Application of EMDR Therapy for Borderline Personality Disorder

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There is a growing interest in the use of eye movement desensitization and reprocessing (EMDR) therapy beyond posttraumatic stress disorder (PTSD) where its application is well established. With strong scholarly consensus that early traumatic and adverse life experiences contribute to the development of borderline personality disorder (BPD), EMDR would appear to offer much to the treatment of persons with BPD. However, given the specific characteristics of these clients, the application of EMDR therapy to their treatment can be challenging and necessitates several minor adaptations of the standard EMDR procedures for PTSD. This article provides an orientation to principles and strategies for safely and effectively preparing clients with BPD for EMDR therapy and for accessing and reprocessing the traumatic origins of BPD. Clinical examples are provided throughout.

Keywords: borderline personality disorder; EMDR; psychotherapy; trauma

In the eye movement desensitization and reprocessing (EMDR) approach to psychotherapy, psychological problems are viewed as being mainly caused by the cumulative effect of unresolved traumatic and adverse experiences (Shapiro, 2007). EMDR therapy has been shown to be an effective, efficient, and well-tolerated treatment for posttraumatic stress disorder (PTSD; Bisson & Andrew, 2007; Foa, Keane, Friedman, & Cohen, 2009; Ursano et al., 2004) and is effective for both adult and childhood onset PTSD (Adler-Tapia & Settle, 2009; Field & Cottrell, 2011; Korn, 2009; van der Kolk et al., 2007). In EMDR therapy, the client is directed to mindfully notice what happens to representations of disturbing or dysfunctional perceptions, emotions, sensations, action urges, and self-statements while attending to a series of sets of bilateral stimulation (BLS) involving alternating eye movements, taps, or auditory tones (Leeds, 2009; Shapiro, 2001). A large body of research supports the hypothesis that borderline personality disorder (BPD) is strongly related to early traumatic and adverse life experiences (Ball & Links, 2009; Horesh et al., 2008; Tyrka, Wyche, Kelly, Price, & Carpenter, 2009; Zanarini et al., 2002), yet few published reports describe the application of EMDR to clients with BPD.

Korn and Leeds (2002) reported evidence of significant symptom relief following application of Resource Development and Installation (RDI) in the stabilization phase of treatment in two cases of Disorders of Extreme Stress Not Otherwise Specified (DESNOS) that also met criteria for BPD; however, they did not report on the subsequent use of EMDR reprocessing to address traumatic memories. Brown and Shapiro (2006) reported clinically significant reductions on all subscales of the Inventory of Altered Self-Capacities (Briere, 2004) to below the clinical cutoff after 20 sessions of EMDR therapy provided over a period of 6 months in a single case report of a woman diagnosed with BPD. The woman had remained unstable in her marital functioning after an initial course of treatment (from the same clinician) that involved cognitive behavioral and psychodynamic/insight-oriented psychotherapy over a period of 18 months that ended 2 years before her eventual return for treatment with EMDR therapy.

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The third of the three cases reported on by Wesselmann and Potter (2009) may have met criteria for BPD, although she had been diagnosed with major depressive disorder by her psychiatrist. "Mrs. K described acute depression and frequent suicidal thoughts, and she self-harmed by cutting her arms, legs, or stomach with a razor nearly every day and sometimes more than one time per day" (p. 187). Also, "She became emotionally overwhelmed and self-harmed following contacts with her parents" (p. 187). She had previously received several years of treatment including a course of in-hospital treatment for self-injurious behavior as well as 1 year of dialectical behavior therapy (DBT; Linehan, 1993). Mrs. K completed 13 sessions of EMDR therapy within 40 individual therapy sessions over the course of 1 year. During her EMDR therapy, she separately continued in weekly DBT classes. Following her EMDR therapy, she achieved remission from her self-injurious behavior at 1-year follow-up and her scores on the The Adult Attachment Interview (AAI; Hesse, 1999), shifted from Ds1 (dismissive) with an alternate U/d (unresolved/disorganized) designation to F1 (earned secure).

Etiologic Factors in BPD

Attachment and BPD

Early attachment disturbances have been related to the development of BPD by many authors, but different studies have shown disparate insecure attachment classifications as being more related with adult borderline features. Discussion of these findings is complicated by the various measures used. Some studies use the AAI with its dimensional set of attachment classifications that includes an unresolved/disorganized classification. Other studies use various self-report instruments with entirely different categorical classifications that lack an unresolved/disorganized classification. Agrawal, Gunderson, Holmes, and Lyons-Ruth (2004) reviewed attachment studies of individuals meeting criteria for BPD, concluding that the most consistent findings show that these individuals have unresolved and fearful types of attachment. In studies reviewed by Agrawal et al. using the AAI from 50% to 80% of patients with BPD were classified as "unresolved." On the other hand, a recent study by Barone, Fossati, and Guiducci (2011) using the AAI found Insecure Organized (Dismissing 51% and Preoccupied 35%) and Disorganized (Unresolved—Cannot Classify) categories (40%) were overrepresented on a global view of subjects with BPD, with significantly different distribution of attachment classification found in four BPD subgroups (co-occurring mood/anxiety disorder, substance abuse/dependence, alcohol abuse/dependence, and eating disorders). In the self-report studies reviewed by Agrawal et al. that included a fearful classification, preoccupied attachment was the second most strongly endorsed category among subjects with BPD. Barone et al. found preoccupied attachment most prevalent (52%) in the mood/anxiety disorder subgroup. In no global BPD study, that included the unresolved or fearful classification, was preoccupied the most prevalent overall classification.

Adverse Life Experiences and BPD

Several studies have described the frequent comorbidity between PTSD and BPD (Driessen et al., 2002; McLean & Gallop, 2003; Pagura et al., 2010; Pietrzak, Goldstein, Southwick, & Grant, 2011). Others found a relationship between BPD and specific kinds of abuse (Battle et al., 2004; Cohen, Crawford, Johnson, & Kasen, 2005; Golier et al., 2003; Goodman & Yehuda, 2002; Grover et al., 2007; Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Laporte & Guttman, 1996; Sabo, 1997; Tyrka et al., 2009; Yen et al., 2002; Zanarini, 2000; Zanarini et al., 2002). Ball and Links (2009) reviewed the literature on trauma and BPD in the context of Hill's (1965) classic criteria for demonstrating causation (strength, consistency, specificity, temporality, biological gradient, plausibility, coherence, experimental evidence, and analogy). These authors demonstrated that trauma can be considered a causal factor in the development of BPD as part of a multifactorial etiologic model.

Preliminary research (Leeds & Mosquera, 2012) with clients diagnosed with BPD explored early adverse and traumatic experiences retrospectively with the Family Experiences in Childhood Scale (FECS; Gonzalez, Mosquera, & Leeds, 2011). The FECS is a self-report instrument covering diverse subjective and traumatic experiences during childhood in family. Unsurprisingly, this research found consistent reports of adverse experiences of emotional neglect and lack of affection, losses, parent–child role reversal, lack of respect, and aggressive behaviors. Major traumatic experiences such as sexual abuse were also very prevalent (54% in the Gonzalez et al., 2011, sample), but both experiences of neglect and of abuse probably potentiate each other.

Borderline symptoms are similar to the common known consequences of early traumatization (Timmerman & Emmelkamp, 2001). Various experts have proposed that borderline symptoms be classified as disorders of stress: DESNOS (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005), complex posttraumatic stress disorder (C-PTSD; Herman, 1992), and posttraumatic personality disorder (Classen, Pain, Field,

& Woods, 2006). Many characteristic consequences of early, severe, and chronic trauma overlap with borderline personality symptomatology (Driessen et al., 2002; Gunderson & Sabo, 1993; McLean & Gallop, 2003; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; van der Kolk et al., 2005; Yen et al., 2002) pointing to a causal pathway that goes from early adverse and traumatic experiences to adult with BPD. Because there is broad evidence about the contributions of early, chronic, severe interpersonal trauma, early attachment disturbances, and negative life experiences in the development of BPD, the indications of a role for EMDR treatment of individuals with BPD seem clear.

Genetics and BPD

In addition to the contributions of adverse and traumatic early life experiences to the risk of developing BPD, genetic and biological factors have been identified in the development of borderline features (Siever, Torgersen, Gunderson, Livesley, & Kendler, 2002), as well as in the development of attachment security and emotional regulation skills (Brussoni, Jang, Livesley, & MacBeth, 2000; Crawford et al., 2007; Goldsmith & Harman, 1994). How much environmental and biologic factors contribute to the development of BPD is a matter of some controversy (Bakermans-Kranenburg, van Uzendoorn, Bokhorst, & Schuengel, 2004; Bokhorst et al., 2003; O'Connor & Croft, 2001). Most likely the degree of these influences varies in each specific case and have a complex interaction (M. Mosquera, Gonzalez, & van der Hart, 2011). Despite the present difficulties in directly identifying genetic and biological factors in persons with BPD, these aspects are relevant to a discussion of EMDR case conceptualization and for optimizing pharmacological treatment, which frequently is a necessary parallel approach in persons with BPD. See Gianoli, Jane, O'Brien, and Ralevski (2012) and Lieb, Völlm, Rücker, Timmer, and Stoffers (2010) for recent reviews of pharmacotherapy for persons with BPD. EMDR may provide an interesting tool to assist in discriminating the role of these early experiences in clients' present problems, as Shapiro (2010) remarked.

BPD and Dissociation

Research finds a high frequency of pathological dissociation among clients with BPD (Chu & Dill, 1991; Galletly, 1997; Paris & Zweig-Frank, 1997) with dissociative symptoms identified in more than two-thirds of those diagnosed with BPD (Korzekwa, Dell, & Pain, 2009; Ross, 2007). When working with an EMDR approach, it is essential to clarify as early as possible when significant structural dissociation (van der Hart, Nijenhuis, & Steele, 2006) is present, because in these cases a specific "progressive approach" is needed to identify and work through dissociative phobias and safely access traumatic material (Gonzalez & Mosquera, 2012). The relationship between structural dissociation and BPD is too complex to be developed in this article (see M. Mosquera et al., 2011, for a comprehensive review of this topic).

Considering Etiological Subgroups of BPD in the Therapeutic Plan: Biological, Attachment, and Dissociative Issues

M. Mosquera et al. (2011) proposed three subgroups of borderline presentations that are relevant for EMDR case conceptualization:

1. A more biological group that has stronger biological factors (genetic impulsivity or emotional dysregulation, comorbid bipolar disorder, or substance abuse).
2. An attachment-based group that is predominantly based on early attachment disturbances.
3. A dissociative group that has an early history of disorganized attachment and more severe history of traumatization and presents with a comorbid dissociative disorder or prominent dissociative features.

The first and second groups will be addressed in this article. These two groups may be treated with similar, standard procedures, with the adaptations described in the following text. The primary difference being that the "more biological group" will need a more intensive intervention on these factors and comorbid conditions (e.g., pharmacologically treating impulsivity traits or emotional dysregulation, or giving specific support for drug or alcohol abuse). The third group—with prominent dissociative features—is treated from a similar perspective as those with dissociative disorders, and as noted by Shapiro (2001, p. 443) requires significant modifications in EMDR procedures (see *EMDR and Dissociation: The Progressive Approach*; Gonzalez & Mosquera, 2012). These three groups do not exclude each other but may help to define priorities for treatment and differences in the case conceptualization.

For example, a patient with comorbid bipolar features needed a long period of pharmacological stabilization, followed by a progressive approach to addressing core traumatic memories, alternating EMDR reprocessing with a more supportive psychotherapy when she was more unstable in her mood because of her biological vulnerability. A patient with prominent dissociative symptoms and hostile auditory hallucinations

needed an extended negotiation with dissociative parts and EMDR therapy focused on dissociative phobias before commencing EMDR reprocessing for memories of traumatic experiences. Nevertheless, there is a significant portion of patients with BPD where EMDR reprocessing for memories of traumatic experiences can be offered early in the treatment process, and where the severity of symptoms or patient responses to the safe place installation or RDI are not the main factors in the decision of when to proceed with trauma reprocessing.

BPD and EMDR

The Adaptive Information Processing (AIP; Shapiro, 2001) model provides a conceptual foundation for understanding how relevant biographical information about childhood experiences can be related to specific features of adult psychopathology and offers an excellent therapeutic framework for a disorder that, as mentioned earlier, is strongly related to adverse and traumatic early experiences (Brown & Shapiro, 2006). Nevertheless, some adaptations in standard EMDR procedures are needed to work with clients with BPD throughout the eight phases of EMDR therapy (Leeds & Mosquera, 2012; D. Mosquera, 2012b; D. Mosquera & Gonzalez, 2011a).

Phase 1 in EMDR Therapy: History Taking

In working with the EMDR approach to psychotherapy, clinicians need to gather information about present problems as well as past adverse and traumatic life experiences. However, many clients with BPD do not readily disclose their most relevant current problems or past experiences unless they are addressed carefully and specifically. Dysfunctional attachment patterns, substance abuse, high-risk behaviors, and other relevant problems may not be spontaneously revealed by clients who may be more focused on anxiety or depressive symptoms or on current interpersonal difficulties. One helpful tool for exploring relevant early experiences is the FECS (Gonzalez et al., 2011). The FECS can be useful in exploring issues that clients do not recognize as problematic or that they are reluctant to disclose because of shame or a defensive concept of "family privacy." The FECS goes well beyond a simple list of the top 10 traumatic memories (Shapiro, 2001, p. 202), helping to explore a wide range of adverse life experiences.

Pacing History Taking to Limited Affect Tolerance Capacities. Issues of pacing and affect tolerance must be kept in mind when exploring the client's history and current difficulties. Clients with BPD vary in their capacities to manage the feelings and the memories that are invariably triggered in examining their current maladaptive coping strategies and their generally complex early and adult histories. For example, although some clients may be capable of completing a self-report instrument like the FECS on their own, many find this solitary task overwhelming and destabilizing. These clients need to complete the FECS as a collaborative interview over several sessions with the support and guidance of the clinician. Clinicians need to actively monitor the degree to which clients with BPD feel activated by the history-taking process and to be ready to slow down and shift the focus to developing containment, presentification, and affect regulation skills. A standardized approach to history taking is not adequate for those with complex histories of neglect and trauma. What can be a useful style for one client may be completely inadequate for another. Following guidelines and standards should not make us forget each patient's specific situation and characteristics. Decision making in cases with BPD is more accurate when it is based on a well-bounded therapeutic relationship and a good knowledge in the clinician about the disorder and the AIP model. As Shapiro (2001) states, "It is better to provide practitioners with a conceptual framework or model to serve as a guide to their clinical practice than merely to give them an inflexible step-by step [*sic*] procedure for implementing EMDR" (p. xiii). In working with patients with BPD, these words become especially relevant.

Phase 2: Preparation and Stabilization

The stabilization phase has been characterized as essential prior to trauma work (Courtois, Ford, & Cloitre, 2009; van der Hart, Brown, & van der Kolk, 1989). In treating BPD and disorders of early and chronic extreme stress, this implies many particularities that should be kept in mind including the role of attachment-related states of mind and phobias for attachment, affect, and traumatic memories (Pearlman & Courtois, 2005; van der Hart et al., 2006). Working with cases of BPD and complex trauma is intrinsically relational and often involves the need to manage moments of intense affect and affect phobias in the transference and countertransference. Understanding these aspects and having strategies for addressing them is essential both before and during EMDR reprocessing of traumatic memories to ensure that reprocessing of traumatic memories can be done safely and effectively with these patients (Leeds & Mosquera, 2012).

Therapeutic Relationship. The most challenging aspect of the treatment of the client with BPD is to establish a therapeutic relationship that is both *supportive* and *well bounded* with clients who present

pronounced difficulties in adult attachment and interpersonal connection. One of the most challenging aspects of treating those with BPD is the management of the strong emotional reactions that arise in the therapist during EMDR sessions (Leeds & Mosquera, 2012; D. Mosquera, 2012b; D. Mosquera & Gonzalez, 2011a, 2011b). Clinicians need to have the affect tolerance to remain reflective about the significance of the strong emotions that can be evoked in them when clients with BPD express vehement emotions (Dworkin, 2005). These countertransference responses can be the doorways to recognizing essential issues to be addressed skillfully or to involuntary reenactments of the client's or clinician's or both prior adverse experiences (Dalenberg, 2000). Appropriate specialty education, training, and consultation are indicated when developing these therapeutic skills. In some cases, clinicians need to address the foundations of their own affect tolerance issues in personal EMDR therapy. As part of developing the therapeutic alliance with clients with BPD, clinicians should actively inquire about clients' problems from previous psychotherapies to prevent or minimize recurrences of these past relational difficulties in the present therapeutic relationship.

Psychoeducational Interventions. Psychoeducation should be provided to the client from the initial stage of the therapy (about defenses, problem solving, emotions, needs and especially self-care), helping the client to understand his or her problems, to acquire perspective, and to develop resources that he or she will need before trauma reprocessing. This process need not be extensive in all cases. Indeed, in some cases, resolving relevant traumatic memories as soon as possible can be the best stabilization intervention. Psychoeducation should not be considered as a time-limited intervention with patients with BPD but a longitudinal one. It is often necessary to introduce adaptive information all along the therapeutic process. For example, information about healthy attachment should be introduced in Phase 1 during history taking, addressed more specifically with self-care work, and reintroduced as interweaves during Phases 4–7.

Working on Self-Care Patterns. Self-care patterns are usually problematic in clients with BPD. They tend to lack adequate self-care habits and to focus on external recognition or immediate satisfaction. They have difficulties protecting themselves and establishing healthy boundaries. They lack a healthy balance between caring for themselves and caring for others. They often cannot tolerate positive affect. They have problems asking for help—sometimes being extremely dependent, other times not allowing others to help them. Many individuals with BPD mistreat themselves internally through negative self-dialogue or resort to overtly self-harming behaviors. Specific procedures for improving healthy self-care patterns often need to be applied in this clinical group (Gonzalez & Mosquera, 2012; D. Mosquera, 2012a) in the preparation phase. In complex trauma cases, RDI (Korn & Leeds, 2002; Leeds, 2009) should be extended to include self-care procedures and specific coping skills development (Gonzalez & Mosquera, 2012; D. Mosquera, 2004), giving priority to targets that support healthy functioning in normal activities of day-to-day functioning: regular sleep, regular exercise, ordered eating, freedom from substance abuse, social support, and economic stability. A "test" can be done to see how clients respond to the positive affect in RDI because in rare cases paradoxical (adverse) responses have been reported to RDI procedures in clients with impaired positive affect tolerance (Leeds, 2009, p. 120).

Coping With Urges for Deliberate Self-Harm and Suicidal Threats. Of all the issues that may be encountered in the treatment of those with BPD, deliberate self-harm and threats of suicide are the two aspects that often present the greatest relational challenge for the therapist. The patient who self-injures or thinks about killing himself or herself poses a complex situation at the relational level, and being aware of our emotional responses as clinicians is a central aspect of the therapeutic response. The hopelessness and despair of patients who sees no meaning in life can lead clinicians to see them as lost cases. On the other hand, some therapists can become overly involved in taking responsibility for the patient's life, which invariably leads to a dead end in the therapeutic process. Deliberate self-harm and suicidal threats are multifaceted problems that may be related to a lack of emotional regulation, to negative patterns of self-care, to unprocessed guilt, and to relational issues.

The management of these issues needs to be developed as part of a comprehensive case conceptualization because with different clients, similar behaviors will not respond successfully to the same interventions. A client who threatens or attempts suicide because he or she feels incapable of managing ongoing problems may respond best to a family intervention to mobilize more support. In other cases with suicidal threats, the correct intervention would be to develop better self-care procedures and stronger boundaries to decrease his or her dependency on others and to help focus on his or her own resources. A client who tends to cut himself or herself because he or she lacks adequate regulatory capacities may benefit from a psychoeducational

approach as described in the next section on emotional regulation. In other cases where self-harming behavior is strongly related to irrational thoughts of guilt (e.g., "It's my fault"), the most powerful stabilization intervention may be to reprocess a core memory linked with this negative cognition. The targets for reprocessing in these cases are not the self-harming behaviors themselves, but rather the circumstances surrounding the first time in which self-harm occurred, the origin of the negative beliefs associated with the problem, and memories that can be identified through an affect, cognitive or action urge bridge (Leeds, 2009; Watkins, 1971, 1990).

As in every EMDR procedure performed with clients with BPD, a firm, supportive, and well-bounded relationship is crucial to managing these challenging situations. The client must be held as responsible over his or her choices and behaviors, although still feeling that he or she is being supported by the clinician. A plan for dealing with self-harming and suicidal threats should be developed for each specific case with the client and any family members who are involved.

Developing Capacities for Emotional Regulation. Clients with BPD are prone to intense emotional states that they feel unable to manage, or which they amplify through secondary emotional reactions (e.g., becoming angry because they feel sadness). From one perspective, they seem to tolerate a broad range of emotional reactivity and yet at the same time they often demonstrate an extremely limited tolerance for some specific emotions. Clients with BPD need to learn to accept all their emotional reactions and to place them in situational contexts so that they can understand what triggers them (including past and present events). Psychoeducation about emotions and their functions is crucial for them to realize that feeling hurt and angry does not mean that they are "disgusting," "defective," or "in the wrong."

In the early stages of therapy, it is essential to encourage self-observation because clients with BPD tend to become overwhelmed by their emotions without reflecting on their significance. Developing a meta-cognitive perspective (Fonagy, Gergely, Jurist, & Target, 2002) is a basic regulatory achievement in clients with BPD, who in that way may become aware of their reactions. This "meta" perspective is also essential to facilitate the capacity for dual attention (to past and to present) necessary for effective EMDR memory reprocessing in Phases 4–7. For example, a client with BPD became angry at herself after she opened up to someone who subsequently betrayed her. She reported that her initial emotion was *sadness*, but that she immediately began insulting herself for being *weak* and *emotional*. She was asked to notice what, if anything, changed if she looked at her sadness without judgment and with total acceptance and then did a set of BLS. She then reported she was able to feel compassion for herself. With another set of BLS, her self-compassion increased and she began to think about warning signs of untrustworthiness in that relationship. Then she added that she could learn from this experience.

When clients report excessive fears of others' adverse reactions to their appropriate limit setting or self-directed actions, the origins of these fears can be identified through history taking or the use of an affect bridge and then reprocessed. Self-distracting activities may be more helpful than containment work because these clients habitually tend to contain too much until they explode. Externally driven regulatory strategies (desperately calling friends or relatives, searching for "real" romantic love, etc.) should gradually change to learning to self-regulate (through supportive internal dialogue, changing attentional focus, etc.). Magical solutions should be turned toward realistic strategies. Self-care procedures can help these clients understand their emotional states, to accept them and look at themselves compassionately without judgment, and to set boundaries in relationships. Emotion regulation interventions should not be understood merely as a preparation phase of the treatment previous to starting reprocessing. Both interventions can be combined dynamically depending on each patient-specific characteristics. In some cases, the best self-regulation intervention is to reprocess unresolved core traumatic experiences of being invisible, not being cared for or having no one to turn to for support and protection.

Focused Work on Substance Abuse. Alcohol and drug abuse are frequently co-occurring disorders in BPD (Paris & Zweig-Frank, 2001; Trull, Sher, Minks-Brown, Durbin, & Burr, 2000; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2004; Zimmerman & Mattia, 1999) that should be specifically explored. Substance abuse is often related to the limited capacities for emotional self-regulation observed in individuals with BPD and is a frequent ingredient in the myriad of complex interactions that confounds the treatment of borderline pathology and requires specific approaches. Referral to an evidence-based group treatment for substance abuse such as seeking safety (Najavits, 2002; Najavits, Weiss, Shaw, & Muenz, 1998) may be indicated in the early phases of treatment in parallel with the development of the therapeutic relationship and treatment plan to support development of abstinence. Individual EMDR treatment focused on the development of coping skills

(Korn & Leeds, 2002) and on treatment of current relapse triggers (Hase, 2010; Hase, Schallmayer, & Sack, 2008; Hofmann, 2004, 2010; Popky, 2005) may also need to be integrated into the treatment plan.

Some clients may need to be referred to residential or outpatient treatment programs early in their individual treatment to support their achieving abstinence or in overcoming the risk of dangerous substance abuse related behaviors (e.g., alcoholic blackout or drug overdose). In other cases, they may have repeatedly failed to benefit from such treatment programs and may need focused EMDR treatment on current relapse triggers (Hase, 2010; Hase et al., 2008; Hofmann, 2004, 2010; Popky, 2005) or even on relevant early traumatic memories. For example, a 43-year-old male client presented compulsive drinking and severe aggressive behaviors when under the effects of alcohol. The risk of him hurting someone was high, so his therapist referred him to a residential alcohol treatment program. After 1 month at the hospital, he was thrown out because of frequent interpersonal problems with other patients. His therapist then decided to attempt EMDR reprocessing on an early memory connected with a feeling of powerlessness and guilt that preceded his worst episodes of drinking. Successful reprocessing of that memory ended the problematic behaviors and made it possible for his outpatient therapy to continue. In cases such as this example, conservative work on preparation phase tasks for skills building and self-regulation may be inadequate to meet a client's need to address one or more early memories that underlie reactive behaviors or recurring relapses.

Working on Defenses. In the most general sense, psychological defenses involve a range of internal and external coping behaviors that serve to avoid conflicted feelings and impulses (McCullough, 2003). Defenses can be understood as protections, as affect phobias (McCullough, 2012) or interoceptive phobias of trauma-derived mental actions (van der Hart et al., 2006). They should not be confronted or bypassed in a forced way. Rather they should be approached progressively at a pace the client can tolerate (Gonzalez & Mosquera, 2012; McCullough, 1997). Psychoeducation is a basic intervention in this regard. McCullough (2012) describes this step as defense recognition.

Defenses can often be turned into therapy allies when client and therapist understand their underlying function. When the client is able to identify a defense that the therapist believes is blocking the therapeutic process, it is sometimes possible to reprocess the defense with specific EMDR interventions (Gonzalez & Mosquera, 2012; Knipe, 1999, 2003, 2005, 2009, 2010a, 2010b, 2010c; Leeds, 2009, p. 164; Leeds, 2012; Shapiro, 2001, pp. 192–197). For example, a patient presented frequent defensive attitudes in therapy such as minimization, tending to engage in a superficial conversation and avoidance, and cancelling or arriving late to his appointments. The therapist identified his avoidance tendencies as a central issue and selected them as current triggers so they could be reprocessed. Following this therapeutic compliance and engagement improved.

Specific Procedures for Self-Differentiation. A relevant point that should be addressed is self-differentiation. Harter (1999) reviews different perspectives about the construction of the self-concept and proposes a developmental perspective that explains how early interaction with caregivers (frequently disturbed in patients with BPD) shapes the adult representations of the self. Many individuals with BPD present a lack of differentiation of the self in which the perception of the self contains a mixture of emotions from the self and other people. That is, in the undifferentiated self of clients with BPD, there is a commonality between internal and external perceptions of emotions. Kernberg (1993) describes interventions to address this issue as the first step for treating borderlines. Bateman and Fonagy (2004) call this central issue the "psychic equivalence." Several EMDR specific procedures for differentiation have been proposed (Litt, 2007).

Working With Dissociative Parts of the Personality. We generally find degrees of structural dissociation (van der Hart et al., 2006) even in clients with BPD with milder dissociative symptoms. Dissociative parts of the personality may be perceived and described by clients as "different aspects" or as "changing reactions." Exploring the presence of dissociative parts of the personality through concrete representations (drawings, little figures, etc.) is useful for clinicians in developing and refining a deeper case formulation and for clients in developing capacities for reflective thinking and a metacognitive perspective (van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2013, pp. 8–9). A shared understanding of these diverse aspects of the personality is essential to successful trauma reprocessing with EMDR (Gonzalez & Mosquera, 2012). In cases where structural dissociation is not prominent, it is not necessary to work with dissociative parts of the personality for a long time, but a specific exploration of these aspects in the preparation phase often helps to prevent or to resolve difficulties during Phases 3–7.

Trauma Reprocessing: Phases 3–7

With most individuals with BPD who present with limited current coping skills and minimal emotional

stability, it is generally best not to begin reprocessing with their worst memories or on any early traumatic or adverse memories. In many of these less stable cases, we can nevertheless begin to use standard EMDR procedures in relatively early phases of therapy on current triggers (Hofmann, 2010; Leeds & Mosquera, 2012; D. Mosquera, 2012b) such as emotional reactivity to a current life partner, coworker, or supervisor. With more stable clients with BPD, it is occasionally possible to begin reprocessing on old memories, but this is not typical.

Pacing the Therapeutic Process. When starting reprocessing, the decision-making process for target selection and sequencing may be influenced by many factors both in clinician and patient (Leeds & Mosquera, 2012). Some clinicians (under the influence of an early idealizing countertransference of rescuing or saving the patient) may tend to move too rapidly toward uncovering traumatic material without first understanding the client's capacity to cope with day-to-day difficulties as well as the client's challenges in confronting traumatic material. On the other hand, either the client or the therapist may defensively avoid or delay trauma reprocessing because of a phobia of affect or a phobia for traumatic contents (McCullough, 1997; van der Hart et al., 2006).

Determining (Testing) Readiness for Processing

Testing the standard EMDR procedural steps. A prudent attempt to use the full standard EMDR PTSD protocol (Leeds, 2009; Shapiro, 2001) can be initiated when the client shows signs of stability (as described in the following section). This initial attempt can be labeled as a test, to see if it is a good time to begin directly addressing early adverse and traumatic memories. If the first target is well chosen, if the client understands the aim of the procedure and has a realistic expectative, the results of this test can guide decisions in moving forward toward reprocessing other targets.

Testing modified EMDR procedural steps. A tentative test may be offered even in low-functioning clients using slight modifications to the standard EMDR procedural steps. This test can consist of a short and incomplete reprocessing of a negative element: an uncomfortable situation in daily life, or a low-disturbance (low SUD level) memory from the recent past. Here, it is important to return to target after a few sets of BLS (thereby limiting associations) and stopping the procedure as soon as the disturbance decreases even a little or some insights appear. This short test should take just a few minutes. It can be presented to the patient as an experiment to test the effects of BLS procedures on negative disturbing experiences and to decide collaboratively if BLS procedures may be useful early in therapy or if it should be delayed.

The therapist should explain to the client that even knowing that EMDR therapy with BLS can be useful in his case, the right time to do it is very relevant. The therapist should describe the "experiment" as a situation with many possible outcomes: positive and negative sensations may increase, decrease, or stay the same and they might change places (felt location in the body) or not. BLS may unblock situations that are stuck in the client's brain, and this may be noticed in different ways: The client can become more aware of his emotions, may notice them as more or less intense, different memories may come . . . and all of this is OK. All these possible responses will give information about how the client's brain processes information.

With the results of this test, client and therapist will know if EMDR reprocessing procedures can be introduced early in the treatment or if a longer preparation phase is needed before retrying the test again some months later. The therapist should insist that the patient does not force anything; this will show a great respect for the client's opinion in the decision making. Even when the experiment shows that EMDR reprocessing can be distressing for this specific patient, the therapeutic relationship can be strengthened with the client learning that the therapy is founded on collaborative stance, where the client is the main protagonist.

Selecting Targets. In working with clients with BPD, selecting targets may be challenging for various reasons. There may be many relevant targets with many adverse life experiences and many unique or recurring traumatic experiences (Leeds & Mosquera, 2012; D. Mosquera, 2012b). On the other hand, in complex trauma cases, amnesia or fragmented memories may interfere with identification of crucial targets in the past. When there are clearly identified memories, defense and avoidance mechanisms may not allow them to be addressed directly. Instead, more preparation, psychoeducation, and stabilization work may need to be done. Not infrequently, the defensive, phobic avoidance surrounding certain memories (van der Hart et al., 2013) need to be the initial targets for reprocessing until sufficient specific fears are resolved and sufficient affect tolerance is developed.

Determining Readiness. In accordance with the phase-oriented, consensus model (Courtois et al., 2009; van der Hart et al., 1989), Hofmann (2010) proposed that clients with significantly unstable C-PSTD should generally meet the following four criteria for stability before proceeding to uncovering and reprocessing of core traumatic memories: good self-care in

day-to-day functioning, containment and self-soothing resources, connection with body sensations, and capacity to speak about a traumatic memory without dysregulation. Hofmann proposed that significantly unstable clients with C-PTSD who do not meet these criteria be offered RDI (Korn & Leeds, 2002), Constant Installation of Present Orientation and Safety (CIPOS; Knipe, 2010d), and reprocessing on everyday life targets (current triggers) until they become more stable. Clinicians who consistently elect to wait for these four conditions before starting with EMDR trauma reprocessing may end up waiting for years or may never arrive at the "necessary stability" at all. This "conservative" way of using EMDR may unduly delay or prevent many clients with BPD from benefiting from the core of EMDR therapy (Gonzalez & Mosquera, 2012).

In some cases, where clients with BPD lack good self-care and good self-regulation skills, trauma reprocessing can turn out to be well-tolerated and effective. These clients may become better regulated after limited trauma reprocessing, whereas other "less intense" interventions, which defer or avoid trauma memory confrontation—such as RDI or DBT—may not work as well with them. In some cases, there are no other available resources for the individual or he or she is running out of options. When this is the case, identifying the adverse and traumatic life experiences clearly linked to the most high-risk behaviors and debilitating problems and reprocessing them early in the therapy can be the most stabilizing intervention. With some clients, "going slow" and following a prudent approach is best. With other cases, a more direct approach is needed. Information from "therapeutic tests" is necessary to design a comprehensive case formulation.

Because clients who meet criteria for BPD can be so diverse in their individual organization and responsiveness to our interventions, we need to propose each intervention as an experiment and to carefully consider their responses within and between sessions as essential information for clinical decision making. As we observe evidence of clients with BPD tolerating our interventions and becoming more stable, we transition toward reprocessing the most relevant and sometimes increasingly disturbing targets. Some proposals to structure targeting and reprocessing will be described in the following text.

Different Pathways in the Treatment Plan of BPD. Clients with BPD present different specific situations that influence the pathway the therapeutic process will follow. With the progressive approach, we can start working from more tolerable tasks to more challenging tasks that make use of EMDR therapy with BLS. In general, when working with clients with BPD (apart from the dissociative subtype), five basic options for EMDR interventions may be considered from the more tolerable and accessible to the more difficult to deal with and access:

1. Offering psychoeducation and RDI. This is appropriate when the therapist accurately judges that the client needs specific preparation and is not ready for reprocessing of dysfunctional elements.
2. Collaboratively exploring the effects of BLS on limited dysfunctional elements just to test how BLS works on this specific client. These elements include uncomfortable sensations and difficult but not overly challenging daily life situations.
3. Targeting and reprocessing selective limited dysfunctional defensive elements. This is different from full memory network reprocessing of specific memories. Examples include targeting defensive urges to avoid, compulsive urges to distract, or transference material.
4. Targeting and reprocessing current triggers (while deliberately pruning or deferring core memories). These are selected when the therapist judges that the client is not ready for targeting old memories yet, but is ready to reprocess.
5. Targeting and reprocessing old memories—These are selected when the therapist judges the client is ready to reprocess old memories. These might be early adult, teen, or childhood memories based on their contribution to the worst of their current symptoms. We might find these through (a) direct history taking, (b) the affect bridge (Watkins, 1971, 1990) or floatback (Young, Zangwill, & Behary, 2002, p. 195) or from current triggers, and (c) spontaneous association from more recent memories to an earlier, core memory.

Client Characteristics That Guide Target Sequencing. Specific client characteristics must be kept in mind to guide target sequencing and to organize a therapeutic plan. Here are some examples of the decision-making process:

If there are high-risk behaviors or symptoms that lead to the client decompensating. To support the client in achieving stability, begin with targets in the present or the past that are clearly associated with the client's most debilitating symptom(s) and continuing to work with the targets associated with those specific symptoms until the client shows stable gains with a reduction or elimination of the associated symptoms. Self-harm, aggression or high-risk behaviors, or targets related with decompensation of the client should be

approached first. When the client can tolerate speaking about early memories, even those with intense emotions, begin working on an early memory that the client and therapist understand is connected with high-risk behaviors or debilitating problems. When clients demonstrate they cannot yet tolerate focusing on more disturbing targets from the past, focus on reprocessing current triggers alternating with brief spontaneous or guided contact with targets from the past until the client can tolerate more extensive contact with the past.

If there are intrusive memories, thoughts, or beliefs. When there are *intrusive* memories, work on these first. When memory intrusions are intense and recurrent, the client may strongly benefit from reprocessing them. Often, such intrusive memories are so activated that an attempt to reprocess any other material would be ineffective. Persistent negative thoughts or limiting self-beliefs can be a productive initial target, followed by searching for a specific memory using the procedures previously described.

When there are no (remaining) high-risk behaviors or intrusive memories, thoughts, or beliefs. When high-risk behaviors and intrusions have been resolved or are absent, targets should generally be selected based on the client's capacity for tolerating the work with early and disturbing memories.

When clients report contact with activated memories (Korn, 2009), it is best to select a memory on which the client would like to work to decrease the disturbance associated with it. This is always a better choice than a memory the clinician believes is relevant in situations where (a) there is no client–therapist agreement about its relationship with patient's present problems, and when (b) the client is not willing and ready to work on the memory preferred by the clinician.

When clients do not connect with early disturbing memories or there is dissociative amnesia, begin reprocessing on associated current *triggers*.

In working with clients with BPD, where "spreading activation" to many associated adverse experiences (Collins & Loftus, 1975; Leeds, 1998) is common and affect tolerance capacities remain impaired, it is generally important to limit the scope of associated material that emerges during reprocessing of a current trigger. When associated material arises, the clinician should generally respond by acknowledging the significance of earlier targets and returning attention to the current trigger. However, if the clinician believes a tolerable memory has emerged, the clinician may consider testing continuing reprocessing with that memory *only after checking first for permission to continue with the client* and only as long as reprocessing focused on the memory remains tolerable.

When memories emerge that are intolerable: (a) set these aside; (b) if needed, help the client to restabilize; (c) continue with the current trigger; and (d) *only if the client is willing to resume reprocessing*. The clinician should be alert to indirect signs of discomfort (such as growing restlessness, agitation, or reduced capacities to engage in smooth pursuit eye movement). Because of clients with more severe structural dissociation can be both unaware of such growing discomfort and fail to display observable signals, the clinician should be prepared to search for implicit stop signals from other parts of the personality system such as by using the inner scan (Gonzalez & Mosquera, 2012). Keep in mind that smaller units of work are preferable when they remain within the window of tolerance and the amount of mental energy available to the client. In cases of complex trauma with early histories of learned helplessness, it is essential and highly therapeutic to give clients an active role in decision making, never forcing and checking regularly to make sure he or she has not become overwhelmed or depleted.

When the client is ready to reprocess early traumatic memories. When the client is (a) stable and strong enough to deal with early and highly disturbing *traumatic memories*, (b) there are no relevant defenses or dissociative amnesia, and (c) a first experimental test with BLS has been performed, we can target those memories directly, but the previously described progressive approaches are generally recommended at first.

Adaptations in the Assessment Phase. Having selected a proposed target for reprocessing, it is important to remain alert to additional cautions during Phase 3. The work with selecting negative and positive cognitions sometimes needs simplification and help from the therapist. Although it is useful to know which negative cognition is most strongly related to the target, it is essential to prevent clients with BPD from getting completely lost in a growing cascade of negative self-beliefs. Clients with BPD usually have many strong negative self-beliefs. They often have difficulties when it comes to selecting just one as most strongly connected with a particular experience (Leeds & Mosquera, 2012; D. Mosquera, 2012b). To build their capacity for mentalization (Bateman & Fonagy, 2004), it is highly therapeutic for clients with BPD to recognize that their self-concept emerged from specific (external) experiences. So this standard aspect of Phase 3 is a highly relevant and potentially adaptive intervention that should be retained in the standard EMDR procedure. However, clients who tend to become overwhelmed with this step need more help from the therapist to avoid becoming overwhelmed or

lost. For example, the therapist might say, "I know this is difficult and that many negative statements might be coming up for you now, but please try to think about the situation and pick the one statement that fits best. Take the time you need." Or the therapist might say, "When you focus on that memory and the feelings that it brings up for you, are they more related to a sense of lack of control, a sense of immediate danger, or a sense of worthlessness?" At the same time, therapists need to be alert to *avoid doing the work in this step for the client* such as by initially offering a specific negative cognition. Psychoeducative information can be included, and reflective thinking should be stimulated.

Not infrequently with clients with BPD, identifying a positive cognition (PC) can be more challenging than identifying a negative one. Patients who lack early experiences of shared, interpersonal positive affect and recognition (Leeds, 2006) may lack the positive affect tolerance or the positive self-schemas to name even the simplest self-affirming self-statements. In some cases, specific work on positive affect tolerance can be helpful prior to proceeding with trauma reprocessing. In other cases, the PC initially proposed by the client may be an idealized and not realistic idea that should be modified with guidance from the therapist through a collaborative discussion with the patient. Simple examples include "It never happened," "I can have everything under control," or "I am invincible." A more subtle example might be a client who offers "I am strong" as the PC when the negative cognition was "It is not safe for me to show my needs or ask for help." Here, the idea of being "strong" is actually a defense against the vulnerability of asking for what one needs. In any case, an appropriate PC should be selected before proceeding to Phase 4 (desensitization), or the client would be exposed to a reprocessing that goes from negative to negative, without connecting at any point with positive memory networks. If a strong, specific PC is not possible ("I am a good person"), a bridging one can be chosen, such as "I can learn to accept myself as I am."

Adaptations in the Desensitization Phase

Building structure in the face of spreading activation. A central issue during desensitization in Phase 4 for clients with BPD is to the need to maintain structure (focus). These clients are prone to "spreading activation" (Collins & Loftus, 1975; