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Common Strategies for Cultivating a Positive Therapy Relationship in the Treatment of Borderline Personality Disorder

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A positive therapeutic relationship is widely recognized as an important factor that contributes to the effectiveness of clinical outcomes in psychotherapy for borderline personality disorder (BPD). All psychotherapy approaches for the treatment of BPD emphasize the importance of the relationship, yet with BPD clients, a positive relationship is often slow to develop, inconsistent, and difficult to maintain. The interpersonal sensitivity and reactivity that characterize borderline pathology often evokes countertherapeutic reactions in psychotherapists. Therapist contributions to the interaction frequently impede the development and maintenance of a positive relationship. This paper outlines 5 strategies that are common across psychotherapies for BPD for cultivating a positive therapeutic relationship: (a) cultivating emotional awareness, (b) structuring treatment, (c) being responsive, (d) supervision or team involvement, and (e) exploring ruptures. We discuss how these strategies serve to increase the effectiveness of treatment with individuals with BPD by decreasing intense emotional arousal and reactivity of both the client and the therapist.

Keywords: borderline personality disorder, treatment, therapeutic alliance, psychotherapy integration

The effectiveness of psychotherapy for the treatment of borderline personality disorder (BPD) is supported by several studies (for recent reviews see Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Stoffers et al., 2012). Different psychotherapeutic approaches have been shown to be effective, with no evidence to date for the superiority of one approach over another (Stoffers et al., 2012). A current focus within psychotherapy research more generally and BPD research more specifically is on identifying the common factors that contribute to positive outcomes across different types of treatments (Messer & Wampold, 2002). One common factor that has received considerable attention is the therapeutic relationship, which is typically measured by client and therapist ratings of the therapeutic alliance. Within the broader psychotherapy research literature, there is a robust empirical base that demonstrates that the therapeutic alliance accounts for more variance in psychotherapy outcomes than any other variable (Wampold, 2000); and in BPD research, it is widely recognized that the development and maintenance of a positive therapeutic relationship is an essential ingredient of effective therapy (e.g., Bateman & Fonagy, 2004; Gunderson & Links, 2014; Linehan, 1993). To date, studies investigating the therapeutic alliance in BPD have shown that the strength of the alliance is associated with both treatment outcome and treatment retention in this population (Gunderson, Najavits, Leonhard, Sullivan, & Sabo, 1997; Hirsh, Quilty, Bagby, & McMain, 2012; Marziali, Munroe-Blum, & McLeary, 1999; Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007).

Despite awareness that a strong therapeutic relationship is associated with positive treat-

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ment outcome, a gap still remains in the identification and elaboration of strategies used to facilitate such a relationship. Additionally, there are considerable challenges to developing and maintaining a therapeutic relationship in the treatment of individuals with BPD in particular. With BPD clients, a positive relationship is often slow to develop, inconsistent, and difficult to maintain (Gunderson, 2001). This is due, in part, to the pervasive emotion dysregulation, impulsivity, and interpersonal difficulties that characterize the day-to-day lives of individuals with this disorder. Consequently, interactions with BPD clients often evoke intense reactions in the therapist, which can easily become countertherapeutic if not addressed.

This article outlines strategies that facilitate the development of a positive therapeutic relationship across diverse psychotherapies for BPD, and offers a nuanced understanding of how these strategies exert their effects on both client and therapist. We begin by discussing the unique relationship challenges encountered in treating a BPD population, and then present specific strategies that can be used to address these challenges.

Specific Challenges in the Therapeutic Relationship in BPD Treatments

Individuals with BPD typically experience emotional instability, heightened sensitivity to stimuli, intense emotional reactivity, a slow return to emotional baseline, and greater susceptibility to negative emotions (American Psychiatric Association, 2000; Lieb et al., 2004; Linehan, 1993; Linehan, Bohus, & Lynch, 2007; Links et al., 2007; Sadikaj, Russell, Moskowitz, & Paris, 2010). There is a general consensus that these emotional vulnerabilities develop as a consequence of the interaction between a biological predisposition and the familial and social environment. One study found that BPD clients experience more frequent, more intense, and longer-lasting aversive states compared to controls (Stiglmayr et al., 2005). Others have shown that heightened levels of emotional distress are associated with deficits in emotional awareness, difficulties with emotion modulation, and problems with impulse control (Dixon-Gordon, Chapman, & Turner, in press; Gratz & Roemer, 2004; Gratz & Tull, 2010). Further illumination comes from neurobiological research: compared to healthy controls, individuals with BPD demonstrate increased amygdala hyperreactivity (Donegan et al., 2003), higher cortisol reactivity to stress (Elzinga, Schmahl, Vermetten, van Dyck, & Bremner, 2003), and abnormal frontal limbic circuitry (Levy, Beeney, Wasserman, & Clarkin, 2010), the last of which may explain why poorer executive attention in BPD is associated with more labile mental states.

