, Henry, Guilé, & Dougherty, 2007; Xingqun et al., 2006). It appears that the jury is still out on the topic of a genetic link to BPD. Essentially, however, the biosocial perspective addresses what might be considered as missing from attachment theory with the contention that the IDBPD's experience is filtered through biologically determined parameters (D. Hughes, personal communication, December 9, 2013).

As previously mentioned, Linehan (1993a, 1993b) explained that the primary social factor contributing to the development of BPD is a dysfunctional and invalidating environment, and defined it as "an invalidating environment is one in which communication of private experiences is met by erratic, inappropriate, and extreme responses ..., it is often punished, and/or trivialized" (Linehan, 1993a, p. 49).

The invalidating individual(s) within the environment, be it a parent, spouse, friend, teacher, etcetera, insist(s) that IDBPDs are wrong in their interpretation of their feelings, events, and others' intentions. The invalidating environment places a high value on self-sufficiency, sublimation of emotions such as anger or sadness, mastery and achievement, and the maintenance of a positive attitude at all times. Examples of invalidations, the context within which they are communicated, and the consequences to the IDBPD, as proposed by Linehan (1993a), are presented in Table 2.1.

The invalidating environment and the child's emotional temperament interact in a mutually exacerbating and intensifying manner. As a result of consistent exposure to an invalidating environment and a biological predisposition to emotional dysregulation, the child develops a set of behavioural patterns in an attempt to mitigate the intensity of emotions or the consequences thereof. These behavioural patterns, underpinned by biological factors, consist of: *emotional vulnerability* (which includes a victimizing perspective of the self), *self-invalidation* (an internalization of the messages received from the invalidating environment, yielding feelings of shame and self-loathing), *unrelenting crises* (brought about by the individual and/or their poor choice of environment, each of which affects the other negatively), *inhibited grieving* (excessive restriction of the experience of unpleasant emotions), *active passivity* (the approach to problem-solving is to actively seek out help, but then to rely on others to solve the problem for them) , and *apparent competence* (inability to communicate emotional distress non-verbally) (Linehan, 1993a).

According to Linehan's biosocial theory (1993a, 1993b), BPD can thus be recognized as a set of behaviour patterns that are set in motion by the individual's

experience of intense unmanageable emotions. Emotional dysregulation is viewed as a biological predisposition which is exacerbated by exposure to an invalidating environment wherein role models fail to teach effective skills for living, emotional self-awareness, distress tolerance, and problem solving.

Table 2.1

Examples of Invalidating Attributions, the Context that Instigates them, and Associated Consequences for the Invalidated Individual

Context	Attribution	Consequence
Negative emotional expression	Overreactivity Oversensitivity Paranoia Distorted view of events Failure to adopt a positive attitude	Child is not taught to label own emotions or modulate emotional arousal. Child's problems remain unrecognized and child does not learn effective problem solving or distress tolerance.
Positive emotional expression, beliefs, or action plans	Lack of discrimination Naiveté Overidealization Immaturity	Child learns not to trust own emotional and cognitive responses as reflections of valid interpretations. Child learns instead to seek out cues for valid behaviour, emotions, and thoughts, from the environment.
Extreme emotional expression	None	Child learns that extreme emotional displays are necessary to provoke helpful response from the environment
Failure to live up to expectations (success, positive emotion, self-sufficiency)	Lack of motivation Lack of discipline Lack of effort	Child does not learn to form realistic goals and expectations.

Note. Descriptions of context, attribution, and consequence based on Linehan (1993a, pp. 50-52).

Abandonment

"Abandonment is a complex human issue; its wound deeply entrenched in fear and insecurity. Without recovery, abandonment can linger beneath the surface, undermining self-esteem and sabotaging future relationships." (Anderson, 1999, p. viii)

Through my personal and scholarly investigation of the meaning of abandonment, I have encountered different points of view. According to these different sources, abandonment can be a noun, a verb, a legal term, equivalent to rejection, far more soul splintering than rejection, the cause of a lifelong crippling wound, or even become a part of a person's sense of self. In the following section I explore the various definitions of abandonment.

Defining Abandonment

"Abandonment is a fear that we will be left alone forever with no one to protect us, to see to our most urgent needs" (Anderson, 2000, p. 9).

Physical versus emotional abandonment. The term abandonment is widely used in Western society in a diverse array of contexts. Regardless of the context, however, abandonment usually refers to the action of giving up control, influence, or interest in someone or something (*Merriam-Webster's Collegiate Dictionary*, 2005).

In her book *The Journey from Abandonment to Healing*, Anderson's (2000) definition of abandonment and course of self-therapy for recovery from abandonment are addressed to the general population, with the stipulation that anyone can experience a traumatizing loss of love. Anderson (2000) referred to abandonment as a loss of love consisting of five stages:

1. Shattering: characterized by feelings of anxiety, a loss of hope, suicidal ideation, and the recall and re-experiencing of former feelings of hopelessness, helplessness, and emotional dependency.
2. Withdrawal: the loss of love is accompanied by withdrawal effects akin to withdrawal from a drug, and attachment needs are intensified.
3. Internalizing: to compensate for intensified attachment needs, the abandoner is idealized while the abandonee assumes responsibility for the abandonment event and increasingly finds fault in themselves for any event perceived as having contributed to the abandonment. Stagnation within this stage can lead to long-term issues with self-esteem.
4. Rage: The sense of self attempts to defend itself with anger, which, if turned outwards and self-affirming, can contribute to healing the abandonment wound. If the individual does not possess the ability to express anger in a healthy manner, rage can be internalized or misdirected.
5. Lifting: Transcendence of the abandonment wound can only be achieved with successful progression through each of the four previous stages. A new ability to give and receive love is born.

In *Changing Course: Healing from Loss, Abandonment, and Fear*, Black (1999) differentiated between physical and emotional abandonment. Black (1999) echoed the tenets of attachment theory in characterizing emotional abandonment as the condition that occurs when parents fail to provide a child with the emotional support required for normal emotional and psychological development. As a result, the child learns to sublimate parts of their self to avoid rejection by others.

A definition of abandonment, of the emotional kind at least, seems to beg an accompanying definition of interpersonal rejection since the two are often linked in the literature. Leary (2001) explained that the concept of interpersonal rejection can be understood if acceptance and rejection are viewed on a continuum based on relational evaluation. Relational evaluation is defined as the value ascribed to one's relationship with another individual. Leary (2001) further explained that experiences such as being ignored, excluded, romantically rejected, ostracized, banished, or abandoned, reside on points on the continuum that move progressively further from the acceptance pole towards the rejection/abandonment pole based on decreasing relational evaluation. In the case of rejection, the rejecter's negative evaluation of the relationship results in what Leary (2001) considered to be the objective rejection event. The perception and experience of the rejection event by the rejected individual, however, is based on that individual's assumptions regarding the rejecter's evaluation of the relationship and on their own relational evaluation. Leary (2001) stated that a rejection event can cause greater emotional distress to the rejected individual if they have a higher need to be relationally valued by the rejecter. The rejection event could thus cause significant distress and be subjectively viewed as an abandonment by a rejected individual who places great importance on being relationally valued.

The normative experience of abandonment. Some research has focused on the emotional experience of physical abandonment in adopted children (e.g., Landerholm, 2001; Howe & Fearnley, 2003), but very little is known about the experience of abandonment in a normative population. In order to adequately discuss the IDBPD's experience of abandonment, one first needs to establish a normative baseline for the

experience of abandonment, thereby making it possible to recognize whether IDBPDs' experiences are in fact different from the norm. Two phenomenological dissertations on the normative experience of abandonment will be used to establish this baseline for comparison: Zipris (1982) and Ott (1988).

Zipris' (1982) dissertation explored the normative experience of loneliness, in which he included the experience of being abandoned. According to Zipris' (1982) findings, the normative experience of abandonment includes the unexpected severing of a relationship in which there had been some form of dependence. The abandonment is perceived as an intentional betrayal of the abandonee's previously positive evaluation of the relationship, and results in the abandonee's disorientation with respect to their world-view. The abandonee does not make any attempts to return to the relationship as it was prior to the abandonment but rather adapts their world-view independent of the abandoner in order to re-establish a sense of security.

Ott's (1988) dissertation explored the experience of abandonment specifically in the dissolution of a romantic relationship, as perceived by six participants with no history of mental health issues. According to Ott's (1988) findings, the experience of this particular type of abandonment included four successive stages. The first stage after the abandonment consisted of the abandonee's confused sense of self, fear of fully experiencing the emotions of anger and grief accompanying this disorientation, and an unwillingness to accept the abandoner's new hostile and unloving identity. The second stage consisted of a surrender of denial and an acceptance of the loss through the experience of grief. The third stage involved the abandonee's personal assessment of accountability as the abandonee gained a retrospective understanding of how the

relationship had contributed to their sense of self. Finally, in the fourth stage of this normative experience the abandonee engaged in adaptive measures to redefine their sense of self. These adaptive measures were either positive, involving active engagement of their support network, or negative, involving an unreceptive and defensive stance towards any future possibilities of intimacy or hurt.

The IDBPD's experience of abandonment. Some research has examined sensitivity to rejection and abandonment amongst IDBPDs, although not from an insider's perspective. In their research on affective instability and low self-esteem among IDBPDs, Zeigler-Hill and Abraham (2006) proposed a direct correlation between daily interpersonal stress and sensitivity to rejection. Misencik (2002) studied the quantitative relationship between the perception of maternal abandonment and engulfment and defensive behaviours such as clinging and distancing. Participants of the study included a group of female IDBPDs and a control group of females with the diagnosis of personality disorder not otherwise specified. Misencik (2002) measured the fear of abandonment using a questionnaire designed specifically for the study, and assessed defensive reactions by administering a questionnaire measuring defensive reactions to a video depicting maternal abandonment. The results of her analyses indicated an absence of differences between groups and no relationships were found between abandonment and defensive behaviours in either group. Misencik (2002) theorized that a lack of within-group heterogeneity and the potential similarity of her control group to the test group were responsible for the lack of significant findings. Although this study examined the phenomena of abandonment in female IDBPDs, it did not attempt to elicit the

insider's perspective of the experience but rather imposed an outsider's preconceptions in the form of the questionnaires used and video clips presented.

There have been few attempts to understand the meaning of abandonment from the IDBPD's perspective. In an extensive search of research databases I found only two examples of such attempts, namely two doctoral dissertations:
O'Boyle (2002) and Vardy (2011).

O'Boyle's (2002) dissertation consisted of an existential phenomenological analysis of IDBPDs' experience of abandonment. The information that O'Boyle collected from four female IDBPDs included written narratives about their first abandonment experience and semi-structured interviews which expanded on the content of the narratives. From her analyses, O'Boyle concluded that the IDBPD's experience of abandonment, either real or perceived, is based on the cumulative effect of past abandonment experiences which influence the lens through which the IDBPD understands her present-day experiences. Despite her small sample size, O'Boyle was able to identify several themes. Abandonment was viewed as intentional and involved internalization of responsibility. Abandonment experiences inspired feelings of devaluation, diminished self-worth, shame, and being unwanted, all of which were experienced as intolerable and over a lengthy period of time. O'Boyle recognized some of the BPD behavioral symptoms, such as dissociation and self-mutilation, as the participants' methods of coping with the intolerable emotions resulting from abandonment. Finally, the original abandonment was described as a *life-altering* event, the emotional scarring of which was re-experienced in its fullness by each participant

with each subsequent actual or perceived abandonment as if it were occurring in the present-day.

Vardy's (2011) dissertation consisted of two studies investigating how IDBPDs experience intolerance of aloneness (which she likened to the fear of abandonment). In the first study, Vardy conducted a phenomenological analysis of the interview transcripts of 12 IDBPDs, identifying themes of positive and negative time alone. She concluded that IDBPDs describe their experience of time alone as negative when it is accompanied by depression, a loss of motivation, and presence of dialectical thoughts without the necessary synthesis. Vardy further noted that the participants avoided the experience of negative time alone as much as possible. In the second study, Vardy compared the responses to an on-line self-report scale measuring alone-time of 112 IDBPDs to 105 non-BPD participants. Vardy (2011) concluded that the BPD group differed from the non-BPD group with respect to their intolerance of aloneness, and that the BPD group's responses reflected a theme of an inability to "cope alone". The results of Vardy's studies support the differentiation of IDBPDs from non-IDBPDs with respect to the degree to which they view alone time as negative, due perhaps to their inability to manage the resulting emotions (such as depression) and cognitions (unsynthesized dialectical thoughts).

The Place of Abandonment in BPD

"... Abandonment represents one example of a situation of emotional abuse, particularly salient for the case of BPD" (Schmahl et al., 2003, p. 142).

Sensitivity to rejection and abandonment, real or perceived, co-occur in BPD and are considered primary identifiers of this personality disorder (Kernberg, 1984; Zanarini,

Gunderson, Marino, Schwartz, & Frankenberg, 1989). How is this abandonment sensitivity related to the other borderline traits? Some researchers have suggested that the fear of abandonment and the accompanying intolerance of aloneness are the most significant and salient borderline traits (Benjamin, 1996; Gunderson, 1996, 2001). In a 10-year follow-up study of the remission status of borderline symptoms, Zanarini and colleagues (2007) noted that symptoms and traits related to the fear of abandonment were among the most persistent and enduring characteristics, whereas others had resolved relatively quickly.

Most attachment theorists appear to consider abandonment issues to be the root of the manifestation of BPD (Levy, 2005; Masterson, 2013; Shemmings & Shemmings, 2011; Vardy, 2011), while proponents of the biosocial model eschew abandonment in favor of emotional dysregulation as the foundational borderline symptom (Linehan, 1993a; Putnam & Silk, 2005). Support for either position is ambiguous, however, due to the challenges involved in disentangling the symptoms of this complex disorder.

Empirical support for abandonment as a core symptom of BPD. In a comparison of IDBPD and non-borderline research participants, Gratz, Rosenthal, Tull, Leijuez, and Gunderson (2006) noted that the BPD group indicated greater aversion to the experience of distress created by images of faces depicting negative emotion than the control group, but were equally able to complete a goal-oriented task while in an emotionally distressed state. This finding may suggest that emotional dysregulation is not at the root of dysfunction for IDBPDs, that it is not the most debilitating symptom, or that the emotional trigger must be of greater importance to the IDBPD to elicit the characteristic array of aversive behaviours.

In another study, Donegan et al. (2003) used functional magnetic resonance imaging to compare activity within the amygdala of IDBPDs versus non-clinical individuals presented with pictures of faces displaying a happy, sad, fearful, or neutral expression. The researchers noted a markedly increased reactivity in the left amygdala of the IDBPDs over the non-clinical participants. The amygdala is the brain structure involved in vigilance and both the generation and processing of negative emotions (Davis, 2000; Schneider et al., 1997), and is often hyperactive in individuals experiencing mood disorders (Drevets, 1998; Rauch et al., 2000). Several studies have also reported findings of hippocampal, frontal, and prefrontal hypometabolism in IDBPDs but not in control individuals (de la Fuente et al., 1997; Juengling et al., 2003; Soloff, Meltzer, Greer, Constantine, & Kelly, 2000). These findings are of importance due to the involvement of these structures in the regulation of emotion and impulse control (Simonov, 1986).

While these studies certainly support the presence of emotional sensitivity and dysregulation in IDBPDs, they do not negate the possibility that the specific fear of abandonment may be at the core of the IDBPD's experience. To my current knowledge, only one study has attempted to clarify the neurological response of IDBPDs to the specific trigger of abandonment. Using positron emission tomography, Schmahl et al. (2003) found evidence of higher levels of activity in the prefrontal cortex of IDBPDs when exposed to memories of abandonment.

A number of studies have investigated the relationship between the trademark BPD symptom of parasuicidal behaviour and the fear of abandonment in individuals. Rao (2000) reported that subjects' self-mutilating behaviour occurred in response to

memories of rejection by a trusted and/or loved individual. Kashgarian (1999) reported a similar relationship between feelings of abandonment and parasuicidal behaviour, with hopelessness and emotional dysregulation as intermediaries.

Theoretical support for abandonment as a core symptom of BPD. In discussing insecure styles of attachment relationships, typical of IDBPDs, Cori (2010) described patterns of behaviours including clinging, compulsive care and reassurance seeking, angry rejection, and ambivalence as ways to protect against the fear of abandonment. As the individual with an insecure attachment style matures into adulthood, the strategies he or she employs to manage the fear of abandonment and ensure consistent attachment include:

> Heightened needs for closeness; hypervigilance about attachment signals; always questioning and testing the other's commitment; emphasizing need and helplessness in order to get others to stay; punishing others for not providing what is desired; anger when attachment needs are not met. (Cori, 2010, p. 51)

Treatment of BPD

"Patients with borderline personality disorder (BPD) are famous for being difficult. Their problems can challenge even the most experienced therapists" (Paris, 2008, p. vii).

Treatment outcomes for IDBPDs are not standard across all cases, regardless of the type of therapy, but seem to be correlated rather, with aetiological factors and symptom severity (McGlashan, 1985; Paris, Brown, & Nowlis, 1987; Paris, Zweig-Frank, & Guzder, 1993; Soloff, Lynch, & Kelly, 2002; Stone, 1990). Although BPD is characterized as a chronic disorder, symptoms may go into remission over time, with or without treatment. Factors such as a general decrease in impulsivity (due to maturity),

relocation of the individual to a more stable and supportive environment, and improvement in social skills over the life-span (due to experiential learning) are considered primary in the naturalistic remission of BPD symptoms. Short-term improvements have been supported by research, but the endurance of these improvements currently remains unknown (Paris, 2008).

Not all forms of psychotherapy are considered effective or even appropriate for the treatment of BPD (Paris, 2008). There are two main categories of therapy for BPD: cognitive therapies and psychodynamic therapies. The evidence base for cognitive therapies is much more impressive than that of the psychodynamic therapies primarily due to the cognitive camp's penchant for empirical research, and the tradition of psychodynamic practitioners to base their research on clinical case studies. A short review of the therapies in each category accompanied by a selection of research supporting the use of each therapy for BPD is presented in Table 2.2. DBT will be discussed in greater detail in the following section.

Dialectical Behaviour Therapy

"DBT's ultimate goal is to help people build lives they experience as worth living" (Linehan & Lungu, 2012, p.207).

Theoretical Foundations. DBT, which is theoretically located within the cognitive-behavioural framework (Koerner & Dimeff, 2007), was originally created by Dr. Marsha Linehan (1993a, 1993b) in response to her work with highly suicidal female patients (Chapman & Gratz, 2007). The original goal in the development of this new therapy was to assist these highly suicidal women in developing a "life worth living" (Chapman & Gratz, 2007, p. 135). During her work with highly suicidal female IDBPDs,

Linehan carefully documented what did and did not work, using standard behaviour therapy as the base to which she added other interventions in the aim of facilitating change in her patients' investment in living (Goldfried & Davison, 1976). The result was the publication of treatment manuals that delineated the structured DBT approach and would assist practitioners in how to navigate the potential minefield of working with challenging borderline clients (Linehan 1993a, 1993b). Though previously stated as belonging to the cognitive-behavioural framework, DBT draws from several theoretical orientations, including psychodynamic, client-centred, paradoxical therapy, the eastern philosophy of mindfulness, and the philosophy of dialectics (Koerner & Dimeff, 2007; Linehan, 1993a, 1993b).

Linehan (1993a, 1993b) stated that BPD can be understood from the dialectical perspective of the common features of reality and human behaviour:

- Reality must be viewed as a whole, consisting of interrelated parts. Human behaviour is thus viewed as a system of interrelated behaviour patterns facilitated by the environment.
- Reality is dynamic. For every thesis, there exists an antithesis: "(…) [T]ruth is paradoxical, (…) each article of wisdom contains within it its own contradictions, (…) truths stand sided by side" (Goldberg, 1980, pp. 295-296). An accurate perspective of reality involves successful integration of the thesis and antithesis,
- yielding a synthesis. Black and white thinking and the related emotional and behavioural extremes are typical of BPD and due to a failure to proceed towards synthesis (Linehan, 1993a, 1993b).

Table 2.2

Empirically Supported Psychotherapies of BPD

Therapy	Purpose	Study	Results
CBT[a]	Correction of maladaptive cognitions	Davidson et al., 2006	CBT > TAU after 16 sessions
SFT[b]	Correction of maladaptive schema originating in childhood	Giesen-Bloo et al., 2006; Spinhoven., Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007	SFT > TFP after 3 years biweekly sessions. Therapeutic alliance greater in SFT
STEPPS[c]	Cognitive psychoeducational group program, used in addition to TAU.	Blum et al., 2008	Increased efficacy of TAU when used together with STEPPS
MBT[d]	Teach clients to objectively assess their emotions and the feelings of others.	Bateman & Fonagy, 1999	MBT > TAU after 18 months
TFP[e]	Correct patient's skewed observations of significant others using the relationship with the therapist	Clarkin, Levy, Lenzweger, & Kernberg, 2007	TFP > DBT over 1 year

Note. CBT=Cognitive Behavioural Therapy; > indicates a greater improvement in BPD related symptoms; TAU=Treatment As Usual; SFT=Schema-Focused Therapy; TFP=Transference-Focused Psychotherapy; STEPPS=Systems Training for Emotional Predictability and Problem-Solving; MBT=Mentalization-Based Therapy.
[a](Beck, 1964). [b](Young, 1999). [c](Blum, Pfohl, St. John, Monahan, & Black, 2002). [d](Bateman & Fonagy, 2006). [e](Clarkin, Levy, Lenzenweger, & Kernberg, 2004; Levy et al., 2006).

- "The fundamental nature of reality is change and process, rather than content or structure" (Linehan, 1993b, p. 2).

Evidence of these philosophical tenets is found in DBT's focus on the confirmation of polar dualities such as validation and challenging, acceptance and change, and the construction of boundaries while simultaneously increasing the capacity for intimacy (Linehan, 1993a).

The Structure and Purpose of DBT. Standard DBT is delivered via three modes: weekly hour-long individual therapy sessions with a primary counsellor trained in DBT, weekly 21/2-hour skills training group sessions with a DBT-trained group facilitator, and 24/7 availability of the primary DBT counselor for emergency support (Linehan, 1993b). The application of DBT is structured over four stages.

The focus of stage 1 is on achieving control over behaviours that are life-threatening, interfere with therapy, and compromise quality-of-life, while simultaneously increasing DBT-related behavioural skills (Dimeff & Linehan, 2001; Linehan, 1993a). Acquisition of DBT-related behavioural skills occurs in the psychoeducational skills training group and is further supported in individual therapy. DBT skills training consist of skills in emotion regulation, interpersonal effectiveness, distress tolerance, and mindfulness.

In the emotion regulation module, individuals learn both behavioural and cognitive strategies to help them identify and describe their emotions and how to change undesired negative emotions in a non-destructive manner. In the subsequent distress tolerance module, clients learn strategies to tolerate their experience of distress by controlling their impulses and engaging in self-soothing behaviours to enable radical

acceptance. Radical acceptance, a term coined by Linehan (1993a), is defined as "complete acceptance from deep within" (p. 148). The interpersonal effectiveness module consists of assertiveness training in which individuals are taught how to communicate their needs while simultaneously setting and maintaining interpersonal boundaries. Mindfulness training is the fourth module and consists of training in skills that facilitate acceptance, self-awareness, and the development of effectiveness (Dimeff & Linehan, 2001; Linehan, 1993a, 1993b). A comprehensive list of the skills in each of the four modules is included in Appendix C.

Individuals engaged in DBT are only permitted to proceed to the second stage once the goals of the first stage are achieved. In stage 2, the reduction of stress related to trauma becomes the primary focus. Stage 3 and 4 usually overlap the first two treatment stages. The targets of stage 3 and stage 4 are the generalization of skills to contexts outside of therapy, an increase of trust in the self, and achievement of personal goals (Dimeff & Linehan, 2001; Linehan, 1993a).

The DBT Counsellor. Not all psychotherapists are considered suitable to work with IDBPDs since this requires "specific experience, training, and personal qualities" (Gunderson & Links, 2008, p. 236). It is generally suggested that professionals working with IDBPDs have experience and training in long-term and intensive therapies, an ability to set and maintain boundaries regarding the therapeutic relationship, and session frequency, and specific knowledge about BPD (Gunderson & Links, 2008). A study undertaken by Rosenkrantz and Morrison (1992) determined that therapists with firm boundaries could successfully work with IDBPDs, whereas psychotherapists with

depressive tendencies or weaker personal or professional boundaries were deemed unsuitable.

Linehan (1993a) specified three categories of therapist characteristics required for DBT. She explained that therapist characteristics "are the attitudes and pervasive interpersonal positions that the therapist takes in relationship to the patient" (p. 108). Each of the three categories delineated by Linehan (1993a) consists of polar opposites between which the skilled therapist must find balance. The first dialectical dimension, orientation to acceptance versus orientation to change, is, according to Linehan (1993a) the cornerstone of DBT practice. The second dimension is unwavering centeredness versus compassionate flexibility, and the third is benevolent demanding versus nurturing. In practice, the second and third dimensions must reflect a balance between acceptance and change. Linehan (1993a) summarized the interrelationship of the three dimensional characteristics as follows: "the therapist must balance the patient's capabilities and deficiencies, flexibly synthesizing acceptance and nurturing strategies with change-demanding strategies in a clear and centered manner. Exhortations to change must be integrated in a clear and centered manner" (p. 108) with the simultaneous expression of warmth and control. The specific therapist traits specified for each therapist characteristic are listed in Table 2.3.

Does DBT really work for BPD? DBT is the treatment of choice for BPD because of the abundance of empirical support for its efficacy. The first randomized control trial investigating the efficacy of DBT was conducted by Linehan, Armstrong, Suarez, Allmon, and Heard (1991), who compared the effect of DBT to treatment as

Table 2.3

Three Dimensions of Therapist Characteristics and Traits in DBT

Dimension	Characteristic	Associated Traits
1	Orientation to acceptance	Non-judgemental; warm
	Orientation to change	Responsible for direction of therapy
2	Unwavering centeredness	Observe limits; stable and firm belief in self, therapy, and patient
	Compassionate flexibility	Adaptable as required; willingness to recognize and address own mistakes
3	Benevolent demanding	Skillful use of contingencies to promote change; empowering, not enabling
	Nurturing	Compassionate; sensitive

Note. The first dimension consists of a balance between orientation to acceptance and orientation to change.

usual on dimensions suicidal and parasuicidal behaviour, the regulation of anger, and reliance on emergency services. DBT had a greater effect on each aspect. Additional research has replicated these findings and also supported the increased or equal efficacy of DBT over other forms of therapy for BPD in improving impulse control, emotion regulation in general, and social functioning (Bohus et al., 2004; Clarkin et al., 2007; Koons et al., 2001; Linehan et al., 1999; Linehan et al., 2006; Robins & Chapman, 2004;

van den Bosch, Koeler, Stijnen, Verheul, & van den Brink, 2005; Verheul et al., 2003). In their 2007 pilot study, Schnell and Herpertz (2007) investigated the potential changes in neurological activation triggered by emotional stimuli in IDBPDs who had received DBT. Decreased neurological activity was noted in all four participants indicating that the stimuli were no longer eliciting an abnormally intense response.

DBT and Abandonment. As previously alluded to, DBT does not address abandonment issues, but rather targets the various manifestations and consequences of emotional dysregulation. This abstention is based on the position of biosocial theorists that emotional dysregulation, not abandonment, is at the core of BPD symptomology (Linehan, 1993a; Putnam & Silk, 2005).

Summary

The aetiology, development, and underlying mechanisms of BPD can be understood from two primary perspectives: attachment theory and biosocial theory. Attachment theory postulates that IDBPDs' interpersonal difficulties, reliance on others' for their sense of self, and fear of abandonment are readily explained from the perspective of biologically and environmentally reinforced attachment insecurity (Levy, 2005), and research has demonstrated correlation between disorganized attachment and BPD (Carlson, 1998; Liotti, 2004; Shemmings & Shemmings, 2011; Sroufe et al., 2005). According to biosocial theory, however, IDBPDs' biological predisposition to emotional dysregulation, reinforced by an invalidating environment, explain the development of BPD symptomology (Linehan, 1993a 1993b; Millon, 1981, 1987). Biosocial theory argues for the centrality of emotional dysregulation in BPD symptomology (Linehan, 1993a; Putnam & Silk, 2005). Attachment theory, on the other hand, emphasizes the

centrality of attachment insecurity and the fear of abandonment in the borderline symptom structure (Levy, 2005; Masterson, 2013; Shemmings & Shemmings, 2011; Vardy, 2011).

The generally accepted treatment of choice for BPD is DBT (Bohus et al., 2004; Koons et al., 2001; Linehan et al., 2006; van den Bosch et al., 2005; Verheul et al., 2003), a cognitive-behavioural therapy developed by Linehan (1993a, 1993b) based on the biosocial perspective of the disorder. The primary goal of DBT is to assist IDBPDs in reducing life-threatening and quality-of-life compromising behaviours by teaching skills to regulate emotions, tolerate distress, and improve interpersonal effectiveness (Dimeff & Linehan, 2001; Linehan, 1993a). Given attachment theory's insistence upon the centrality of abandonment in the constellation of BPD, the empirical and theoretical support for the importance of the fear of abandonment as a core symptom in BPD (Benjamin, 1996; Gunderson, 1996, 2001; Kashgarian, 1999; Rao, 2000; Vardy, 2011), and the biosocial theory's and DBT's eschewal of abandonment, how, then, can DBT be so effective in the long-term treatment of BPD? I believe that it is worth investigating, from an insider's perspective, IDBPDs' experience of abandonment before and after receiving DBT, as well as their perceptions of the efficacy of DBT in the potential change in their experience of abandonment. The following chapter will describe how the current study was conducted in order to achieve these goals.

CHAPTER 3 – METHODOLOGY

The Existential-Phenomenological Method

Description of the Existential-Phenomenological Method

According to existential-phenomenological theory a person's experience of an environment must be considered in the context of how that particular environment has affected that individual's experience of said environment (Husserl, 1977; Merleau-Ponty, 1962). In addition, the phenomenon under investigation must be described rather than explained, and this can be done through the thematic analysis of first-person accounts (Giorgi, 1986; Giorgi & Giorgi, 2003). The clarification of IDBPDs' understanding of rejection, abandonment, and empathy, contextualized in their own lived experience and self-reflection can thus best be done within the existential-phenomenological framework.

Existential-phenomenological research can take one of two approaches: Husserlian phenomenology or Heideggerian phenomenology. Husserlian phenomenology seeks immersion in the participant's world of experience and meaning through description and the use of common language (Husserl, 1970). Attempts are made to avoid interpretation by bracketing the researcher's preconceptions and biases (Giorgi, 1985). Heideggerian phenomenology, on the other hand, seeks to interpret phenomena (Heidegger, 1962). The aim of the current study is to provide as unbiased as possible insider's perspective of the experience of abandonment by IDBPDs, and I thus chose to work from the Husserlian perspective of existential-phenomenology.

The existential aspect of the chosen theoretical framework and methodology identifies specific aspects of the phenomena under investigation including temporality,

relationship of self to other, emotional identity, recollection of perceived fact, and the relation of an experience to mortality (O'Boyle, 2002).

Data Collection Procedure

The methodology used in the present study is consistent with the existential-phenomenological framework and Giorgi's (1975) descriptive phenomenological reduction. The information collected from participants consisted of demographic information and personal accounts of abandonment-related experiences. As previously stated, the subject matter involved existential-related issues (O'Boyle, 2002), and was discussed in terms of the participants' experiential perspective and the personalized meaning they ascribed to said experiences (Husserl, 1977; Merleau-Ponty, 1962). In taking an existential-phenomenological approach, I communicated with participants as co-researchers (Osborne, 1990).

Potential co-researchers contacted me via e-mail and a brief explanation of the purpose of the study as well as the contribution requested of them was provided. Potential co-researchers and I then agreed upon a time and date upon which we would meet for the first of two data collection sessions.

All sessions were held in a clinic at the University of Calgary. The room utilized for the interviews contained four leather sofa chairs configured around a low square table. The door to the room remained closed during sessions to further ensure the confidentiality of the data collected. All data collection sessions were held during regular business hours, Monday through Friday, either between 9:00 a.m. and 12:00 p.m. or between 1:00 p.m. and 4:00 p.m.

During the first data collection session with a co-researcher, he or she was provided with an Informed Consent Form (Appendix D). Co-researchers were asked to read the Informed Consent Form and discuss it with me prior to signing it. Participation was dependent on the determination of complete understanding and signature of the consent form. As adults, co-researchers were thus able to provide fully informed consent. The Informed Consent Form advised co-researchers of their right to withdraw from the study at any time without consequences. Once co-researchers read the Informed Consent Form and agreed to the administration of the biographical questionnaire, the researcher and the co-researcher discussed the informed consent process and proceeded with signing of said form. Co-researchers were then asked to complete a biographical questionnaire in my presence, in the event that either party required clarification (Appendix E). This first one-on-one session was approximately 60 minutes in duration. Data from the biographical questionnaire was used to collect demographic information such as age, gender, marital status, and level of education, as well as establish the co-researcher's historical experience of BPD, mental health diagnoses, and experience with other forms of treatment. Co-researchers were also introduced to questions eliciting short written answers such as the definition of abandonment and a written description of their first abandonment experience. Co-researchers were asked to complete a modified version of the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) (Zanarini, Gunderson, Frankenburg, & Chauncey, 1989). This rating scale was chosen for its comprehensive valuation of the four categories of BPD symptoms (e.g. affective, cognitive, impulsive behaviours, relationship difficulties). The ZAN-BPD was administered to help verify which BPD symptoms co-researchers had experienced prior

to receiving DBT and to compare possible changes in severity of these BPD symptoms after having received DBT. Because the ZAN-BPD was administered as a self-report assessment tool, it allowed access to the co-researchers' perceptions of their symptoms, both before and after DBT. Information collected during this first session helped me decide whether co-researchers met the specified participation requirements stipulated in the research design. If, after verifying the biographical interview, I deemed a co-researcher to be eligible, he or she was asked to return for a second one-on-one personal interview.

There was only one circumstance in which a co-researcher was deemed ineligible for further participation. This decision was based on ethical consideration of the co-researcher's emotional well-being once I observed the distressing effect of the simple mention of the word abandonment. Both the co-researcher and I agreed that it would be unwise to continue data collection and the protocol was terminated. The co-researcher and I discussed her consent that any information provided up to that point would still be eligible for inclusion within the study and she confirmed her consent. I then referred her to sources of support.

The second data collection session was scheduled with eligible co-researchers at the conclusion of the biographical interview. Each of the co-researchers' two sessions were spaced one week apart. This spacing allows time for the co-researcher to reflect over the abandonment questions introduced during the first session and begin to collect memories of experience to be discussed during the second session. Additional rationale for the separation of data collection into two interviews spaced one week apart is that it

allowed for the development of a positive and collaborative working relationship between the co-researcher and myself (Seidman, 2006).

The second data collection session lasted between 90 and 120 minutes. These sessions were audio-recorded using a Sony 4GB digital voice recorder (Model #ICDUX533S), to enable accurate verbatim transcription at a later time. Information was elicited from co-researchers inductively using a semi-structured interview format organized around 12 guiding questions which reflect the objectives of the study (Appendix F). Responses on the ZAN-BPD were also used during the second data collection session to facilitate discussion of the potential relationship between the various symptoms and the experience of abandonment, and inquiry regarding the reasons for possible changes in symptom severity after having received DBT.

Co-Researchers

Recruiting a Hidden Population

Co-researchers eligible for inclusion in this study comprised and were limited to men and women between the ages of 18 and 75 who had been diagnosed with BPD and completed DBT treatment. Individuals with a history of disorders commonly co-morbid with BPD (e.g., depression, post-traumatic stress disorder, generalized anxiety disorder, bi-polar disorder, or addiction) were admissible as participants. Individuals with a history of disorders that are less commonly co-morbid with BPD (e.g., schizophrenia) were excluded from this study.

Co-researchers were recruited through purposive sampling using three methods. First, the author contacted practitioners employed by organizations offering DBT in Calgary, Alberta. There are two such facilities in Calgary: Inner Solutions and the

Sheldon M. Chumir Health Centre. The directors of each program were contacted via e-mail. Both facilities indicated interest at first, but only one followed through with the author. I presented the proposed research to the team of practitioners at the facility and responded to any and all questions and concerns raised. After receiving consent from the program director and agreement to assist with recruitment from each of the practitioners, I posted a recruitment notice (Appendix G) in the public area of the facility and provided recruitment notices to each practitioner. The facility's practitioners agreed to invite clients that they deemed eligible for participation to contact me by e-mail. Given that this facility is the one in which I received DBT, it was agreed that any clients with whom I had had previous interactions in group therapy would not be considered as potential co-researchers, thereby avoiding the risk of dual relationships between myself and co-researchers. The second recruitment method employed was the snowball method (also known as respondent driven sampling), a sampling method often used with hidden populations (Biernacki & Waldorf, 1981; Heckathorn, 1997, 2002; Thompson & Collins, 2002). Once a potential co-researcher made contact and discussed the details of informed consent with the author, they were invited to notify their peers diagnosed with BPD and have received DBT about the study, and provide them with a copy of the recruitment notice. Finally, recruitment notices were posted on internet message boards and chat rooms that cater to IDBPDs. These sites included http://borderline.livejournal.com, http://dbtselfhelp.livejournal.com, http://theborder-lines.livejournal.com, and http://borderlinepersonalitydisordersanctuaryforum.yuku.com.

Although Patton (2002) stated precise rules regarding sample size in qualitative methodology, I chose to follow the saturation point guidelines stipulated by Giorgi

(1997). Recruitment and collection of data thus continued until the common themes identified become redundant and no new themes were identified.

Co-Researcher Information

The co-researchers involved in this research consisted of 4 women and 1 man. One woman was deemed ineligible for participation after the first data collection session. Details about this case are provided in the following section. The 4 remaining participants ranged in age from 24 to 44 years of age and were of Caucasian descent. A summary of participants' demographic information is provided in Table 3.1.

All co-researchers met criteria for BPD and had completed the skills training portion of DBT. Detailed information regarding BPD symptoms experienced before and after DBT by the 4 participants who completed the study is provided in Appendix H.

Nicole. The first participant, Nicole, was a 24 year-old divorced woman. At the time of this study, she was in the process of completing an undergraduate degree in psychology, was single, and living with two roommates. Nicole was first diagnosed with BPD at the age of 21, and began DBT the following year for a period of approximately two years. At the time of this study, Nicole continued to engage in informal group therapy (12-step program) on a weekly basis. Her mental health history consisted of co-morbid depression, addiction, anorexia nervosa, bulimia, and numerous hospitalizations for psychosis and suicidality. She had received multiple modes of treatment prior to DBT, including cognitive behaviour therapy (CBT) and what she named addictions treatment.

Table 3.1

Co-Researcher Information

Co-Researcher Pseudonym	Sex	Age	Marital Status	Diagnoses prior to BPD	Treatments prior to DBT
Nicole	F	24	Divorced	Depression Addiction [a] Anorexia nervosa Bulimia	CBT Addictions treatment [a]
Sal	M	31	Single		Substance abuse treatments [a]
Barb	F	44	Separated	Depression	CBT EMDR Outpatient psychiatric [b]
Tina	F	36	Divorced	Depression Post-partum psychosis Post-partum depression Bipolar	CBT Self-empowerment group therapy [a]
Kit	F	51	Divorced	-- [c]	-- [c]

Note: BPD = Borderline Personality Disorder; DBT = Dialectical Behaviour Therapy; CBT = Cognitive Behaviour Therapy; EMDR = Eye Movement Desensitization and Reprocessing.

[a] Participant's term.

[b] Participant could not remember type of therapy received.

[c] Information was not collected due to withdrawal of participant from study.

Nicole's primary caregivers during childhood were her mother and father. She described her father as affectionate, and rated his approach to discipline as lenient with encouraging feedback. She stated that her relationship with him was excellent during childhood and good after the age of 11. Nicole's father passed away when she was 21 years of age.

Nicole described her mother as alternating between affectionate and dismissive, and rated her approach to discipline as strict with criticism as feedback. She stated that her relationship with her mother was good until the age of 11, poor during adolescence and early adulthood, and only improving to fair after Nicole's involvement in DBT.

Nicole has one younger sister, her relationship with whom she described as distant. She does not have any children.

Sal. The second participant, Sal, was a 31 year-old man. At the time of this study, he was in the process of completing an undergraduate degree (though he did not disclose his area of study), was single, and living with his parents. Sal was first diagnosed with BPD traits at the age of 28, and began DBT three months later and continuing for a period of two years. At the time of this study, Sal continued to engage in individual counselling on a weekly basis. Sal had not received any other mental health diagnosis but, in addition to DBT, has received various forms of what he named "substance abuse counselling".

Sal's primary caregivers during childhood were his mother and father. He described his father as "somewhat distant", and he rated his approach to discipline as "lenient" with "criticism" as feedback. He stated that his relationship with him was "good" until the age of 11 when it became "fair" but then improved to "good" again after

Sal's involvement in DBT. Sal attributed this change to his own improvement in communication.

Sal described his mother as conditionally "affectionate", and rated her approach to discipline as "strict" with "criticism" as feedback. He stated that his relationship with his father followed the same pattern as his relationship with his mother.

Sal reported having one younger brother, his relationship with which he qualified as competitive during childhood. He does not have any children.

Barb. The second participant, Barb, was a 44 year-old woman who was married but separated from her husband. Barb held a BSc in nursing and, at the time of this study, was gainfully employed as a counsellor working with the homeless and individuals with substance abuse issues. Barb was first diagnosed with BPD at the age of 41 after which she immediately began DBT and, at the time of this study, continued to meet with her therapist on a weekly basis. Her mental health history consisted of major depressive disorder and several hospitalizations for being suicidal. Barb had received multiple types of therapy prior to DBT, all to treat her depression. These therapies include CBT, Eye Movement Desensitization and Reprocessing (EMDR), and outpatient treatment at a psychiatric hospital (although she could not recall the type of therapy received).

Barb's primary caregivers during childhood were her mother and father. She described her father as "dismissive", and rated his approach to discipline as "very strict" with "criticism" as feedback. She stated that her relationship with him was "good" during childhood and "fair" after the age of 11. The quality of her relationship with her father did not improve after her involvement in DBT.

Barb described her mother as “affectionate”, and rated her approach to discipline as “lenient” with “encouragement” as feedback. She stated that her relationship with her mother was “good” until the age of 18 and “fair” during adulthood. The quality of her relationship with her mother did not improve after her involvement in DBT.

Barb reported having two older sisters with whom she does not maintain a relationship. She reported having three daughters with whom she has had difficult relationships. She stated that one of her daughters is displaying BPD traits.

Tina. The third participant, Tina, was a 36 year-old divorced woman. At the time of this study, Tina was in a long-term romantic relationship and she was in the process of completing a Bachelor of Social Work. Tina was first diagnosed with BPD at the age of 32 and began DBT two years later. She received DBT for a period of 18 months and, 6 months later was involved in a DBT booster group for 3 months. Tina’s mental health history included diagnoses of depression, post-partum psychosis, post-partum depression, and bipolar disorder, all of which she confirmed were no longer considered valid diagnoses after her diagnosis of BPD. Prior to receiving DBT, Tina sought treatment with CBT and what she termed a “self-empowerment group therapy”.

Tina’s primary caregivers during childhood were her mother and father. She described her father as “somewhat distant”, and rated his approach to discipline as “strict” with “criticism” as feedback. She stated that her relationship with him was “good” during childhood and “poor” after the age of 11. The quality of her relationship with her father improved to “fair” after her involvement in DBT.

Tina described her mother as minimally “affectionate” and “somewhat distant”, and rated her approach to discipline as “lenient” with “criticism” as feedback. She stated

that her relationship with her mother was "good" until the age of 11, "poor" until the age of 18, and cycling between "good" and "fair" during adulthood. The quality of her relationship with her mother became stable and "good" after her involvement in DBT.

Tina reported having one younger sister towards whom she has had feelings of animosity since feeling displaced by her birth when Tina was 5-years old. Tina stated that the feelings of animosity have steadily decreased since her involvement in DBT. She reported having two daughters with whom she has a positive relationship.

Kit. The fifth participant, Kit, who was deemed ineligible for further participation due to ethical concerns, was a 51 year-old, twice-divorced woman. At the time of this study she held two college degrees, the first in liberal arts, and the second in arts administration. Information regarding Kit's diagnosis with DBT, mental health history, and previous treatment experience was not collected due to mutual agreement that her participation in the study would be terminated.

Analysis of Data

Upon completion of each semi-structured interview, I transcribed the discourse according to the naturalized approach (Schegloff, 1997), including stutters, pauses, nonverbals, and involuntary vocalisations, thereby yielding a verbatim account of the co-researcher's answers and descriptions. The transcript was then read twice over prior to conducting any analyses, to gain an understanding of the co-researcher's manner of expression and submerge myself in his or her reconstruction of experience. In the analysis phase, common themes regarding process, experience, and meaning were reduced to provide insight from the insider's point-of-view (Giorgi, 1975, 1997; Merleau-Ponty, 1962). The analysis was conducted by completing the following steps suggested

by Giorgi (1975): Each transcript was separated into meaning units and transformed into psychological paraphrases; each paraphrased meaning unit was interpreted through free imaginative variation and further reduced to a distinct meaning; similar themes were grouped into clusters; similar clusters were grouped into higher-order clusters. The aim of this reduction is to describe the essential structure of the phenomenon.

Quality of Data

The use of semi-structured interviews for data collection in phenomenological research has been discussed at length and endorsed by Kvale (1983). As previously mentioned, the second data collection session was audio-recorded to ensure accurate transcription of co-researcher responses. During these interviews I repeatedly asked the co-researcher to elaborate on their responses or provide examples to clarify their meaning and thus reduce imposition of assumptions on my part. To further ensure an unbiased representation of co-researchers' experiences, once themes were identified through the phenomenological reduction, co-researchers were asked to review the analysis to determine whether I had correctly understood and reflected their personal experience. Member-checking thus enhanced the accuracy of representation (Agar, 1986) of the results as the data was to be reanalyzed if co-researchers identified it as an erroneous interpretation. Reanalysis was not required, however, as all four co-researchers confirmed the validity of the identified themes. The trustworthiness and confirmability of results was further verified through triangulation (Guba, 1981; Knafl & Breitmayer, 1989). The hierarchical organization of themes, sub-themes, and overarching categories was first conducted by me, and then verified by two MSc graduate students in counselling psychology and by my supervisor. In accordance with the existential-

phenomenological method, I engaged in bracketing my potential biases regarding the subject matter. This practice reduces obfuscation of original meaning and enables readers to ascertain through what lens conclusions were being made.

Ethical Considerations

IDBPDs have ongoing issues with emotional regulation. Consequently, everyday life brings with it some level of emotional arousal for IDBPDs. However, co-researchers for this study had already completed DBT, which is the one treatment that has empirically supported effectiveness in reducing emotional dysregulation. There was thus reduced risk that co-researchers would be harmed or find this interview distressing while they were asked to explore the issue of abandonment. Although the focus of the discussion was on the skills employed to overcome abandonment issues, the recall of abandonment scenarios had the potential of becoming upsetting to some. Information regarding this minimal risk was provided during the informed consent process and included in the informed consent form.

When one distressed individual was identified, the researcher and the individual discussed the risks versus the benefits of continued participation and agreed that he or she would withdraw from the study without consequence. The researcher referred the individual to her current mental health practitioner. The names and contact information of counselling resources available in Calgary were also provided in the informed consent form. There was minimal risk that co-researchers would experience any social risk since their confidentiality was ensured through the use of a pseudonym and omission of any personal identifiers.

Co-researchers may have found their experience in this study to be beneficial as they focussed on what has been helpful to them in their treatment. Exploring the ways DBT may have altered their perception of abandonment may help to affirm positive changes and result in an increased sense of empowerment.

If at any point a co-researcher wished to withdraw from the study the administration of the biographical questionnaire or the interview would be terminated at their request. The co-researcher was thanked and absolutely no pressure was put on the co-researcher to finish the interview. The information contributed up to that point would have been destroyed upon the co-researcher's request. The individual who was terminated from the study, however, did permit her partial data to be included in the analysis.

CHAPTER 4 – RESULTS

The purpose of this research was to gain an understanding of how IDBPDs experience, perceive, and manage abandonment issues. Specifically, changes in individuals' experience, perceptions, and management skills after having received DBT were investigated. This information was collected from co-researcher's oral accounts of abandonment experiences during semi-structured interviews. The results of the analysis of this information, done according to the existential phenomenological method, will be presented in this chapter.

Before DBT

The analyzed responses were separated according to two primary categories: Before DBT and After DBT. The former category represents all themes and sub-themes pertaining to the co-researchers' recollection of their experience of abandonment prior to receiving DBT. The hierarchical organization of themes and sub-themes within the Before DBT category is presented in Table 4.1, followed by a brief explanation of each identified theme or sub-theme and verbatim examples from the semi-structured interviews supporting the respective theme or sub-theme. Where verbatim examples required expanded context for the purpose of clarity, the interviewer's questions and responses are included within brackets.

Table 4.1

Themes and Sub-Themes within the Category BEFORE DBT, Derived from the Semi-Structured Interviews

REACTIONS		
Emotional	**Cognitive**	**Behavioural**
1. Hopelessness 2. Self-blame 3. Feelings of dependency 4. Fear *a. of abandonment* *b. of destruction* 5. Anxiety 6. Desperation 7. Emotional dysregulation 8. Sadness	1. Low self-worth 2. Cognitive impairment *a. Impaired reality testing* *b. Black and white thinking* c. *Obsession*	1. Self-destructive *a. Self-harm* *b. Suicidality* *c. Substance abuse* 2. Avoidance behaviours *a. Avoiding conflict* *b. Avoiding abandonment* *c. Isolating self* 3. Defensive behavioural patterns *a. Hurting others* *b. Fight-or-flight response*
Interpersonal Difficulties		
1. Familial difficulties *a. Parental invalidation* *b. Negative relationship with mother* *c. Negative relationship with father* *d. Sibling rivalry* *e. Not belonging* 2. Abandonment *a. By family* *b. By significant others*		

Emotional Reactions

During our interviews, the co-researchers were asked if situations of abandonment, real or perceived, elicited any particular emotions. Each of the co-researchers described similar emotional reactions. These emotions have been grouped as sub-themes of the emotional reaction theme identified by all four co-researchers in response to abandonment prior to receiving DBT.

Hopelessness. Three of the four co-researchers stated that after experiencing what they perceived to be abandonment, they felt a sense of hopelessness. Verbatim excerpts from co-researchers' responses during the semi-structured interview illustrate the sub-theme of hopelessness: "Then there's the other part that's, um, it takes a few days, or, you know what, I can't deal with this" (Nicole, age 24); "Something will trigger and then I get that same emotional adrenaline feeling of hopelessness" (Barb, age 44); "A really confused sense that nothing's gonna work out, just everything's kind [of] hopeless, everything's really bad, you know" (Sal, age 31).

Self-blame. All four of the co-researchers identified feelings of guilt and a tendency to blame themselves for the other person abandoning them. Nicole attributed her guilt to an inherent flaw in herself: "Before I went through DBT it would always be, it's me, it's my, it, there's something wrong with me, I did this, [Nicole's] the big fuck up." Barb attributed her responsibility for the abandonment to her poor performance within the relationship: "Yeah, it's my fault, if I had just done this better, um, so, and I, that still plays in my head." Sal also related feelings of self-blame but recognized alternate possibilities.

> And I wanna find out who's to blame. [Okay, who's to blame.] Yeah, who's to blame. [For the abandonment?] Yes. [And who are the possibilities?] Uh, well, it could be me, or it could be the person on the other end of the abandonment.

Tina (age 36) attributed her responsibility for the abandonment to her inability to circumvent the abandonment:

> Well like, there's nothing I can do to make, to, to, bring them back, it feels like, and it's always feels like my fault, like I really, it always, it's a very personal thing, um, yeah, well I've tied it to personal thing, but, um, yeah, being, being abandoned, just being left alone.

Feelings of dependency. Three of the four co-researchers stated that feeling abandoned required a sense of dependency on the person who abandoned them. The following quote illustrates Nicole's viewpoint of feeling abandoned as requiring that she be in a state of dependency:

> Abandonment to me means the feeling or the actual act of someone leaving me in a place where I'm vulnerable or a place where I'm not comfortable and when I'm not able to stand on my own two feet – so it's the act of someone leaving me when I'm in need. [Okay, and what do you mean by vulnerable?] Vulnerable whether it would be an emotionally turmoiled or I'm in a spot where I'm in need of assistance. Um, where I can't be self-sufficient, or where I don't want to be self-sufficient. That would be kind of vulnerable for me.

Sal further refined the definition of dependency by associating it with the abandoner: "when somebody that you have some level of dependence on decides that they're not gonna be involved with you on any level." Finally, Tina differentiated between her sense

of abandonment and rejection in terms of the importance of the abandoner in her life. In her response, Tina alludes to a feeling of dependence on the other person insofar as their involvement in her daily life:

> There's some differentiation between abandonment and rejection as far as importance. Um, you can be rejected by anybody. [What makes people more important to you?] I think the nature of our relationship, as far as its relevance in my everyday life, and my, maybe my thoughts and plans for the future.

Fear. Each of the co-researchers described fear as one of the feelings they experienced in response to abandonment. The co-researchers differentiated between two types of fear, however: fear of abandonment and fear of destruction.

Fear of abandonment. Three of four co-researchers mentioned a fear response to a perceived or actual threat of abandonment. When asked what feelings are triggered by the threat of abandonment, Nicole answered: "Panic, sheer panic. Overwhelming fear." Barb explained: "I am afraid I will be left alone, that's the fear of abandonment." Finally, Tina answered similarly: "panicking ... willing to do anything to not be left."

Fear of destruction. When asked to describe the fear they identified as resulting from a perceived or actual abandonment, three of four co-researchers qualified it as tantamount to fear of a life-threatening situation. Nicole explained this fear as a cumulative result, and may have used the terms abandonment and rejection interchangeably:

> [You said before that sometimes um, you see things as abandonment, um, if you haven't been taking care of yourself?] Yeah. [So they creep up and build up because?] They build up because I don't break them down individually and then

> all of a sudden we, because that person rejected me that means this person's gonna reject me and this, and all of a sudden the rejection of, small rejection of one person, small rejection of another person, small rejection …. They all accumulate to the point where sometimes I felt that the world's out to get me.

The following quote illustrates Sal's description of the fear of the sense of void, akin to death, caused by abandonment:

> So that provides kind of a do-or-die attitude towards your anger and anxiety. So that makes it harder to walk away from. [Right. Well and that feeling of desperation, that do or die, what is the risk?] I guess the risk is going back to a feeling of void.... It's like an instinct ... It feels like a physical survival.

Tina commented on the strength of her emotional reaction to abandonment, comparing it to a life-threatening situation: "And in the moment ... it's the only thing, and my life could end on this, kind of that kind of intensity."

Anxiety. Three of four co-researchers associated abandonment with a feeling of anxiety. Two co-researchers directly stated that the threat of abandonment triggers "anxiety" (Nicole), or "anger and anxiety" (Sal), while Tina explained that when she feels abandoned she feels "panic."

Desperation. When elaborating on their emotional reactions to abandonment, two of four co-researchers related a sense of desperation. Sal described the quality of the emotional reaction to abandonment in the following way: "It's more desperate. Um, anger and anxiety in, in other situation where, where there isn't the perceived fear of abandonment is anger that is um, more casual and easier to think logically about and easier to walk away from." Tina qualified the desperation brought about by abandonment

as motivating her to go to any lengths, regardless how uncomfortable for her: “desperate enough to say it ... so I’m willing to, yes, even to be vulnerable to fix it, or to change it.”

Emotional dysregulation. When asked to elaborate on the experience of their emotional reactions to abandonment, three of four co-researchers stated either directly or indirectly that their emotions would become dysregulated, potentially impairing them in some way. Nicole stated that prior to DBT, she “used to just crisis and end up in a suicidal emotional mess”, thereby indirectly indicating emotional dysregulation. Two other co-researchers directly stated that abandonment brought about emotional dysregulation. Barb explained that the fear of abandonment serves as a trigger “and then I get really dysregulated,” while Tina described abandonment as “detrimental long-term because it causes more internal distress, right, like more dysregulation.”

Sadness. Three of four co-researchers identified a sense of depression or unhappiness in response to abandonment. Sal explained that a particular abandonment “would be a triggering event, and then a period of ... what you might call depression, in which there were ups and downs.” When asked what her emotional reaction to the threat of abandonment was, Barb responded that she felt: “lonely, unhappy, the crazy cat lady.” Finally, Tina differentiated her emotional reaction to abandonment from that of rejection by stating: “When I feel rejected I get more angry, whereas abandonment I, it’s sadness and guilt.”

Cognitive Reactions

During interviews, co-researchers were asked if they experienced any specific thoughts when faced with abandonment. The co-researchers identified specific thoughts, thinking styles, and a change in their ability to process the experience.

Low self-worth. While a decreased sense of self-worth was mentioned by all four co-researchers, only three of four co-researchers linked thoughts of diminished self-worth directly to abandonment. The following quotes illustrates Nicole's self-effacing thought pattern as a result of abandonment: "Sometimes I can get that negative thinking going 'well I'm not worth anything' and I question whether – why people want to come alongside me because don't you know how big of a fuck-up I am." Sal explained the connection between dependence, abandonment, and self-esteem: "Well then if you're dependent on that person to fulfill some degree of self-esteem, then you're left with an emptiness there, and so that can cause trauma." Referring to abandonment and rejection, Tina stated the following: "I'm still affected by them, and I tie those things directly to self-worth."

Cognitive impairment. All four co-researchers identified some sort of diminished efficacy in their cognitive functioning as an aspect of their experience of abandonment.

Impaired reality testing. Two of the four co-researchers explained an inability to consider alternate explanations or think rationally when faced with abandonment. The following quotes illustrate each co-researcher's experience of difficulty challenging irrational thoughts due to the emotional state triggered by abandonment: "I lose a lot of my cognitive processing when it comes to that. The logic, the rationale behind any of it, going 'maybe they're just busy', doesn't tend to faze me when I'm emotional like that" (Nicole); "I read into that ... as abandonment. That she wants nothing more to do with me, she doesn't want me to be her mother and, when it could be she just forgot 'cause she's 14 years old" (Barb).

Black and white thinking. Two of four co-researchers stated that when faced with abandonment their thinking becomes polarized, in that their thoughts become all-or-nothing. Nicole stated that, when experiencing abandonment, her thinking "tends to be very black and white." Barb provided an example of her polarization when thinking about being abandoned by her daughter: "I practice in the black-and-white of, you emancipated, and this is what it means by legal terms, and by that you mean you don't want me to be your mum."

Obsession. Three of four co-researchers explained that when experiencing abandonment, their thoughts become highly focussed on the abandonment, to the extent of being obsessive. Nicole explained the manifestation of obsession in response to abandonment as follows:

> It's tunnel vision of what am I gonna do here? What am I gonna do specifically to this situation? I'm not thinking about hey I need to put gas in my car, I'm not thinking about eating dinner, I'm not thinking about taking care of my vulnerabilities, I'm not thinking about anything else, or the paper that I had due yesterday. It's what is the situation's fastest solution, which may not be the correct solution or the best solution.

Sal stated that, when responding to abandonment, "the thoughts were of getting the situation in a way uh, back so that it would be the way it was before. And uh, everything was focused on that." Finally, in speaking about her obsessive reaction to a threatened or actual abandonment, Tina explained that "when something like that happens, that's at the front of my mind., and everything else that's going on, it's the only thing."

Behavioural Reactions

Each of the four co-researchers identified specific behaviours that they would intentionally engage in as a way to either manage the emotions and thoughts associated with perceived or actual abandonment. The behavioural reactions identified by the co-researchers can be grouped into three sub-themes: self-destructive, avoidance behaviours, and defensive behavioural pattern. A fourth sub-theme of the behavioural reaction theme pertains to the interpersonal relationships in which these behaviours occur.

Self-destructive. The co-researchers, although differing in their individual choice of self-destructive behaviour, each expressed that they had used a form of self-destruction to manage the emotions involved in their experience of abandonment.

Self-harm. Three of four co-researchers stated that they caused themselves bodily harm, either through self-mutilation or, in one case, deliberate abstention from mood-regulating medication. Nicole described her behavioural reaction to the emotions triggered by abandonment:

> I'm going to go to x, y, z, that's destructive, whether that's cutting, burning, drinking, using, committing suicide, breaking bones.... I've shattered my hand on a few occasions.... Because when I get to those areas, or when I hurt, when that cascades, when that mushrooms... it becomes about stopping the emotion. And, uh, if I'm not practicing the skills, or if I'm not using my twelve-step program, my immediate resort to, is destructive, make it stop.... [Can you flush out that character of 'it'?] It is the emotion. It is the overwhelming panic. It's the fear. It's, I don't really know how to describe it, the best way is anybody who's been a drug addict knows when you're coming out of detox everything in you just

> screams. And that's kind of what the it is to me, where everything is screaming, and it's just, I want it to stop but I don't know how, at least, before I got to DBT.

Sal described the types of behaviours in which he engaged as a response to the emotions triggered by abandonment as follows:

> I start getting these funny ideas, that for some reason it just seems like it would be a really good idea to sort of paint myself in my own blood. You know, just completely red.... Other times, you know some self-destructive behaviours that I've had are... doing exercise drills that sort of go beyond being just exercise drills, they become, I guess, pain tolerance exercise.

Finally, Barb, in response to questions regarding her reactions to actual or threatened abandonment, stated: "Quite often I'll stop taking my meds ... I mean they're all self-harm behaviours."

Suicidality. Although three of four co-researchers disclosed a history of suicide attempts during the biographical interview, only two co-researchers overtly related suicide to their experiences of abandonment. Nicole, who had been hospitalized several times for suicide attempts, stated the following: "I felt at times where I'm so emotional I don't think I'm ever gonna come down for it, and the only way to stop it is to kill myself." Tina described her hospitalization due to the suicidality brought on by her emotional and cognitive reactions to abandonment: "I was hospitalized once, because it really felt like madness in my head and I couldn't, none of this was worth it, this was just way too painful, living was just too painful, so just, [suicide] was the answer."

Substance abuse. Three of the four co-researchers reported a history of substance abuse. All three of these co-researchers related their substance abuse behaviour to the

emotional experience of abandonment: “When I had something come up that produced these overwhelming feelings ... if I had dope I went straight to my dope, o to alcohol, or whatever” (Nicole); “I would start looking for destructive behaviours to do like for example, getting into conflicts, and substance abuse” (Sal); “But then after the marriage I, by then I got into drugs and so cocaine took those feelings away” (Tina).

Avoidance behaviours. The co-researchers also spoke of behaviours they engaged in to avoid further experience of abandonment or to avoid situations that might result in abandonment.

Avoiding conflict. Conflict in the form of raised voices and arguments can sometimes result in the disruption of a relationship and possibly rejection and abandonment. Three of four co-researchers indicated that they physically remove themselves from situation in which conflict arises. Nicole referred to her reaction to verbal abuse: “A lot of times I’m known for running when there’s conflict that come up like that. I want nothing to do with it.” Barb made reference to avoiding arguments as an escape:

> I run out of bad situations.... If I’m having a fight with my siblings... I just would walk out of the house. I have walked out of my parents’ house; I’ve walked out of meetings. So I escape, I retreat, I run.

Finally, Tina also spoke of her avoidance of verbal conflict, “When we would get yelled at by my mum, I would run and cry in my bedroom, [my sister] would yell back.”

Avoiding abandonment. All four co-researchers shared a belief that certain behaviours could prevent a person from abandoning them. Three co-researchers spoke of preventative measures employed in response to feelings of anxiety or fear prompted by

abandonment, “With significant others it’s an overwhelming panic of what I can do to make this better to make you stay” (Nicole), “My understanding of abandonment issues is that you do behaviours due to the fear of being abandoned.... So it’s the behaviour that occurs from that fear” (Barb), and:

> Abandonment issues; it’s willing to do anything to not be left. So even if it means not saying, not speaking up or saying what you’re feeling or thinking because you don’t, uh, your fear is that if you tell him, he’s gonna leave, so it’s better to shut your mouth and keep it inside.... So it’s a panicky kind of, just willing to change anything and everything about myself to make sure that he doesn’t leave. (Tina)

Sal also spoke of evasive maneuvers but qualified his experience of the avoidance behaviours as inevitable:

> The nature of the fear of abandonment is that you feel like you don’t have an alternative. So you have to, you have a feeling that you have to do what it takes not to let whatever the negative event is occur.

Isolating self. The ultimate avoidance behaviour is withdrawal from the undesired stimulus, which in this case is social interaction. Three co-researchers shared a tendency towards isolation when experiencing the threat of abandonment. Two of these three co-researchers qualified their isolation as a deliberate response to the threat of abandonment, as illustrated by the following, “I also stop answering phone calls. Like, I isolate myself and pull myself completely into a circle” (Barb), and “I would choose to stay home, to not participate, to distance myself” (Tina). Nicole, however, spoke of her isolation as a result of her reactions to the threat of abandonment, rather than as a deliberate reaction in and of itself:

> So, whenever I started reacting, or whenever I did this, I ended up very, very alone. The things I did to try and stop myself from going crazy where pushing everybody away and pushing me further and further down a hole.

Defensive behavioural patterns. In addition to self-destruction and avoidance, another type of behavioural coping mechanism identified by three of the four co-researchers was defensive.

Hurting others. Three co-researchers stated that when they felt threatened with abandonment, actual or perceived, they would react with a pre-emptive strike towards the source of the threat. Two co-researchers spoke of hurting the offender either directly or indirectly by hurting themselves. This sentiment is exemplified in the following quotes: "My mentality is I'll show you, I'll hurt me, and that can take a number of forms. That can take the, I'm gonna cut you out before you cut me out." (Nicole), and "If you don't know any positive and healthy coping methods, then usually it looks like some type of destructive behaviour. You know, you either outwardly directed or inwardly directed" (Sal). Barb spoke only of hurting the offender as a pre-emptive move, as illustrated in the following, "With me, I will abandon people before they abandon me so that I do it first."

Fight-or-flight response. Two co-researchers mentioned experiencing an internal conflict between the urge to strike out at the threat and the urge to flee the threat of abandonment. Barb simply stated that abandonment triggers a "fight ad flight surge," while Nicole elaborated on the meaning of being caught between the urge to fight or flee in stating that, "It'll actually make me freeze. So you got a play of all of them together, things wanting me to push forward, things pulling me back, and I'm kinda caught in the middle of it all."

Interpersonal difficulties

It is not surprising that interpersonal difficulties arose as a theme in the co-researchers' accounts of their experience of abandonment, given that it is one of the known characteristics of BPD. The relationship difficulties described during the interviews consisted primarily of problems with family members or significant others. Relationships with friends were also described by two of the co-researchers but only one of them related this to the experience of abandonment.

Familial difficulties. The theme of negative relationships with family members arose during each co-researcher's discussion of abandonment experiences.

Parental invalidation. Each of the four co-researchers described their interactions with at least one of their parents as invalidating. They stated that the feedback they received from that parent was in the form of judgement and criticism rather than encouragement or acceptance. Nicole qualified her mother's disposition towards her as invalidating by stating, "I don't have time nor the energy to sit and fight with her or to sit there and be told that I'm worthless." Sal described his father's feedback as invalidating by stating, "I rarely got encouragement in that this is good, you know, you did a good job, keep it up. It was always like, you did this wrong, you should do it this way, fix this, you're not doing this." Barb provided several examples of what she considered parental invalidation, as exemplified in the following quote:

> But they wouldn't let me have my kids and they kept telling me everything I was doing wrong and they kept taking my kids away, if…something happened. Um…and then my parents would keep saying, 'well [middle sister] can't do this much longer' you know, 'are you getting any better?' you know, '[middle sister]

> has done so much for you' and no matter how grateful, or whatever, I kept saying it.

Finally, Tina confirmed that her parents were invalidating of both her thoughts and feelings:

> I could think of a lot of instances where it was certainly invalidating, or telling me how I should feel about things, and, 'it's stupid that you feel that way, and that's just stupid'. Like my thoughts were stupid. My feelings were stupid.

Negative relationship with mother. Two co-researchers identified a negative orientation towards their relationship with their mother. This negative orientation was characterized by conflict as exemplified by Nicole's statement that, "By the time I went into DBT my mother and I couldn't even talk about the weather. She's got some issues of her own, and incorporated with my issues, it was just a catastrophe every time we talked." An additional disdain for the manner in which they were parented by their maternal figure is illustrated in the following quote Sal, "She was a controlling type of affectionate.... It didn't make me feel like I was part of a group because I didn't like being, um, having a controlling influence upon me all the time."

Negative relationship with father. Three co-researchers identified a negative orientation towards their relationship with their father. This negative orientation was characterized by feelings of being disregarded by their paternal figure due to a lack of affection, as exemplified in the following quotes regarding each co-researcher's description of their father's attitude towards them: "It gave me a sense of isolation, marginalization, um, it reinforced the idea that I was an outsider" (Sal), "It wasn't name-

calling, it was more ‘you have disappointed me’, and then he would withdraw his attention, by ignoring you” (Barb), and “He was always just really distant” (Tina).

Sibling rivalry. All four co-researchers were raised with siblings. While none of the four co-researchers characterized their relationship with their sibling as positive, only two of the co-researchers associated the sibling relationship with the experience of abandonment by attributing the lack of acceptance from their parents to their siblings’ presence. Barb spoke of what she felt was preferential treatment of her sister by her parents: “I’m tired of hearing how wonderful my middle sister is. And I’m also really tired of them condoning my oldest sister’s behaviour, which was really terrible to me.” Tina described her sense of abandonment by her parents after the birth of her sister: “They always loved her better, kind of thing. And that was, there’s a bit of abandonment there too right? After she showed up then I wasn’t wanted anymore.”

Not belonging. Two of the four researchers described a sense of separateness from their family. Sal spoke about how what he perceived to be abandonment experiences and parental invalidation contributed to his enduring sense of not belonging: “I think they seeded and reinforced the idea that I was an outsider, that I was always gonna be an outsider... somebody that doesn’t belong to the group.” Tina communicated her familiarization with being apart from her family when they would leave for an excursion and she would say behind: “It wasn’t anything that was new, as far as being left alone.”

Abandonment. Within the experience of abandonment is, of course, the abandonment itself. The four co-researchers made distinctions regarding whom they would feel abandoned by. Abandoner identity as defined by the co-researchers was

distinguished by a level of relational value such as familial relation, romantic relation, or close friend.

By family. Three co-researchers identified the abandoner as a family member. Two of the three co-researchers recognized an absent parent as someone who could abandon them. In the first quote illustrating parental abandonment, Nicole explains the effect that this had on her future perception of abandonment: "If it's a parent that was perceived to not be there, then there's that underlying fear of waiting for the next shoe to drop, so there's always, it's a pattern coming most times from in my past." The second quote relates Sal's memory of the first experience of perceived abandonment by his mother:

> My friends at the park beat me up, basically, when I was about five, and I thought my mum was watching, you know, from the window cause the park was just 50 yards, the playground, and you know, she never came, so.

Barb identified her child rather than a parent as someone who could abandon her:

> And then abandonment is also my kids, um, that they have chosen to live with their dad. Or, my oldest one chose to leave the home, house at 15, um, for various reasons, but they chose to leave me, which, um, when you're a mom and they're young, they should be with you.

By significant others. Three co-researchers identified someone other than a family member as someone who could abandon them. In the following quote, Nicole describes the experience of abandonment by a close friend of the same gender:

> Abandonment issues, um, in relation to me is when I have someone that, it mimics the same pattern, so I have a close female friend, and there is a fracture in the relationship and then all of a sudden I feel abandoned.

The other two co-researchers characterized this extra-familial abandoner as a romantic partner. In the following quote, Sal speaks of the dissolution of his longest romantic relationship, relating it to abandonment:

> Well, first the, you know, the relationship would start to get conflictive.... So that's when the fear of abandonment would start to set in gradually. And so that would only make things worse, gradually, until you know, separation occurred. And then it would really start to kick in, you know the abandonment and then I would start enacting negative behaviours and stuff like that.

Tina also describes a romantic partner as an abandoner but within their relationship rather than in the process of dissolution:

> And whereas abandonment more feels like…um…at the beginning of my relationship with [boyfriend] he would just not answer his phone or, or texts, or anything like that for like a week. And it was…that felt like abandonment, that was fear, right, that was panic. What did I do? What did I do wrong? Please just tell me what I did wrong I promise I won't do it anymore.

After DBT

The co-researchers' described experience of abandonment differed in some aspects after receiving DBT. The hierarchical organization of themes and sub-themes within the After DBT category is presented in Table 4.2, followed by a brief explanations and examples of each identified theme or sub-theme.

Table 4.2

Themes and Sub-Themes within the Category AFTER DBT, Derived from the Semi-Structured Interviews.

REACTIONS HAVE CHANGED		
Emotional	**Cognitive**	**Behavioural**
1. Feelings are the same 2. Emotional regulation a. Less intense b. Don't last as long	1. Fewer cognitive distortions a. Shades of grey b. Lessened perceived abandonment c. Improved trigger identification	1. Improved self-care 2. Improved coping skills a. Check the facts b. Mindfulness skills
DBT COUNSELLOR ATTRIBUTES		
1. Understanding 2. Non-judgemental 3. Validating 4. Empathic 5. Relatable		

Changed Emotional Reactions

All four co-researchers stated that their emotional experience of abandonment, perceived or actual, changed after receiving DBT.

Feelings are the same. Despite the common theme of a different emotional experience after DBT, three of the four co-researchers clarified that the type of feelings experienced in response to abandonment did not change after receiving DBT. Two of these three co-researchers further clarified that it was their reaction to the emotions elicited by abandonment that was affected by DBT: "No, the feelings and thoughts didn't, but my coping mechanisms did" (Sal), and "The feeling is the exact same. It's what I do with the feeling that has changed" (Barb). When asked if her thoughts and feelings in response to abandonment changed after DBT, Tina simply stated, "Did they change? No."

Emotional regulation. Even though co-researchers reported that the types of feelings elicited by perceived abandonment remained the same after DBT, all of the co-researchers stated that the manner in which they were able to experience these feelings changed from dysregulated to regulated as a result of DBT.

Less intense. All four co-researchers reported that the intensity of the feelings triggered by abandonment was reduced after they received DBT, as illustrated by the following quotes: "As much as I still get a rise out of perceived abandonment and rejection, it's not the same level as it once was. It's not the level where I swear it's gonna kill me" (Nicole), "But you know it wasn't anywhere near as bad as it was before because I already had been developing my skills" (Sal), "I'm not feeling the intense extremes that I was feeling prior" (Barb), and "I would say the intensity of them did [change]" (Tina).

Don't last as long. Two co-researchers remarked that their experience of the emotions associated with abandonment became more transitory after DBT compared to before DBT, as exemplified by the following quotes: "The other part is that I can very quickly become unstable, but I can also now very quickly become stable again" (Barb), and "I feel like I can manage them when the thoughts and feelings hit me, and I come down from it quicker" (Tina).

Cognitive Reactions Changed

With a change in the intensity of emotions experienced after DBT, the co-researchers also described a change in their cognitive reactions to abandonment.

Fewer cognitive distortions. The extent of cognitive impairment, as well as more realistic perceptions of events, were the most common types of cognitive changes identified by co-researchers in relation to their experience of abandonment after having received DBT.

Shades of grey. Three co-researchers described a change in their ability to think dialectically, in that they no longer thought of things as just black or white when emotionally triggered by an abandonment experience, but rather were able consider alternative and subtler explanations. Two of these co-researchers made explicit reference to a shift away from black-and-white thinking in response to abandonment as a result of DBT, as shown by the subsequent quotes: "Being able to be, see the greys not black or white" (Nicole), and "And because the lack of black and white thinking, or the ability to look past all or nothing" (Tina). Sal made allusion to his shift towards less polar thinking:

> Yeah, there's an allowance and um, more of an acceptance that it's human nature to be a little bit selfish and that other people, yeah okay, just because you can't trust them absolutely with everything, it doesn't mean you can't trust them a little bit with many things.

Lessened perceived abandonment. Three of the four co-researchers stated that after receiving DBT they had an improved ability to distinguish between actual and perceived abandonment, thereby decreasing the number of events erroneously classified as actual abandonment. The following quote illustrates Nicole's improvement after receiving DBT in differentiating between the feeling of abandonment and the more objective actual abandonment:

> Because perceived abandonment or actual, you're able to make the distinction between what is perceived and what is not. And I think that's the biggest thing, is before abandonment was, it just had to be a feeling and I knew, or I thought I knew.

Sal simply mentioned a marked decrease in overall perception of abandonment after DBT: "More and more I'm leaning towards not perceiving it at all." Tina commented on a decreased frequency in perception of abandonment after DBT, but added that this may, in part, be attributable to a reduction in the threat level carried by abandonment: "There's less perceived threat of abandonment, but also less importance placed on it, that I know that even if he abandons me and, and it's over, um, I'm still breathing."

Improved trigger identification. Three of the four co-researchers noted an improved ability to identify the original stimulus that set their abandonment reaction in motion, thereby arresting progression towards the behavioural stage of the abandonment

reaction. This change was attributed by the co-researchers to their involvement in DBT. The following quote illustrates Nicole's trigger identification process:

> But with going through DBT, the emotions aren't as high. I know it for myself, I had an emotional jump this past week, where someone did press that button, [the abandonment trigger], and how I kinda looked at it: 'cause I went "holy shit, well I haven't been sleeping, and my eating hasn't been as well as it could have been, and I've started some treatment to deal with my brain damage, so my emotions were not as in control as they used to be". So all these protective covers I had ... were removed. So something small all of a sudden it jumps, and I looked at it and went "what the hell just happened here?" and then I started back-tracking.

Sal explained his improvement in trigger identification as a result of DBT. Consistent with his responses throughout our interview, he referred to the emotional, cognitive, and behavioural reactions to abandonment collectively as abandonment issues. The following quote demonstrates his recognition of his ability to foresee his abandonment issues:

> It's been two and a half years after I first started with DBT, I'm only starting to see the change, you know. I'm starting to bypass that whole abandonment issue phase, and I really mean I'm only just starting to. It means I recognize the abandonment issues before they start to happen. So it's like I anticipate them.

Barb spoke about how DBT counselling helped her to recognize inter-relational aspects that activate her emotional responses to abandonment , as exemplified in the subsequent quote: "With the counselling being able to see what is a good and not good relationship. Um, so being able to identify that that is triggering my behaviours and making me worse."

Behavioural Reactions Changed

All four co-researchers described a change in their behavioural reactions to abandonment after DBT. Their descriptions of these behavioural changes relied heavily on the skills taught in DBT.

Improved self-care. Three co-researchers identified an improvement in their basic self-care as contributing to the positive change in their experience of abandonment after DBT. The following quotes illustrate the theme of improved self-care and the perceived relationship with emotional regulation and their response to abandonment: "It took nine months of fighting with my counsellor before I started eating, before I realized that food helped regulate my emotions, and sleep in moderation regulated my emotions" (Nicole),

> You always have to make sure that you're healthy, you know like eating and sleeping and exercising. And after that, as long as you make sure that you're healthy then you're in a mindset that you're actually able to deal with problems and able to learn skills and apply them. (Sal)

and

> Post-DBT, I can still function, I can still get up at eight o'clock and still shower and get dressed and go to work. And even though I'm thinking about it and I might be kinda snippy with people and a little bit short, I can function and get through the day, whereas before DBT I wasn't getting out of bed. (Tina)

Improved coping skills. All four co-researchers described DBT skills that help them regulate their emotions and thereby decrease the adverse effects of their experience of abandonment.

Check the facts. Each of the four co-researchers stated that they regularly use the DBT skill of checking the facts to regulate their experience of abandonment. This skill was described by the co-researchers as consisting of reality-testing and thought-challenging techniques. In the following quote Nicole describes her process of checking the facts when triggered by abandonment:

> Now it's, there's that feeling, but I'm able to pull back and look at this and go "is this actually abandonment, is it not?" And then if it is abandonment, realize not everybody in the world has to like me, not everybody in the world has to care about me, not everybody in the world has to love me. Alright, I have people that do.

The following two co-researchers, although employing different terminology, succinctly described the checking-the-facts technique which they employ to prevent the progression of their reaction to a perceived or actual abandonment: "Doing kinda like a cost-benefit analysis on my behaviours and my perspectives" (Sal), and "I'm able to re-direct or challenge my mind" (Barb). Tina described the questions she asks to check the facts, in a similar manner to Nicole: "For me it's just the facts: "Am I actually being, is he actually going somewhere? Is he actually not gonna talk to me anymore? Is this relationship actually over? No. He just didn't answer his phone."

Mindfulness skills. Three co-researchers described their use of mindfulness to mitigate their experience of abandonment. Mindfulness, as described by the co-researchers, includes a focus on the present rather than on abandonment experiences from the past or possible outcomes in the future. Two of these co-researchers succinctly described mindfulness in response to questioning regarding what strategies they employ

to regulate their abandonment reaction: “Being able to be present in the moment” (Nicole), and “I use a lot of mindfulness just to get into, like to really be present and not, um, you can’t worry about the past, you’re not a fortune teller, don’t know what’s gonna happen” (Tina). Barb went so far as to describe the mindfulness techniques she has found most useful for her:

> So like listening to Bach is mindful. Playing Bach is mindful, listening to Bach is mindful. Reading…I used an example in DBT that I was teaching on Friday, um…that just reading Bach’s music is enough for me and how I know that’s a very odd thing, but for me it’s what works.

DBT Counsellor’s Attributes

Once the co-researchers had clearly characterized whether DBT had changed their experiences of abandonment and explained how it had done so, they were asked to identify the most beneficial aspect of DBT compared to other therapies they might have received. All four co-researchers attributed their successful experience with DBT to specific attributes possessed by their DBT counsellor.

Understanding. Two co-researchers shared that they felt understood for the first time by their DBT counsellor, as illustrated by the following quotes: “Being able to have someone that I could talk to, that understood the diagnosis, and understood who I was” (Nicole), and “I’ve never felt that any other therapist or any other instructor, facilitator understands me the way [DBT therapist] does” (Tina).

Non-judgemental. Two co-researchers felt that their DBT counsellor took a non-judgemental approach that allowed for the previously discussed sense of being

understood by their DBT counsellor: "... didn't judge me based on borderline" (Nicole), and "... not judged but completely understood" (Tina).

Validating. Three co-researchers identified validation as an important DBT counsellor attribute. Sal described the feedback he received from his DBT therapist as, "a healthy blend of criticism and encouragement." Barb described her experience of validation by her DBT counsellor, "So validating, um, but also validating without enabling. So like I said, when I go, I say oh my God, other..., you know, and she'll, and she says no this is really crappy ... like she's very authentic." Tina emphasized the importance of her DBT therapist's validation of her emotions as an essential factor in the success of her DBT therapy, "He was validating. He got me and we would, I would laugh and cry in one session and I would just feel so validated. So I really put it down to validation."

Empathic. Two co-researchers emphasized the important role of their DBT counsellor's ability to empathize with their experiences. The following interview excerpt is a recapitulation of the discussion that had continued after the interview had been ended and the voice recorder shut off. Upon the interviewer's request, Barb agreed to resume the interview: "[And would you say that the empathy that you identified before I pressed record again…is that a part of the validation?] Absolutely. [Okay] Um...empathy, validation." Tina simply stated the inherent empathic quality possessed by her DBT counsellor: "I always felt like he just, he was like an empath."

Relatable. Three of the four co-researchers described their DBT counsellor as someone that they saw as a real person with whom they felt they could relate and stand on common ground. In the next quote, Sal describes the ability to relate to one's

therapist, which he stated in response to questioning regarding what he viewed as requisites for his DBT counselling to have been successful:

> You have to have a good relationship with you therapist. And that can, you know, that doesn't mean that your therapist doesn't tell you, doesn't kind of like, you know tell you, or doesn't criticize you. But it means you have a decent rapport. You know that you see eye to eye.

Barb also explained that her ability to relate to her DBT counsellor was a factor in the therapy's success, "You know I can relate to her. She can relate to me." Finally, Tina described how her ability to relate to her DBT counsellor might have contributed to her feeling understood and thus validated:

> Maybe because he was close to my age, and he was cute, he was married but he was, he was just goofy and he just ... He was a social work, he was an MSW, and I just felt like he got me.

Summary

Analysis of interview transcripts using the existential phenomenological method yielded two primary categories of themes: Before DBT and After DBT. Themes within each of these categories consisted of emotional, cognitive, and behavioural reactions to actual or perceived abandonment, with a fourth independent theme in each category: Interpersonal Relationships within the Before DBT category and Counsellor Attributes in the After DBT category. The identified themes indicate a decrease in the intensity of emotions within the abandonment experience after DBT, as well as a decrease in cognitive distortions and a shift in behavioural reactions. In the following chapter, these results will be discussed in relation to the theories presented in chapter 2.

CHAPTER 5 – DISCUSSION AND RECOMMENDATIONS

Frantic avoidance of abandonment, real or perceived, is one of the nine criteria used for diagnosing BPD (APA, 2013a). The experience of abandonment and the associated fear of its reoccurrence are certainly not limited to IDBPDs, however. What is important about the relationship between abandonment and the borderline personality is the degree to which the abandonment experience becomes debilitating for IDBPDs.

The objective of this study was to determine whether IDBPDs' perception and experience of actual or perceived abandonment is altered after having received DBT. In particular, IDBPDs' accounts of how they manage the abandonment experience was explored and contrasted in the pre- and post-DBT contexts.

During two separate sessions, biographical information and detailed experiences of abandonment were collected from each of the four co-researchers. By choosing to adhere to the existential phenomenological method during data collection and analysis, the greatest effort was made to preserve the meaning conferred to the experience by co-researchers. The aforementioned objective and approach were deemed essential to ensure that a much-needed insider's perspective of BPD and the central abandonment experience be provided to practitioners and the research community with the aim of improving the quality of treatment provided to IDBPDs and decreasing some of the stigma associated with this personality disorder.

Major Findings

Analysis of the co-researchers' interview transcripts demonstrated that these IDBPDs are, as expected, affected by abandonment, whether actual or perceived, and that there is indeed a common experience of abandonment among them, which differs from

the normative experience. Co-researchers' descriptions of their experience of abandonment revealed that abandonment, or the fear thereof, triggers most other symptoms of BPD. The delineation of two distinct categories, before DBT and after DBT, each containing different themes and sub-themes, indicates that the way each of these co-researchers experience abandonment is different after receiving DBT compared to before.

The Co-Researchers do Perceive Themselves as Affected by Abandonment

Each co-researcher described experiences that they perceived as abandonment within their lifetime and stated that they were affected by them. This finding verifies the conditions for this study, namely that the phenomenon of abandonment is available to be studied.

According to the DSM-5 (APA, 2013a), only five of the nine criteria need to be satisfied for an individual to receive the diagnosis of BPD, and no stipulation is made that one of these five must be "frantic efforts to avoid real or imagined abandonment" (p. 663). Given that the position of the current study is that the fear of abandonment is at the centre of BPD symptomology, the finding that all four co-researchers identified themselves as affected by abandonment provides initial support to the importance of this criterion. It bears noting that the methods of recruitment (e.g., the wording of the recruitment poster) may have predisposed individuals identifying themselves as affected by abandonment to offer their participation in the study. This point will be discussed further in the section pertaining to the potential limitations of this study.

There is a Common Experience of Abandonment among the Co-Researchers

The results indicate that the co-researchers share a common experience of abandonment which may differ from the normative experience. In addition, this common experience, as described by the co-researchers, appears to be rooted in the childhood experience of parental invalidation, which was perceived as the original abandonment experience.

Re-experiencing the abandonment in adulthood. Analysis of co-researchers' descriptions of their experience of abandonment in adulthood yielded three groups of themes, categorized as reactions to the experience of abandonment. Each co-researcher spoke of emotional, cognitive, and behavioural reactions to abandonment.

The co-researchers' descriptions of their adult experiences of abandonment paralleled their descriptions of their earliest experiences of abandonment. This finding supports O'Boyle's (2002) finding that the abandonment experienced by the adult IDBPD is viewed through the lens of past abandonment experiences. Perhaps because of this cumulative reinforcement of the abandonment experience, combined with the IDBPD's emotional dysregulation, the degree to which the emotions commonly elicited by a perceived or actual abandonment is more extreme than it would be for an individual without BPD. The variety of emotional reactions described by IDBPDs in the current study is greater than those described for the normative experience by Zipris (1982) or Ott (1988), but bears less difference from those described by Anderson (2000), as depicted in Table 5.1. It should be noted that Anderson's description, which is addressed to the general population, does not provide within-text citation of peer-reviewed research, nor does it specify whether the emotional reactions described are more commonly

Table 5.1

Comparison of Emotional, Cognitive, and Behavioural Reactions to Abandonment for Normative versus Borderline Populations

	Normative			**Borderline**	
	Zipris (1982)	Ott (1988)	Anderson (2000)	O'Boyle (2002)	Current Results
Emotional					
Fear / Anxiety		**X**	**X**		**X**
Anger		**X**	**X**		**X**
Grief / Sadness		**X**			**X**
Hopelessness			**X**		**X**
Dependence			**X**		**X**
Shame / Guilt			**X**	**X**	**X**
Chronic Emptiness					**X**
Dysregulation					**X**
Desperation					**X**
Cognitive					
Disorientation	**X**	**X**			
Denial		**X**			
Suicidal ideation			**X**		**X**
Dissociation				**X**	
Obsession					**X**
Black/white thinking					**X**
Low self-worth			**X**[a]	**X**	**X**
Impaired reality testing					**X**
Behavioural					
Self-harm			**X**[a]	**X**	**X**
Isolating/avoidance					**X**
Suicidality					**X**
Substance abuse					**X**
Fight-or-flight response					**X**
Hurting others			**X**[a]		**X**

Note. [a] Anderson (2000) identifies these reactions as occurring if the individual fails to progress through the stages of healing from abandonment.

experienced in a population with a history of mental health issues or a normative population.

The only cognitive reactions that appear to be common between the normative population's and borderline population's experience of abandonment are suicidal ideation and diminished self-worth. With regard to suicidal ideation, Anderson (2000), made reference to the possibility of this cognitive reaction within the normative experience of abandonment, and one of the co-researchers within the current study mentioned it directly, while the others referred to suicidality, the precursor of which would logically be suicidal ideation. Anderson also mentioned diminished self-worth as a possible cognitive reaction to abandonment, but only if the individual failed to process their emotions in a "healthy manner." Arguably this reaction would thus not be considered normative.

The cognitive divergence between the normative (Anderson, 2000; Ott, 1988; Zipris, 1982) and borderline experience of abandonment, as described by the co-researchers in this study, could be attributable to two major differences between the populations. Cognitive distortions are prevalent among BPD symptoms, thereby differentiating the borderline population at baseline levels (APA, 2013a). In fact, according to Beck et al. (2001), different sets of cognitive distortions characterize the different personality disorders. In their research verifying the stability of maladaptive schemas held by IDBPDs, Arntz, Dietzel, and Dreessen (1999) confirmed the persistence of said schemas, as well as their role as mediators between childhood experiences of trauma and the manifestation of other BPD symptoms.

The link between emotions and cognitions has been proposed in theory (Beck, 1964; Ledoux, 1989) and supported in neuroimaging research findings (Gray, 1990; Ochsner et al., 2004). The chronological sequence of emotions prompting cognitions or vice versa is controversial (Leventhal & Scherer, 1987), however, and beyond the scope of this thesis. For the purposes of this discussion, it is arguable that the borderline population, with characteristically more dysregulated emotions, would also have more dysregulated and distorted cognitions, perhaps as a way to rationalize emotions that cannot be processed and/or understood.

The inability to name or adequately communicate emotions is known as alexithymia (Nemiah & Sifneos, 1970). In a study of the relationship between alexithymia and interpersonal dysfunction, Nicolò et al. (2011) observed that alexithymia was highly correlated with a need for social approval. In their study of 79 BPD patients, New et al. (2012) also found a strong association between alexithymia and interpersonal dysfunction, namely an impaired ability to correctly identify others' feelings or consider another person's perspective. Some researchers have gone so far as to suggest that alexithymia is an important intermediary between an insecure attachment style and borderline symptoms in adolescence (Deborde et al., 2012). Compensation for the inability to understand one's own emotional experience or accurately assume another's perspective could take the form of distorted cognitions.

As previously mentioned, cognitive theorists have argued for the specificity and stability of cognitions among IDBPDs (Arntz et al., 1999; Jovev & Jackson, 2004). While researching the stability of maladaptive schemas among IDBPDs, Arntz, Dietzel, and Dreessen (1999) also provided additional support for the validity of the Personality

Disorder Beliefs Questionnaire (PDBQ, Dreessen & Arntz, 1995), which contains a set of 20 assumptions considered characteristic of cognitive distortions held by IDBPDs. Of these 20 assumptions, several support the cognitive themes identified in the current study as reactions to abandonment. For example, items 1, 2, 9, and 11 echo the statements made by co-researchers that were categorized in the sub-theme of black-and-white thinking:

> (1) I will always be alone. (2) There is no one who really cares about me, who will be available to help me, and whom I can fall back on.... (9) I need to have complete control of my feelings otherwise things go completely wrong.... (11) If someone fails to keep a promise, that person can no longer be trusted. (Arntz et al., 1999, p. 555)

According to cognitive theory, cognitive schemas are the necessary antecedents and determinants of maladaptive behaviour and emotional dysfunction in individuals with personality disorders (Beck & Freeman, 1990; Beck, Rush, Shaw, & Emery, 1979). The IDBPDs within the current study described similar behavioural reactions to their cognitive distortions and dysregulated emotions within their experience of abandonment. This behavioural component of the co-researchers' abandonment experience differed once again from the normative experience as described by Zipris (1982) and Ott (1988) in that their descriptions of the normative abandonment experience did not contain behavioural reactions. Anderson's (2000) description of the normative experience of abandonment contained two behavioural reactions that were also present within this study's co-researchers' descriptions: self-harm and hurting others. Once again, as was the case with other commonalities with Anderson's (2000) description, these two

behavioural reactions were described with the caveat that they would only occur if the abandoned individual did not progress through the stages of abandonment recovery in a healthy manner, ergo, in a non-normative manner. The only behavioural reaction mentioned in O'Boyle's (2002) study of borderline women's experience of abandonment was self-harm.

Parental invalidation described as abandonment. The analysis of interview transcripts revealed a theme of interpersonal difficulties relevant to each co-researcher's description of the experience of abandonment. Their descriptions of their first abandonment experience were contextualized within familial interactions that occurred in childhood. In terms of whom they felt abandoned by, the themes of family or significant others emerged as well. Germane to their experience of abandonment were themes of parental invalidation, a negative relationship with either their mother or father or both parents, and sibling rivalry. These findings support biosocial theory, which requires the presence of an invalidating environment for the development of BPD (Linehan, 1993a). Verification of whether the invalidating childhood environments described by the co-researchers existed during infancy in the form of guilt or anxiety-inducing maternal behaviours, as described by Mahler (1986), was not possible due to the co-researchers' understandable inability to remember events from infancy. Research has indicated that individuals can only retrieve memories from the age of 2 years at the earliest (Nelson, 1993). It is plausible, however, that the parental invalidation described by the co-researchers was, in fact, a perpetuation of the conditions experienced during infancy. If this is the case, then these findings could also support attachment theory's argument for

the development of insecure attachment and of BPD (Bowlby, 1988; Levy, 2005; Mahler, 1986; Mahler et al., 1970).

A chronological sequence in the development of the sense of abandonment is revealed by the described experience, as depicted in Figure 5.1, with parental invalidation as the source. The expressed emotion, be it due to hypersensitivity, as per biosocial theory (Linehan, 1993a), or an insecure attachment style, as per attachment theory (Mikulincer & Florian, 1998), elicited a negative response from one or both parents. According to the co-researchers' descriptions, the repeated occurrence of this negative parental response to the co-researchers' expression of self resulted in an increasingly negative relationship with the invalidating parent. Interestingly, this also yielded negative relationships with siblings due perhaps to co-researchers' perceptions of preferential treatment of siblings by parents, as evidenced by thematic examples provided in Chapter 4. Experiencing these negative relationships with family members, co-researchers were left with a sense of not belonging. This feeling of displacement within what should be the foundational network for future relationships may have contributed to problematic adult relationships, as suggested by developmental theorists (Carlson & Sroufe, 1995; Elicker, Englund, & Sroufe, 1992).

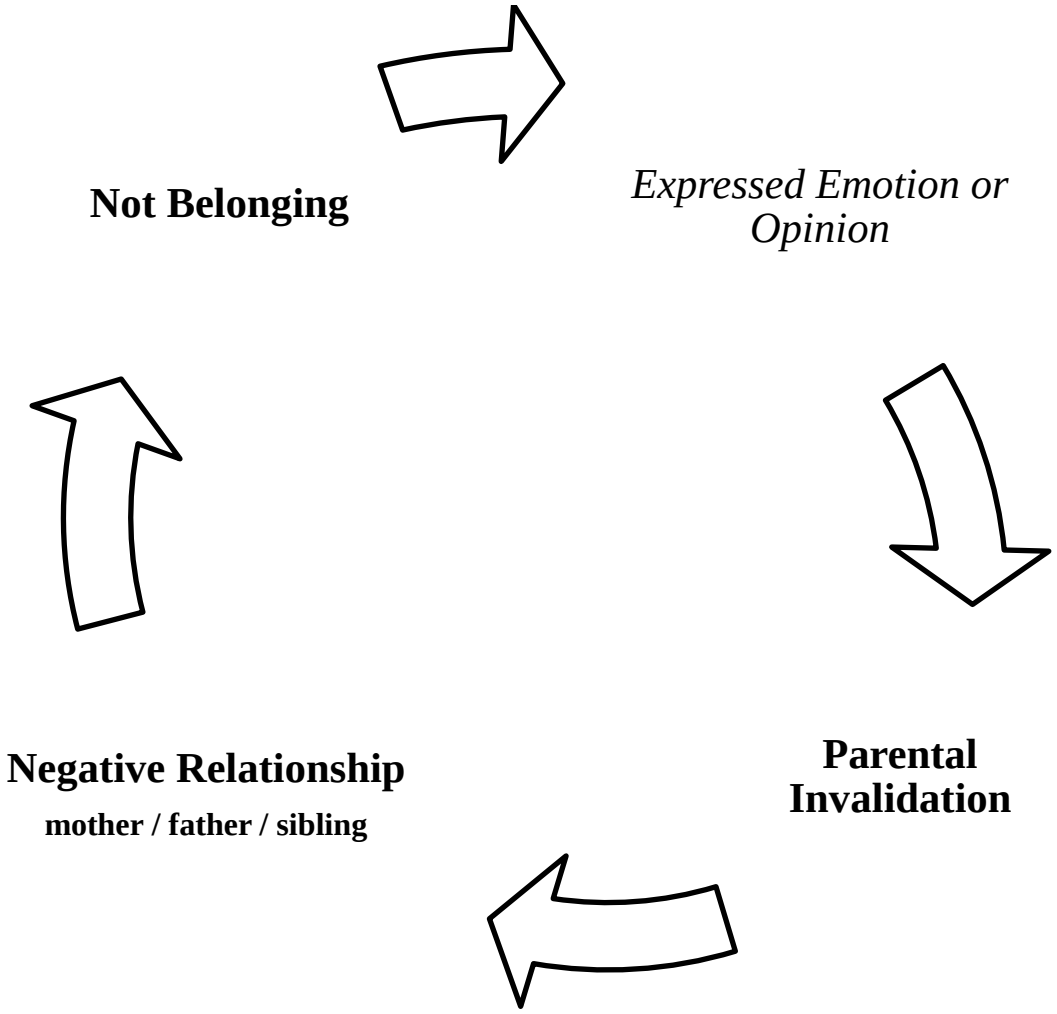

Figure 5.1. Depiction of described sequence of sub-themes within the common theme of familial difficulties, identified as germane to the common experience of abandonment. Sub-themes are in bold typeface, while the factor instigating parental invalidation, the expression of emotion or opinion by the IDBPD, is in italics.

Abandonment is Related to the Other Symptoms of BPD

In their discussion of the relationship between the fear of abandonment and the other *DSM-5* (APA, 2013a) criteria for BPD, Gunderson and Links (2008) refer to aloneness as an experience of abandonment:

> Aloneness is experienced as a terrifying loss of self (Criterion 3) that the person with BPD may defend against by action (Criterion 2) or by distorting reality (Criterion 9). Aloneness can also be diminished either by the use of transitional objects ... or by another person's providing reassuring evidence that he or she cares for the person with BPD. (p. 18)

As previously stated, certain researchers and theorists consider abandonment issues to be at the root of the manifestation of BPD (Levy, 2005; Masterson, 2013; Shemmings & Shemmings, 2011; Vardy, 2011). The results of the current study not only provide tentative support for this position, but also help illustrate the relationship between the fear of abandonment and the other symptoms of BPD. The relationships between these reactions and the equivalent BPD symptoms are depicted in Figure 5.2. Emotional reactions to perceived or actual abandonment included feelings of hopelessness, anxiety, desperation, and sadness. Co-researchers also described feelings of self-blame, dependency, and pronounced fear of both the abandonment itself and of destruction. The co-researchers characterized their emotional reactions as dysregulated.

The cognitive reactions within the co-researchers' overall experience of reacting to abandonment were described as resulting from the emotional reaction to abandonment. Thoughts of diminished self-worth were stated as the result of feelings of self-blame and dependency. Impairments in their cognitive processes were attributed to the intensity of

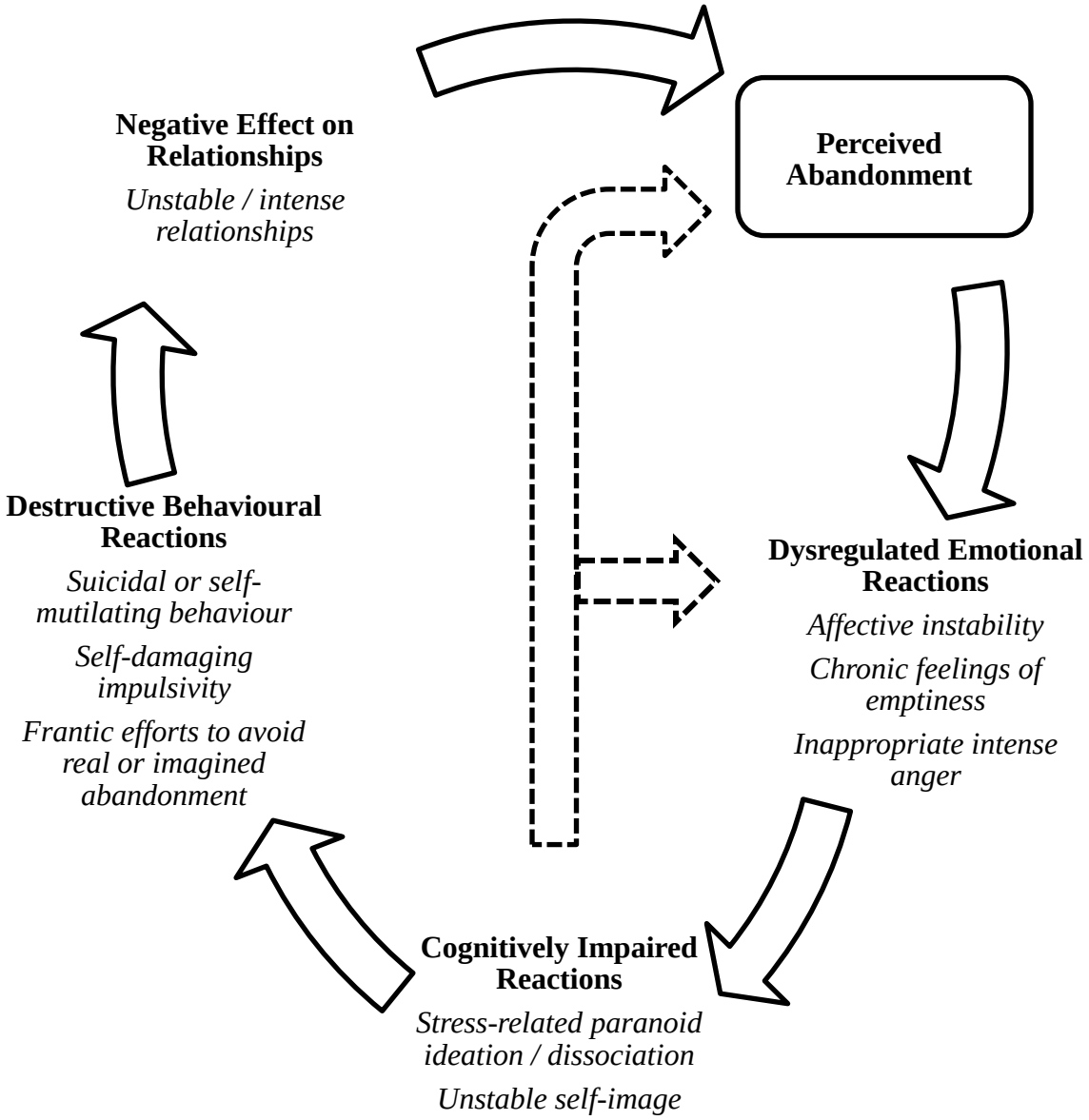

Figure 5.2. Relationships between described reactions to perceived abandonment with equivalent BPD symptoms in italics.

the emotions experienced by co-researchers reacting to abandonment, perceived or actual. The cognitive impairments identified as themes included impaired reality testing, black-and-white thinking, and obsessing. Co-researchers added that their cognitive reactions usually intensified their emotional reactions and increased their tendency to perceive abandonment, as depicted in the feedback loop in Figure 5.2.

The behavioural reactions identified as themes from the co-researchers' accounts of their experience of abandonment were described as ways of managing the cognitive and emotional reactions to perceived or actual abandonment. Each of the behavioural reaction sub-themes identified correlates with the standard diagnostic criteria for BPD, as illustrated in Figure 5.2. These behavioural sub-themes consisted of self-destructive behaviours, avoidance behaviours, and defensive behavioural patterns.

Regarding self-destructive behaviours, a number of studies have demonstrated a relationship between parasuicidal behaviour and the fear of abandonment. Rao (2000) reported that subjects' self-mutilating behaviour occurred in response to memories of rejection by a trusted and/or loved individual. Kashgarian (1999) reported a similar relationship between feelings of abandonment and parasuicidal behaviour, with hopelessness and emotional dysregulation as intermediaries.

Both theorists and research have proposed a link between suicidality and interpersonal triggers among IDBPDs (Brodsky, Groves, Oquendo, Mann, & Stanley, 2006), and suicidality and the fear of abandonment (Ledgerwood, 1999). Research has provided support for the increased risk of suicide after experiencing abandonment-related emotions and cognitions (Friedman, Glasser, Laufer, Laufer, & Wohl, 1972).

The sub-themes of avoidance behaviours, which the co-researchers described as behavioural reactions within the experience of abandonment, included avoiding conflict, avoiding abandonment, and isolating the self. The avoiding conflict sub-theme must be differentiated here from the defensive pattern sub-theme of hurting others. Co-researchers explained that they avoided conflict when they sensed that hostility and anger were directed towards them, which could theoretically have been perceived as a rejection or precursor of abandonment. The identification of the avoiding abandonment sub-theme confirms the first BPD diagnostic criteria, "Frantic efforts to avoid real or imagined abandonment" (APA, 2013a, p. 663).

Finally, the isolating sub-theme was presented as a method to prevent any further negative stimulation by potentially rejecting/abandoning individuals. In a study of fear, anxiety, and social isolation in normative individuals, Sarnoff and Zimbardo (1961) found that as anxiety increased, so did participants' desire to socially isolate. It is thus additionally plausible that isolating was the co-researchers' reaction to the anxiety evoked by the abandonment experience.

The sub-themes of defensive behavioural patterns, which co-researchers described as reactions to defend against perceived or actual abandonment, included hurting others and the fight-or-flight response. The sub-theme, hurting others, was described by the co-researchers as a pre-emptive defense mechanism in response to a perceived threat of abandonment. This identified sub-theme supports previous findings regarding IDBPDs' aggressive responses to a perceived threat, particularly in the context of relationship anxiety (Critchfield, Levy, Clarkin, & Kernberg, 2008). This sub-theme also reflects two of the diagnostic criteria for BPD, namely Criterion 2, "A pattern of unstable and intense

interpersonal relationships characterized by alternating between extremes of idealization and devaluation" (APA, 2013a, p. 663), in which hurting others represents the devaluation of the potential abandoner, and Criterion 8, "Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)" (APA, 2013a, p. 663), for which hurting others is the behavioural manifestation of dysregulated anger in response to perceived or actual abandonment. Gunderson and Links (2008) explain the relationship between the fear of abandonment and hurting others or even the self in the following: "Now, prompted by fears of abandonment, the angry devaluation or the self-injurious behaviors become apparent, often with unexpected suddenness and intensity" (p. 20).

The second identified sub-theme of defensive behavioural patterns is what co-researchers labelled the fight-or-flight response. As previously stated, subtle interpersonal triggers can be perceived by the IDBPD as abandonment or rejection and initiate intense feelings of anxiety, overwhelming sadness, and self-loathing (Sadikaj et al., 2010). Within their description of their fight-or-flight response, co-researchers expressed an internal conflict between the urge to hurt the other and the urge to engage in avoidance behaviour. This internal conflict resulted in a sense of being frozen in non-action. It can be argued that this fight-or-flight response is a reaction to the overwhelming anxiety prompted by the threat of actual or perceived abandonment. This argument is supported by findings of hyperactivity in IDBPDs' amygdala, the brain structure responsible for the fight-or-flight response (Donegan et al., 2003). Hypometabolic activity has also been found in the prefrontal cortex of borderline patients, in tandem with hyperactivity of the amygdala (Juengling et al. 2003; Schmahl &

Bremner, 2006). This is of significance in the current discussion due to the collaborative role of these two structures in guiding intentional behaviour (Bechara, Damasio, & Damasio, 2000; Ghashghaei, Hilgetag, & Barbas, 2007). When confronted with a perceived or actual threat of abandonment, the IDBPD's anxiety levels rise due to the over-reactive amygdala, the amygdala sets off the fight-or-flight response, but the underactive prefrontal cortex may block the individual from engaging in the decision-making process necessary to pursue action, thus the sense of being frozen in inaction.

The Experience of Abandonment Changes after DBT

Each of the four co-researchers confirmed that their experience of abandonment, real or perceived, changed after they received DBT. Co-researchers identified five DBT counsellor attributes that enabled their engagement in DBT, namely understanding, non-judgemental, validating, empathic, and relatable. The co-researchers consistently described changes in their experience of abandonment post-DBT in all three major pre-DBT themes: emotional, cognitive, and behavioural, as illustrated in an overall decrease in post-DBT symptom severity on the ZAN-BPD (Appendix H). The post-DBT sub-themes consisted almost exclusively of DBT skills, with the exception of sub-themes within the emotional theme. The feelings elicited by a perceived or actual abandonment remained the same post-DBT, but the co-researchers' ability to regulate the emotional experience improved. The process by which this improved emotional regulation occurred is illustrated in Figure 5.3.

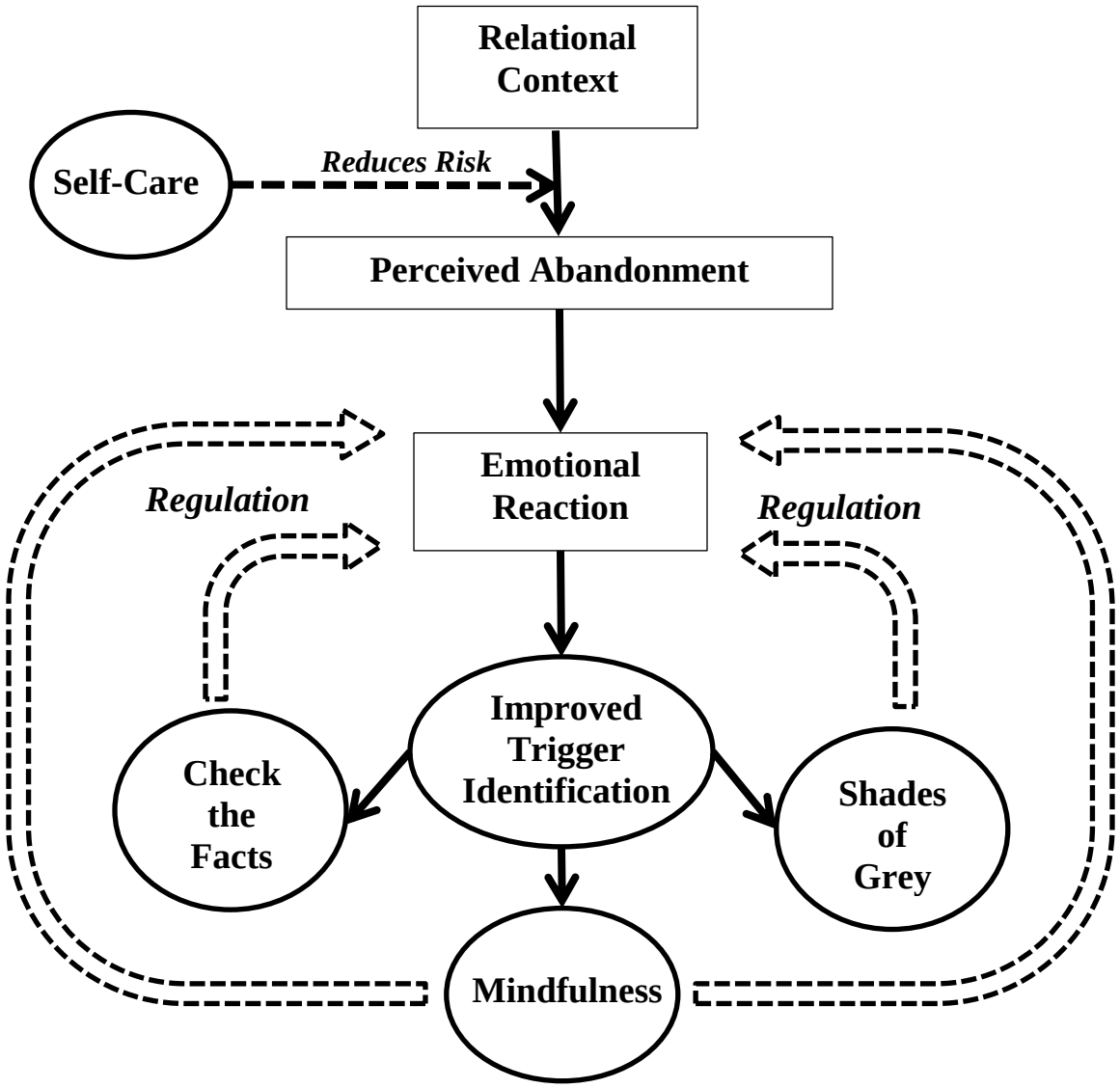

Figure 5.3. Illustration of the process by which the emotional experience of perceived or actual abandonment is regulated using DBT skills, labelled with the themes and sub-themes identified from co-researchers' descriptions.

The co-researchers' improved ability to regulate their emotions had the effect of reducing the intensity and duration of their emotional experience. Whereas the before-DBT experience of abandonment appeared to be a top-down process, moving from the general experience of emotions to the activation of specific BPD symptomology, the post-DBT experience of abandonment appeared to be driven by a different process. As previously stated, the co-researchers stated that feelings were still triggered by a perceived or actual abandonment but intentional cognitive and behavioural activation intercepted the emotional denouement (Figure 5.3), thereby altering the experience of abandonment both in their occurrence and in their effect on the emotional reaction. This finding supports the DBT tenet that dysregulated emotions are fundamental in the activation of dysfunctional behaviour in BPD (Linehan, 1993a).

The co-researchers explained that after completing DBT, they experienced fewer cognitive distortions in their experience of abandonment. They stated that they were able to think in shades of grey rather than their previous black-and-white thinking style. The co-researchers also stated that, as a result of having undergone DBT, they actually tended to perceive abandonment less frequently than before. Finally, the co-researchers identified an improved ability to identify emotional triggers through cognitive appraisal of the situation, thereby enabling rational regulation of their emotional experience.

The co-researchers stated that the behaviours triggered by the experience of abandonment, real or perceived, changed after having received DBT. The behaviours the co-researchers described consisted of DBT skills used to reduce cognitive distortions and regulate emotions. The co-researchers explained that a general improvement in self-care helped them maintain a higher level of functioning than before, which facilitated their

application of positive coping skills. The coping skills most frequently cited by the co-researchers were: check the facts and mindfulness.

These findings indicate that, when the emotion regulation skills taught in DBT are applied, the IDBPDs can, by their own account, regulate their emotions. Research has verified the neural correlates of the use of cognitive reappraisal or psychological distancing (emotion regulation methods used in cognitive therapy) by IDBPDs when presented with negative social cues. It has provided some support for alteration in cortical and limbic structures, although IDBPDs still demonstrated markedly higher emotional reactivity and cognitive impairment compared to healthy controls (Koenigsberg et al., 2009; Schulze et al., 2011). Schnell and Herpertz (2007) researched the effects of DBT on the neural correlates of emotional dysregulation in subjects with BPD presented with negative images, administering five fMRI scans over the course of a 12-week DBT program. Results indicated change in the IDBPDs' scans, but not in controls, in various brain structures involved in the appraisal of emotional significance and in the use of cognitive strategies to regulate emotions. Unfortunately, the researchers did not report what particular skills their borderline participants were employing when viewing the negative images and being scanned.

DBT Counsellor Attributes that Facilitated DBT Effectiveness

The co-researchers unilaterally agreed that it was their respective DBT counsellor's personal attributes that helped them most in DBT. The positive attributes accredited to their DBT counsellor were contextualized in the co-researchers' qualification of a validating relationship in which they felt supported. The attributes of understanding, non-judgemental, validating, empathic, and relatable, are therapist

characteristics identified as necessary for the practice of DBT (Linehan, 1993a), and the conditions necessary for the formation and maintenance of a therapeutic alliance (Duff & Bedi, 2010; Martins, Garske, & Davis, 2000; Rogers, 1992). Duff and Bedi (2010) define the therapeutic alliance as follows: "The client and counsellor's subjective experience of working together towards psychotherapeutic goals in the counselling context, including the experience of an interpersonal bond that develops while engaged in this endeavour" (p. 91). The quality of the therapeutic alliance has been found to be of predictive importance for clients' perceptions of treatment outcome, regardless of the type of therapy employed (Horvath & Symonds, 1991).

This begs the question whether it is the co-researchers' perceptions of DBT counsellor attributes or the skills learned in DBT that are more important in contributing to the change in the co-researchers' experience of abandonment. The co-researchers' descriptions of counsellor traits all seem to lead to the co-researchers' sense of being validated by their counsellor. Linehan et al. (2002) compared the effectiveness of DBT and validation therapy (which included 12-step therapy) in treating women with the comorbid diagnosis of substance dependence and BPD. DBT, which included both DBT skills and validation) was found to be more effective overall than validation therapy in reducing opioid dependence long-term. The inclusion of 12-step therapy in the validation therapy protocol may have confounded the results, however.

Linehan (1997) contended that validation alone cannot effect change. She highlighted the importance of a balance between validation of the IDBPD's insights and emotional experience on the one hand, and a focus on goal-oriented change on the other hand (Linehan, 1993a, 1997). It is plausible that, while the co-researchers attributed their

therapeutic success to their counsellors' non-judgemental, understanding, and validating traits, that these various aspects were in fact part of the validation described by Linehan (1993a, 1997) that goes beyond being a counsellor trait to being an important type of balanced DBT intervention (McMain, Korman, & Dimeff, 2001).

Theoretically, the validation component of DBT serves to undo the maladaptive schemas fostered by the invalidating childhood environment (Linehan, 1993a, 1997; McMain, Korman, & Dimeff, 2001). If, as proposed earlier in the discussion, the co-researchers considered parental invalidation as the basis for their understanding of abandonment, and the emotional point of reference for future abandonment experiences, then it appears that the validation intervention used in DBT does, if indirectly, address the issue of abandonment, while the DBT skills assist in the regulation of emotions so that further potential reinforcement of abandonment-related schema and self-devaluing behaviours do not occur.

Limitations of the Study

The current study is limited by recruitment choices, decisions in methodology, and personal bias. Choices made in the recruitment of co-researchers limited the number of possible co-researchers as well as the potential for a representative sample. The number of potential co-researchers was already limited due to the high investment of time demanded by the chosen methodology and the imposed time limitation for the completion of a Master's degree. The number of potential co-researchers was further limited due to the highly specific participation requirements, namely a diagnosis of BPD and completion of DBT skills training. A further limitation was the recruitment of co-researchers only within Calgary, Alberta, because of the decision to conduct interviews in

person and the cost of travel to other locations. As is true of all qualitative research, the findings cannot be generalized to IDBPDs other than the co-researchers involved in the current study. The recruitment methods used for this study presented abandonment as the primary topic of interest. Recruitment may have thus been biased towards IDBPDs identifying with the topic of abandonment, thereby neglecting to account for the potential proportion of the borderline population that does not identify with abandonment.

This study attempted to make comparisons between the co-researchers' experiences of abandonment and the normative experience of abandonment. These conclusions were limited by the different methodologies and definitions of abandonment used in the research literature about normative experience. This study did not make any attempt to compare the co-researchers' experience of abandonment to other clinical populations' descriptions (e.g., individuals diagnosed with depression who have received DBT).

A considerable effort was made to reduce personal bias during interviews and in the analysis of transcripts. Elimination of all bias was not possible, however, and it is possible that my unintentional non-verbal cues during interviews may have influenced co-researchers' responses. It is also possible that, since 2 of the 5 co-researchers received DBT at the same location that I had (although over different periods of time and with different therapist) that the bias of that DBT program may have been introduced. This is unlikely, however, since I reviewed the themes and sub-themes identified from co-researchers' transcripts and did not find a program-specific pattern.

A final limitation of this study is the reliance on co-researchers' ability to recall and accurately describe their experience of abandonment prior to DBT. Neuroimaging

research conducted by Kensinger and Schacter (2005) revealed that accurate retrieval of emotional salient memories involve different brain structures than neutral memories. Specifically, the researchers found that emotionally salient memories are processed via the limbic system, the same are that exhibits dysfunction in IDBPDs (Schmahl & Bremner, 2006). It is possible that since the interviews only took place post-DBT that the co-researchers' recollections of pre-DBT experiences may have been skewed.

Recommendations

Implications for Future Research

As noted in the limitations of this study, additional research is needed to compare IDBPDs' descriptions of abandonment to both non-clinical and clinical populations with another diagnosis using consistent methodology. These comparisons would not only increase general knowledge of the experience of abandonment but potentially help to further differentiate the IDBPD's experience of abandonment from, for example, abandonment depression, which was originally described by Masterson (1976).

Longitudinal research of IDBPDs' experience of abandonment would be valuable. The acquisition of accounts prior to engagement in a DBT program and after completion of the DBT program would reduce the risk of distorted memories. Ethical issues could be potentially delicate, however, given the current study's findings regarding the emotional dysregulation and self-destructive behaviours triggered by abandonment prior to DBT.

Research involving a greater number of participants is required to determine the generalizability of the current study's findings. Gender differences in the experience of abandonment were not noted in the current study, although the sample only included one male. Ideally a greater number of males would be included in future research. In

addition, it would be interesting to discover whether cultural differences exist in IDBPDs' experience of abandonment, given that there has been much debate about whether the presentation of BPD symptoms is culture-dependent (Castaneda & Franco, 1985; Yang et al., 2000), and that abandonment may be a culturally-dependent construct.

Finally, research comparing the importance of DBT skills versus validating interventions in DBT in the resolution of IDBPDs' abandonment issues would help to clarify exactly which therapeutic process targets the fear of abandonment. A study design in which four participant groups (DBT skills alone, validation interventions alone, DBT skills with validation, and no treatment) are compared based on their experience of abandonment pre- and post-intervention would provide useful information to DBT practitioners.

Implications for Counselling Practice

The effectiveness of DBT in the treatment of BPD has been supported by a fair amount of research (Bohus et al., 2004; Clarkin et al., 2007; Koons et al., 2001; Linehan et al., 1999; Linehan et al., 2006; Robins & Chapman, 2004; van den Bosch et al., 2005; Verheul et al., 2003). DBT does not, however, directly address the issue of abandonment, but instead addresses emotion dysregulation. Given the importance of the experience of abandonment in IDBPDs' symptomology (Brodsky et al., 2006; Friedman et al., 1972; Gunderson & Links, 2008; Ledgerwood, 1999; Levy, 2005; Masterson, 2013; Sadikaj et al., 2010; Shemmings & Shemmings, 2011), it is something that should be more directly addressed in counselling. The co-researchers within this study indicated two components of DBT that helped change their experience of abandonment: DBT skills and the validating interventions used by their DBT therapist. The teaching of DBT skills

takes place in all three modes of the therapy: group skills training, individual sessions, and emergency phone sessions (Linehan, 1993a). It should be noted that the group skills training mode of DBT is delivered by a different practitioner than the individual and emergency phone sessions (Koerner & Dimeff, 2007; Linehan, 1993a). The relationship built in individual sessions between the DBT therapist and BPD client appears to be of importance in addressing abandonment issues and is the medium through which validating interventions can be administered. Validation is already one of the two core strategies applied in DBT, along with problem solving, and includes emotional, cognitive, and behavioural validation strategies to facilitate change strategies (e.g., DBT skills; Linehan, 1993a). The effective application and balance of validation strategies with change strategies is delicate, however, as explained by Linehan (1993a):

> The secrets to effective use of validation are knowing when to use it and when not to, and once it is begun, when to cut it off. This can be a special problem when intense emotions are present or elicited.... The ability to shut off emotional expression and get to problem solving is important if progress is to be made.... Validation can be a brief comment or digression while working on other issues, or it can be the focus of an entire session. As with other DBT strategies, the use of these must be goal-oriented and purposeful. That is, they should be used when the immediate goal is to calm a patient who is too emotionally aroused to talk about anything else; to repair therapeutic errors; to develop the patient's skills in nonjudgmental self-observation and nonpejorative self-descriptions (e.g., to teach her self-validation); to learn about the patient's current experiences or experiences accompanying an event; or to provide a validating context for change. (p. 226)

The therapist's ability to model validation and negotiate the fine balance required between acceptance and change throughout a therapy session is thus imperative in DBT or in working with IDBPDs in general. Should counsellors wish to work with IDBPDs using an alternate form of therapy, specific training in the negotiating between validating and change oriented interventions should still be undertaken.

Researcher Reflexivity

"All my knowledge of the world… is gained from… experience of the world… To return to things themselves is to return to that world which precedes knowledge" (Merleau-Ponty, 1962, p. viii-ix).

The existential-phenomenological method applied in this study required my immersion in the co-researchers' described experiences (Merleau-Ponty, 1962). This immersion into descriptions of abandonment was at times extremely difficult for me to do since I was often reminded of my own painful experiences. In order to maintain an objective distance from the subject matter, I often had to re-examine my personal experiences and step away from the thesis work. The analysis and discussion of this study's subject matter thus occurred in a cyclical manner consisting of immersion, stepping away for self-reflection, and re-immersion. I was thus able to glean an insider's perspective of the experience of abandonment and the effect of DBT on that experience, without clouding that perspective with my own experiences. As a result, my view of DBT as existing almost exclusively within the cognitive domain of psychotherapy has been altered by my new understanding of the way in which it emphasizes the healing role of the therapist. This work has reinforced my belief in the importance of interpersonal

factors (e.g., mutual empathy) in repairing the rifts in an individual's personality caused by early experiences of abandonment.

Conclusions

The current study set out to gain an insider's perspective of how IDBPDs experience and manage abandonment before and after receiving DBT. According to this study's findings, the co-researchers' described experience of perceived or actual abandonment consisted of emotional, cognitive, and behavioural reactions which differed from the normative experience described in the literature and which also matched borderline symptomology. Adult abandonment experiences paralleled co-researchers' recollections of a childhood abandonment experience which was contextualized in parental invalidation. The co-researchers' descriptions of the memory of abandonment experienced prior to DBT were different from their descriptions of the experience of abandonment after receiving DBT. While DBT views BPD from a biosocial perspective (Linehan, 1993a), the issue of abandonment is primarily addressed by attachment theory (Bowlby, 1969; Gunderson, 1996; Masterson, 1972, 2013). Despite the fact that these two perspectives appear to be at odds with one another, the findings in the current research indicate that one of the core strategies of DBT, validation, may be addressing IDBPDs' abandonment issues, thereby altering their experience of abandonment.

It is difficult to make specific suggestions as to what changes should occur in the application of DBT to enable a greater change in IDBPDs' experience of abandonment, as more research is required in this area. It is possible that DBT's focus on current experiences may hamper resolution of abandonment-related conflicts originating in childhood experiences. It is also possible that later phases of DBT treatment, during

which the therapeutic bond between DBT counsellor and borderline client is strengthened and reinforced by validation over time, abandonment issues could surface and be resolved within the therapeutic relationship. The DBT therapist should thus remain conscious of how the therapeutic relationship can serve as a model from which the borderline patient can generalize their experience of relationships, and thus by extension, their experience of abandonment.

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APPENDIX A:

Suggested Revision to Diagnostic Criteria for Borderline Personality Disorder According to DSM-5 (2013a)

Borderline Personality Disorder

Typical features of borderline personality disorder are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domain of Negative Affectivity, and also Antagonism and/or Disinhibition.

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:

1. ***Identity:*** Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
2. ***Self-direction:*** Instability in goals, aspirations, values, or career plans.
3. ***Empathy:*** Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (e.g., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
4. ***Intimacy:*** Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between over involvement and withdrawal.

B. Four or more of the following seven pathological personality traits, a least one of which must be (5) Impulsivity, (6) Risk taking, or (7) Hostility:

1. ***Emotional liability*** (an aspect of **Negative Affectivity**): Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
2. ***Anxiousness*** (an aspect of **Negative Affectivity**): Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
3. ***Separation insecurity*** (an aspect of **Negative Affectivity**): Fears of rejection by – and/or separation from – significant others, associated with fears of excessive dependency and complete loss of autonomy.
4. ***Depressivity*** (an aspect of **Negative Affectivity**): Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feeling of inferior self-worth; thoughts of suicide and suicidal behavior.
5. ***Impulsivity*** (an aspect of **Disinhibition**): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.
6. ***Risk taking*** (an aspect of **Disinhibition**): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to

consequences; lack of concern for one's limitations and denial of the reality of personal danger.

7. ***Hostility*** (an aspect of **Antagonism**): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.

Specifiers. Trait and level of personality functioning specifiers may be used to record additional personality features that may be present in borderline personality disorder but are not required for the diagnosis. For example, traits of Psychoticism (e.g., cognitive and perceptual dysregulation) are not diagnostic criteria for borderline personality disorder (see Criterion B) but can be specified when appropriate. Furthermore, although moderate or greater impairment in personality functioning is required for the diagnosis of borderline personality disorder (Criterion A), the level of personality functioning can also be specified.

(APA, 2013a, p. 766-767)

APPENDIX B:

Four Categories of Common Disturbances in BPD

Four Categories of Common Disturbances in BPD (Friedel, 2004)

1. Poorly regulated emotions
    a. Mood swings and unstable emotions
    b. Anxiety
    c. Inappropriate intense anger or difficulty controlling anger
    d. Chronic feelings of emptiness
2. Impulsivity
    a. Impulsive self-harming behaviour
    b. Recurrent suicidal behaviour, gestures, threats, or self-mutilating behaviour
    c. Munchausen's syndrome
    d. Munchausen's by proxy
    e. Suicide
3. Impaired perception and reasoning
    a. Brief episodes of paranoid thinking
    b. Dissociative symptoms
    c. Magical thinking
    d. Depersonalization
    e. Unstable self-image or sense of self
4. Markedly disturbed relationships
    a. A pattern of unstable and intense personal relationships
    b. A black-and-white life
    c. Frantic efforts to avoid real or imagined abandonment

APPENDIX C:

List of DBT Skills

List of DBT Skills

- Wise mind
- Observe: just notice (Urge Surfing)
- Describe: put words on it
- Participate: enter into the experience
- Nonjudgmental stance
- One-mindfully: in-the-moment
- Effectiveness: focus on what works
- Objective effectiveness: DEAR MAN
- Relationship effectiveness: GIVE
- Self-respect effectiveness: FAST
- Reduce vulnerability: PLEASE
- Build mastery
- Build positive experiences
- Opposite –to-emotion action
- Distract
- Self-soothe
- Improve the moment
- Pros and cons
- Radical acceptance

Based on the skills presented in the *Skills Training Manual for Treating Borderline Personality Disorder* (Linehan, 1993b).

APPENDIX D:

Informed Consent Form

Name of Researcher, Faculty, Department, Telephone & Email:

Ms. Annemarie C. Rued, Faculty of Education, Educational Studies in Counselling Psychology, (403) 457-8193. arued@ucalgary.ca

Supervisor: Dr. Kevin G. Alderson, Educational Studies in Counselling Psychology, (403) 605-5234, alderson@ucalgary.ca

Title of Project:

The Experience of Abandonment Before and After Receiving Dialectical Behaviour Therapy.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study.

Purpose of the Study:

This study will examine how individuals diagnosed with borderline personality disorder perceive and manage abandonment issues. Specifically, the process of change in individuals' perceptions and management skills will be explored through their personal accounts of abandonment reactions before and after receiving dialectical behaviour therapy. The findings from this research will be used in Annemarie Rued's completion of a Master's thesis in Counselling Psychology. The results will also be used in writing an article for publication and for possible presentation at conferences.

The present study will focus on relating thoughts and experiences from an insider's perspective. You are thus invited to share your knowledge and expertise of this topic, thereby contributing to a greater and more accurate understanding of borderline personality disorder.

What Will I be Asked to Do?

You are being asked to participate in this study by completing a biographical questionnaire and engaging in an interview with the principal researcher, Annemarie Rued. This one-on-one

interview could take as long as two hours. Once interviews have been transcribed and the main themes identified, you will be contacted and asked to verify the accuracy of these themes and whether they clearly reflect your own experience.

Your participation is voluntary, and you may refuse to participate altogether, or you may refuse to answer any specific questions that I bring up during the interview. You may also withdraw from the study at any time without penalty or consequence of any kind.

What Type of Personal Information Will Be Collected?

Should -you- agree to participate, you will be asked to provide your gender, age, and educational level. Your name will remain confidential and you will be asked to provide a pseudonym by which you will be referred to in the interview and write-up.

There are several options for you to consider should you decide to take part in this research. You can choose all, some or none of them. Please put a check mark on the corresponding line(s) that grants me permission to:

I grant permission to be audio taped: *Yes:___No:____*

I wish to remain anonymous, but you may refer to me by pseudonym: *Yes:___No:____*

The pseudonym I choose for myself is: _____

You may quote me and use my pseudonym: *Yes:___No:____*

Are there Risks or Benefits if I Participate?

There is a minimal risk that you will find this interview distressing as you will be asked to explore the issue of abandonment. Although we will be focusing our discussion on the skills employed to overcome abandonment issues, the recall of abandonment scenarios may be upsetting to some. In such instances, it might prove beneficial to talk to a professional counsellor about this. Counselling resources available in Calgary include:

1. Eastside Clinic - Phone 403-299-9696 (free one-session counselling service).
2. Distress Centre - Phone 403-265-4980 (crisis service and free counselling provided).
3. Calgary Counselling Centre - Phone 403-265-4980 (sliding fee scale and ongoing counselling provided).

You might also find it beneficial to participate in this study. Exploring the ways dialectical behavioural therapy may have altered your perception of abandonment may help to affirm positive changes and result in an increased sense of empowerment

What Happens to the Information I Provide?

Participation is completely voluntary, anonymous and confidential. You are free to discontinue participation at any time during the study without penalty or consequence. If you decide to discontinue your participation at any point before the study has been completed, all data collected up to that point will be retained and used in the study if appropriate for the study's purpose. No one except the researcher and her supervisor will be allowed to see or hear any of the answers to

the questionnaire or the interview tape. Select quotes may be published, but for the most part data will be summarized for any presentation or publication of results Questionnaires, interview recordings, and interview transcripts are kept ina locked safe accessible only by the researcher. Electronic data will be safely stored on a password protected computer hard drive. The anonymous data will be stored for five years after which time, it will be permanently destroyed.

Signatures (*written consent*)

Your signature on this form indicates that you 1) understand to your satisfaction the information provided to you about your participation in this research project, and 2) agree to participate as a research subject.

In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time. You should feel free to ask for clarification or new information throughout your participation.

Participant's Name: (please print) _____

Participant's Signature _____ Date: _____

Researcher's Name: (please print _____

Researcher's Signature: _____ Date: _____

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Ms. Annemarie Rued

Educational Studies in Counselling Psychology / Faculty of Education

[redacted]

or

Dr. Kevin Alderson

Educational Studies in Counselling Psychology / Faculty of Education

[redacted]

If you have any concerns about the way you've been treated as a participant, please contact the Senior Ethics Resource Officer, Research Services Office, University of Calgary at [redacted]

A copy of this consent form has been given to you to keep for your records and reference. The Investigator has kept a copy of the consent form.

APPENDIX E:

Biographical Questionnaire Administered to Co-Researchers during the First of Two Data Collection Sessions

Biographical Questionnaire

Date: _____

The information requested in this questionnaire is personal in nature and will be treated with the utmost confidentiality. Rest assured that I will be the only individual with access to this information.

1. General Information

A pseudonym will be used in the write-up of results. Please declare the pseudonym you wish to assume:

Pseudonym: _____

Date of Birth: _____ Age: _____ Gender: _____

Education (highest level completed): _____

2. Personal and Social History

With whom have you lived throughout your life? Please list in chronological order.

Ages	Co-residents	Reason for termination of co-

Who were your primary caregivers in childhood? (e.g., mother, father, both, or other - if other, please specify)

_____

Father or Legal Male Guardian (if applicable):

Living? _____ If alive, give father's present age _____

Deceased?_____If deceased, provide your age at the time of his death _____

How would you rate your father's approach (or other male caregiver) to rearing you in childhood? (Please circle one in each row)

Discipline	very strict	strict	lenient	very lenient
Affection	very affectionate	affectionate	somewhat distant	dismissive
Feedback	criticism	encouragement	flattery	none

How would you rate the quality of the relationship (e.g., *excellent, good, fair,* or *poor)* you have had with your father, or other male caregiver, during the following periods of your life:

	Excellent	Good	Fair	Poor
Childhood (0-11)				
Adolescence (12-18)				
Adulthood: pre-DBT				
Adulthood: post-DBT				

Mother or Legal Female Guardian (if applicable)

Living? _____ If alive, give mother's present age _____

Deceased? _____ If deceased, provide your age at the time of her death _____

How would you rate your mother's approach (or other female caregiver) to rearing you in childhood? (Please circle one in each row)

Discipline	very strict	strict	Lenient	very lenient
Affection	very affectionate	affectionate	somewhat distant	dismissive
Feedback	criticism	encouragement	Flattery	none

How would you rate the quality of the relationship (e.g., *excellent, good, fair,* or *poor)* you have had with your mother or other female caregiver, during the following periods of your life:

	Excellent	Good	Fair	Poor
Childhood (0-11)				
Adolescence (12-18)				
Adulthood: pre-DBT				
Adulthood : post-DBT				

Romantic Relationships

What is your personal definition of a committed romantic relationship?

How many committed romantic relationships have you been involved in?

Of these relationships, what was the longest in duration?

Please list the three (or less) most common reasons for the dissolution of your romantic relationships.

Were you involved in a romantic relationship when you were diagnosed with BPD?

Are you still with the same partner you were with following your BPD diagnosis at the present time? If your answer is “no", on a scale of 1*(no effect)* to 10 *(strong effect),* to what extent do you believe BPD symptoms were responsible for the break-up?

Platonic Relationships

What is your definition of a good friendship?

How many good friendships do you currently have?

Do your friendships tend to be short-lasting but intense? If "yes", please explain why you think this is the case.

3. Borderline Personality and Dialectical Behaviour Therapy

When were you first diagnosed with borderline personality disorder (BPD)?

When did you begin treatment with Dialectical Behaviour Therapy (DBT)?

How long did you remain in DBT?

Have you received a mental health diagnosis other than BPD? If "yes", please list.

Have you engaged in some form of treatment other than DBT? If "yes", please list and note whether or not this other treatment was to treat BPD or something else.

From the following list of symptoms please rate each one on a scale of 0 to *5* (where 0 = non- existent and 5 = very severe). Please rate the severity of each symptom for before DBT treatment and after DBT treatment.

		Before DBT	*After DBT*
Affect	*Depression*		
	Helplessness		
	Hopelessness		
	Worthlessness		
	Guilt		
	Anger		
	Angry acts		
	Anxiety		
	Loneliness		
	Boredom		
	Emptiness		
Cognitive	*Unusual perceptual experiences*		
	Paranoia		
	Dissociation		
Impulse Actions	*Substance abuse/dependence*		
	Sexual promiscuity		
	Self-mutilation		
	Suicide attempts		
	Other impulses:		
Relationships	*Intolerance of aloneness*		
	Abandonment concerns		
	Engulfment concerns		
	Annihilation concerns		
	Conflicted feelings about being helped		
	Stormy relationships		
	Dependency		
	Tendency to manipulate others		
	Demandingness		
	Sense of entitlement		

Note: Modified from: Zanarini, M. C., Gunderson, J. G., Frankenburg, F. R., & Chauncey, D. L. (1989). The revised diagnostic interview for borderlines: Discriminating BPD from other Axis II disorders. *Journal of Personality Disorders, 3*, 10-18.

What is your personal definition of “abandonment”?

Please relate the earliest abandonment experience or a circumstance in which you felt afraid of being abandoned.

How do you think the fear of abandonment relates to the other symptoms of BPD?

APPENDIX F:

Semi-Structured Interview Questions Used during Second Data Collection Session

1. How would you define abandonment?
2. What are abandonment issues?
3. What does it feel like when there is a threat of abandonment? (OR What feelings are triggered by the threat of abandonment?)
4. Are these feelings similar to those felt when there is risk of rejection? (How so? OR How are they different?)
5. In what other circumstances do you experience these feelings?
6. What are the thoughts that went through your mind when experiencing the threat of abandonment?
7. Prior to DBT, how did you react to the feelings and thoughts triggered by the threat of abandonment?
8. When reacting to the feelings and thoughts in this way, what was the result?
9. After receiving DBT, did the feelings and thoughts triggered by abandonment change? (If so, how?)
10. After DBT, how did you cope with the feelings and thoughts triggered by the threat of abandonment?
11. When coping with the feelings and thoughts in this way, what was the result?
12. Do you perceive abandonment differently after having received DBT? (How?)

APPENDIX G:

Participant Recruitment Notice

PARTICIPANTS NEEDED
FOR RESEARCH ON
BORDERLINE PERSONALITY DISORDER

Have you been diagnosed with Borderline Personality Disorder?

Have you received Dialectical Behaviour Therapy?

If you answered yes to both of these questions and are at least 18 years of age, you may be eligible to take part in a study of:

"The experience of abandonment before and after receiving Dialectical Behaviour Therapy"

As a participant in this study you would be asked to complete a questionnaire and take part in an interview. You would be using a pseudonym throughout the duration of the study and confidentiality of any information you share is guaranteed.

Your participation would involve two sessions: a one hour session and a two hour session, each held at the University of Calgary.

For more information about this study, or to volunteer, please contact:

Annemarie Rued
Department of Educational Studies in Counselling Psychology,
University of Calgary
at

APPENDIX H:

Co-Researchers' Self-Reported Severity of BPD Symptoms Before and After DBT

Participants were asked to complete a modified version of the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) (Zanarini et al., 1989), indicating the severity of experienced symptoms before and after receiving DBT on a scale of 0 (non-existent) to 5 (very severe).

Symptom	Before DBT				After DBT			
	N	S	B	T	N	S	B	T
Affect								
Depression	5	4	4	5	1	1	3	0
Helplessness	5	1	5	5	0	0	3	0
Hopelessness	5	1	5	4	1	0	3	0
Worthlessness	5	4	5	5	2	0	3	3
Guilt	5	4	5	5	1	3	4	3
Anger	5	5	3	5	0	3	3	0
Angry acts	2	5	1	1	0	2	0	0
Anxiety	4	3	4	5	2	2	3	3
Loneliness	5	4	4	1	1	2	3	0
Boredom	3	4	2	2	0	2	2	0
Emptiness	5	4	4	4	1	0	3	1
Cognitive								
Unusual perceptual experiences	4	4	4	3	0	2	4	0
Paranoia	5	4	3	4	1	2	4	1
Dissociation	4	4	4	3	0	2	3	0
Impulse actions								
Substance abuse / dependence	5	4	0	4	0	1	0	2
Sexual promiscuity	0	1	0	5	0	1	0	0
Self-mutilation	5	3	4	0	0	1	3	0
Suicide attempts	5	0	5	0	2	0	3	0
Relationships								
Intolerance of aloneness	5	0	0	4	1	1	0	0
Abandonment concerns*	5	4	4	5	2	1	3	2
Engulfment concerns	2	3	5	0	0	1	1	0
Annihilation concerns	3	0	5	3	0	0	1	0
Conflicted feelings about being helped	5	3	4	4	3	1	2	0
Stormy relationships	5	4	5	4	1	2	1	1
Dependency	4	3	4	4	2	1	1	0
Tendency to manipulate others	4	4	0	5	0	2	0	2
Demandingness	3	4	1	0	1	2	0	0
Sense of entitlement	1	4	1	4	0	2	0	0

Note: N = Nicole; S = Sal; B = Barb; T= Tina.