These emotional vulnerabilities are particularly evident in the interpersonal domain, where sensitivity and reactivity to situational and social cues often trigger negative emotions (Sadikaj et al., 2010; Stiglmayr et al., 2005). Abandonment fears, rejection sensitivity, and intolerance of being alone frequently underlie many of the interpersonal difficulties experienced by this population (Gunderson & Lyons-Ruth, 2008; Jang, Livesley, & Vernon, 1996). A recent study found that individuals with BPD experience the negative emotions of others with higher than normal intensity (Daros, Uliaszek, & Ruocco, 2014). They also exhibit greater emotional and physiological reactivity to social rejection stressors (Berenson, Downey, Rafaeli, Coifman, & Paquin, 2011; Dixon-Gordon, Chapman, Lovasz, & Walters, 2011; Sadikaj et al., 2010; Tragesser, Lippman, Trull, & Barrett, 2008). Taken together, these studies suggest that individuals with BPD are biologically predisposed to experiencing intense emotion and a persistent sense of threat, both of which have consequences for the development of a positive therapeutic relationship. Understanding these vulnerabilities can shed light on the challenges in achieving this relationship.

The theoretical and empirical literature is replete with examples of the ubiquity of negative reactions on the part of therapists treating this population (Cleary, Siegfried, & Walter, 2002; Rossberg, Karterud, Pedersen, & Friis, 2007). As Gabbard and Wilkinson (1994) observe, "Every session of psychotherapy with a borderline patient involves a countertransference dilemma" (p. 41). Anger on the part of the therapist is a common reaction (Deans & Meocevic, 2006), often arising in response to client attacks, demanding behavior, boundary violations, and lack of compliance with treatment. Therapists also report frequently feeling overwhelmed, anxious, and confused, often in response to unexpected and erratic client behaviors (e.g., life-

threatening or crisis behaviors). Furthermore, the slowness or absence of progress often erodes a therapist's confidence and contributes to feelings of hopelessness and pessimism.

When clinicians are emotionally overwhelmed, they may react in a nontherapeutic manner in a number of ways. Expressions of anger by clients can trigger urges to appease their demands. Expressions of fear can trigger overinvolvement in an effort to rescue clients from distress. Demands for more time and attention can lead therapists to extend their personal limits, potentially leading to the transgression of professional boundaries. Not infrequently, however, a therapist will limit treatment or simply refuse to treat people with BPD, if interactions with these clients are highly aversive. Indeed, these negative reactions are the main barrier to developing a positive therapeutic relationship with BPD clients. When the therapist becomes reactive and nonempathic, the client often responds by withdrawing, becoming angry, prematurely terminating treatment, or engaging in impulsive and reactive manners (Dimaggio, Carcione, Salvatore, Semerari, & Nicolo, 2010; Dimeff & Linehan, 2001; Linehan, Tutek, Heard, & Armstrong, 1994). Similar outcomes have been found in research on depressed clients, in which negative therapist behavior is related to early termination of treatment (Elkin et al., 2014), and in clients with Cluster B personality disorders, where negative countertransference reactions have been shown to predict treatment drop-out (Rossberg et al., 2007).

For psychotherapy to be effective, treatment providers need to be able to modulate countertherapeutic reactions that may be destructive to effective treatment. The ways in which therapists respond to their clients in moments of their own heightened tension is critical, as these experiences can exacerbate symptoms or promote recovery.

Common Strategies for Building and Maintaining a Positive Therapeutic Relationship

In this article, we identify five strategies that are common across a range of psychotherapies for BPD for building and maintaining a positive therapeutic relationship with BPD patients. These are: (a) cultivating emotional awareness, (b) structuring treatment, (c) being responsive, (d) supervision or team involvement, and (e) exploring ruptures. Underlying all of these is a focus on decreasing intense emotional arousal and reactivity in both the client and the therapist. These strategies and their impact on the client, therapist and their relationship are described in turn below.

Cultivating Emotional Awareness

All psychotherapies for BPD highlight the importance of emotional awareness in the therapeutic interaction, as emotional sensitivity and reactivity on the part of either the client or the therapist can impede the therapeutic process (Bateman & Fonagy, 2004; Gunderson et al., 1989) and interfere with the development of a positive therapeutic relationship. Conflict and tension in the therapeutic relationship are heightened when either party is unaware of his or her emotions or neglects them until they become overwhelming. To cultivate a productive therapeutic relationship, it is essential that treatment include the purposeful monitoring and modulation of emotions on both sides. Without this, sessions can easily erode into a problematic conflictual interaction in which both therapist and client are impacted by dysregulated emotions, thoughts, and actions.

An emphasis on client emotional awareness and attentional control cuts across therapies for BPD. In Dialectical Behavior Therapy (DBT), this emphasis is found in the mindfulness, emotional regulation, and distress tolerance modules (Linehan, 1993). In Mentalization-Based Therapy (MBT), there is a focus on enhancing a client's ability to accurately assess moment-to-moment cognitive and affective states (Bateman & Fonagy, 2008). Similarly, in Transference Focused Psychotherapy (TFP), an attempt is made to improve a client's reflective functioning in the therapeutic relationship through confrontation and clarification of here-and-now relational affect (Clarkin, Yeomans, & Kernberg, 2006). All these approaches share an emphasis on helping clients to increase their awareness of moment-to-moment emotional and cognitive processes, to decrease emotional dysregulation, and to act less impulsively when experiencing emotional distress (Bennett, Parry, & Ryle, 2006; Selby, Anestis, Bender, & Joiner, 2009).

An awareness and acceptance of emotional experience is crucial for therapists as well, who

frequently struggle with modulating their own intense reactions. Practitioners and theorists of diverse approaches have long noted the importance of therapist awareness, and all psychotherapeutic approaches emphasize the importance of the therapist maintaining an active awareness of his or her responses to a client. Countertherapeutic reactions largely stem from two problems: the failure to be aware of one's own emotions, and the inability to modulate the responses that emerge from emotional dysregulation. For example, a therapist may become more active and controlling during an interaction with a highly suicidal client, not recognizing that this response may be driven by fear. Indeed, the risk of countertherapeutic reactions is highest when therapists fail to be aware of their responses and lose their ability to control their thoughts and behaviors.

It follows, then, that increasing awareness and acceptance of the feelings that can arise during psychotherapy sessions with BPD clients should help therapists remain grounded and less reactive. Given the atmosphere of heightened emotion in working with this population, Clarkin, Yoemans, and Kernberg (1999) encourage therapists to pay attention to the specific quality of the feelings that are evoked in the therapeutic interaction, in order to refrain from acting on them. The importance of maintaining a "neutral part of the mind" or an "observing" stance is seen as essential (Bateman & Fonagy, 2004; Linehan, 1993). Along these lines, Kernberg, Selzer, Koenigsberg, Carr, and Appelbaum (1989) advise therapists to adopt a therapeutic posture of an open, inquiring, and technically neutral set of attitudes in an effort to inhibit action that is countertherapeutic. Overall, promoting the awareness of emotions plays a critical role in safeguarding both therapist and client against intense unmodulated reactions that can precipitate problems in the therapeutic relationship.

Structuring Treatment

Treatment structure, referred to in the psychodynamic literature as the *therapeutic frame* (Kernberg et al., 1989), consists of the pragmatic aspects of psychotherapy, and involves clarifying the "ground rules" of treatment, such as the duration of treatment, the frequency and length of sessions, fees, vacations, the nature of extratherapeutic contact, management of suicidal crises, and the therapist's role and limits. An additional structural component that is shared by most therapeutic approaches is the structuring of sessions according to a hierarchy of thematic priorities, whereby suicidal or homicidal threats and treatment contract breaches are prioritized over other behaviors (Kernberg et al., 1989; Linehan, 1993). Treatment structure contributes to the development of a positive therapeutic relationship by preventing communication problems, boundary violations, and strains and ruptures in the relationship (Bateman & Fonagy, 2004; Gabbard, 1989; Gunderson & Links, 2014; Linehan, 1993). Commenting on its importance, Paris, (2008) argues that "structure is an essential element for patients who have chaotic lives" (p. 147). The treatment structure is one means of helping therapist and client maintain an optimal distance between each other (Gabbard & Wilkinson, 1994). Therapists working with BPD clients are cautioned against starting treatment without an agreement on the parameters of treatment (Bateman & Fonagy, 2004; Gabbard, 1989; Linehan, 1993).

The structural aspects of treatment, if explained clearly and explicitly, can help to influence client and therapist behavior. For example, a client who knows that a therapist does not like to receive multiple daily phone calls may resist the urge to leave repeated telephone messages. Further, if the treatment parameters have been presented with a clear rationale, this may help to reduce the likelihood of misinterpretations. Knowing the length of the treatment, for example, contract can help to reduce the intensity of feelings of abandonment that often arise related to therapy termination.

Structural aspects can also serve as an early warning system, in that transgressions of the treatment structure can alert both parties to the potential for problems in the therapeutic relationship. That is, the structural aspects of treatment can help a therapist "catch things when they get out of control" (Bateman & Fonagy, 2004). For example, a therapist who extends the length of sessions with a client may be more likely to notice and examine this behavior. The parameters of psychotherapy function can be likened to a rope separating the deep end of a swimming pool from the shallow end: if the rope is crossed, there may be danger.

Finally, given the intense emotions that can at times make therapy sessions feel chaotic and overwhelming, the structural elements of treatment can decrease emotional arousal and help both therapist and client stay focused and "clear amid the chaos" (Linehan, 1993).

In sum, when treatment structure is established explicitly and clearly and both parties commit themselves to a specific set of expectations, this can reduce the likelihood of either party reacting based on intense emotions. Further, because structural transgressions invariably arise, they can serve as a means to signal a problem that needs to be addressed.

Therapist Responsiveness

Therapist responsiveness—a relatively new construct in the psychotherapy research literature—is defined as the ability to tailor interventions to a client's characteristics and behaviors in the unfolding of the therapy process (Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998; Stiles & Shapiro, 1994). The therapist's attitude, style of communication, and intention are important factors in cultivating a positive relationship, and in this regard, therapist responsiveness is emphasized across many psychotherapy approaches. In the context of treatment for BPD, therapist responsiveness includes a strong emphasis on empathic validation, flexibility, and collaboration.

Empathic validation is arguably one of the most important strategies for enhancing the therapeutic relationship (Bateman & Fonagy, 2004; Dimaggio & Semerari, 2001; Gabbard & Wilkinson, 1994; Kernberg et al., 1989; Linehan, 1993; Newman, 2007). As described above, individuals with BPD are emotionally vulnerable and exquisitely sensitive to real or perceived criticism or rejection, which contributes to intense problematic reactions in relationships with others. By communicating an attitude of acceptance, the therapist helps the client to become self-aware and more accepting of his or her emotions, and this in turn facilitates the regulation of emotions and modulation of behaviors (Fonagy & Bateman, 2006; Linehan, 1993; Newman, 2007). Indeed, across all psychotherapies for BPD, change strategies such as confrontation, interpretation, and skills training are accompanied by a strong focus on empathic validation. In DBT, an emphasis on change is balanced with empathic validation as a way of decreasing emotional arousal, increasing collaboration, and strengthening the therapeutic relationship (Linehan, 1993). Similarly, in psychodynamic approaches for BPD, validation and acceptance of the client's experiences are essential to the exploration of the enactment of problematic relationship patterns. In MBT, empathic support is a vehicle for helping clients mentalize and reduce their emotional arousal.

Therapist flexibility, which entails being responsive to changes in the client and adjusting one's interventions accordingly, is common to all therapies for BPD, and is considered an essential strategy for managing the turbulent shifts in a client's in-session affect and behavior. When a therapist responds flexibly to moment-to-moment shifts in a client's presentation, the client faces ever-changing cues in the interpersonal relationship. Constant changing of cues that trigger intense emotions and behaviors is one means of shifting reactions that arise in the therapy relationship. Adopting a flexible stance can also can help the therapist let go of rigid expectations that may be causing frustration and reactivity.

In all psychotherapies for BPD, therapists are encouraged to avoid an authoritative or controlling style in favor of being highly collaborative (Bateman & Fonagy, 2008; Linehan, 1993). Gabbard and Wilkinson (1994) capture the essence of this style as sitting "side by side" the client. Most therapies for BPD stress the importance of treating the client as competent, capable, and an active participant in the treatment process. This collaborative stance enables the client to experience the therapist as nonthreatening, thereby reducing emotional arousal and increasing tolerance of the therapist. Collaboration also enables therapists to mitigate their reactivity toward clients. For example, threats of suicide may trigger an urge to rescue the client: recognizing that such a response can lead a therapist to be more controlling and less collaborative may make it easier to modulate this behavior and support the client in actively solving the problem.

Supervision or Team Involvement

All therapeutic approaches for BPD advise that psychotherapy cannot be delivered effectively unless the therapist is supported by a supervisor and/or a team that shares a treatment philosophy. This support is considered essential to safeguard the therapeutic relationship and the treatment (Bateman & Fonagy, 2004; Gunderson & Links, 2014; Kernberg et al., 1989; Linehan, 1993). Bateman and Fonagy (2004) argue that without it, treatment can become chaotic and boundary transgressions are more likely to occur. In DBT, therapist consultation is considered essential and is used to help therapists manage problematic reactions that that may compromise the delivery of treatment (Linehan, 1993).

One of the primary functions of such support is to help therapists manage their own countertherapeutic reactions toward clients. Supervisors or treatment team members can help each therapist monitor, make sense of, and modify these reactions, and can additionally help share the burden of responsibility for the client's treatment. This is vital to alleviating the therapist's stress and anxiety. Empirical support of this practice was evidenced in a study of professionals learning to implement DBT, who reported that teamwork and supervision helped to reduce stress (Perseius, Ojehagen, Ekdahl, Asberg, & Samuelsson, 2003).

Clients can benefit from the involvement of a treatment team as well, since interpersonal experiences with other clinicians broadens their relationship experiences and can help to counter problematic reactions that arise in the primary therapeutic relationship. For example, a client who is angry with the primary therapist and has urges to quit therapy may remain in treatment because of his or her positive feelings toward other clinicians on the team. In other words, interactions with other team members can help the client tolerate intense negative experiences by allowing these reactions to be contained within one relationship. Across BPD treatments, it is also not uncommon for clients to be encouraged to seek contact with other members of a team in order to buffer and diffuse intense negative emotions (Bateman & Fonagy, 2004; Gunderson, 2001; Linehan, 1993). For example, in MBT and DBT, a client may be encouraged to see another therapist on the team when the primary therapist is on vacation. Bateman and Fonagy (2004) describe this as a way to stay mindful of the therapist, which in turn generates positive affect.

Exploring Ruptures

Ruptures in the therapeutic relationship are recognized as an important focus of treatment across different schools of therapy for BPD. In DBT, they are considered to be a type of *therapy interfering behavior*; in psychodynamic treatments, including Cognitive Analytic Therapy (CAT), as *transference* (Clarkin, Levy, Lenzenweger, & Kernberg, 2007); and in MBT as *failures of mentalization* (Fonagy & Bateman, 2006). When working with clients with BPD, ruptures can be frequent and very intense (Waldinger & Gunderson, 1984), and all approaches agree that competence in exploring and resolving these difficulties is essential for effective psychotherapy. There is no shared model across psychotherapies as to how to address ruptures in the therapeutic relationship, but there are several common themes.

Therapists who work with BPD clients need to carefully consider their style and timing of addressing ruptures. The use of empathic validation, discussed above under the topic of therapeutic responsiveness, is widely considered to be an essential first step (Bateman & Fonagy, 2004; Bennett et al., 2006; Kernberg et al., 1989; Linehan, 1993). It is highlighted again here because of its importance in reducing defensiveness and the emotional arousal that accompanies tensions, strains, and ruptures in the therapeutic relationship (Bateman & Fonagy, 2004). Empathic validation is more than just a verbal expression of empathy: therapists use it in an attempt to understand how a client experiences the relationship (Bateman & Fonagy, 2004; Linehan, 1993).

A form of validation that is considered particularly helpful in many psychotherapies for BPD entails the therapist acknowledging his or her own contribution to the rupture (Cash, Hardy, Kellett, & Parry, 2014). Safran and Muran (1996) discuss this in their model for repairing alliance ruptures. This method of validating clients is considered especially helpful when working with a BPD population, because it helps to normalize fallibility (Linehan, 1993) and promotes the client's experience of the re-

lationship as collaborative (Cash et al., 2014). On a related point, in MBT, when ruptures arise, the therapist is advised against attributing countertransference to the client, even though the therapist's reaction may be a response to the client. Similarly, in TFP, Kernberg et al. (1989) advise that the therapist should refrain from offering genetic interpretations of the early transference and the client should be supported as the final arbiter of what is valid.

With respect to the timing of exploring ruptures, a common guideline for doing so with a client who is highly sensitive and reactive is to pick an opportune moment (Newman, 2007). Generally, addressing ruptures is most effective when the bond with the client is already strong (Gunderson, Hoffman, Steiner-Grossman, & Woodward, 2005) although sometimes this is not possible. When the client likes and trusts the therapist, it facilitates a positive dependency in the relationship, which may be a necessary condition for being able to tolerate the discussion of difficulties in it (Gabbard & Wilkinson, 1994). Otherwise, as Safran and Muran (2000) observe, exploring a rupture with an interpersonally sensitive client runs a risk of aggravating it.

Across psychotherapies for BPD, therapists are cautioned against directly uncovering and restructuring problematic thoughts and feelings related to a ruptures when a client is highly emotionally aroused. Relevant information uncovered in these moments is not likely to be processed productively by the client (Linehan, 1993), and doing so runs the risk of exacerbating the client's negative arousal (Bateman & Fonagy, 2004). Dimaggio and colleagues (2010) also highlight the importance of talking about the therapeutic relationship "in the right moments" (p. 368).

Addressing ruptures can have multiple benefits. For example, uncovering and processing a rupture can increase both the client's and the therapist's awareness of the thoughts and feelings underlying the communication problem, which can help both parties increase their empathy for the other and can lead to emotional, cognitive, and behavioral shifts. As Bateman and Fonagy (2004) explain, addressing relationship difficulties helps clients shift their perceptions of themselves and others.

Another reason for discussing relationship ruptures is to promote change in the client that extends beyond the therapy context. Discussing reactions to the therapist provides clients with an opportunity to learn about how their thoughts, feelings, and behaviors are connected, and thereby gain a better understanding of the impact that their communication has on others.

It is also important that discussions about a rupture or other negative thoughts and feelings in the therapeutic relationship do not dominate the treatment, as clients need to have the space to experience both negative and positive affect within the relationship (Gabbard & Wilkinson, 1994). Refraining from exploring all ruptures helps to model the idea that conflict can exist even within a warm and caring relationship. For example, in two case studies of individuals who underwent successful CAT for BPD, Bennett and colleagues (2006) noted there were times when therapists refrained from addressing ruptures, and instead temporarily allowed problematic patterns in the relationship in the interest of maintaining collaboration and preserving the therapeutic relationship.

In sum, exploring ruptures is an important part of therapy in the treatment of BPD. While the methods are comparable to those used in therapy with non-BPD clients, therapists working with a BPD population must be more responsive to their clients' sensitivity and reactivity, and are more likely to need to focus on validation, including acknowledgment of their own contribution to the rupture. It is best to refrain from exploring a client's dysfunctional schemas unless the bond is already strong and the client is not overly emotionally aroused. Additionally, it is important to ensure that the exploration of alliance ruptures does not dominate the discussions in therapy.

Summary

Difficulties in developing and maintaining a positive therapeutic relationship commonly arise in the treatment of clients with BPD. This paper describes five strategies, recommended across psychotherapies for BPD, for cultivating a positive therapeutic relationship. All five strategies serve to increase the effectiveness of treatment with this population by decreasing intense emotional arousal and reactivity of both the client and the therapist. While the therapy relationship in BPD may at times be fraught, it is also the foundation from which effective thera-

peutic work grows. The strategies highlighted here should be considered essential ingredients in treatment for BPD. Moreover, they can be usefully extended to other types of engagement with this population (e.g., primary care, crisis intervention) to improve the quality of care received by individuals with BPD across diverse settings.

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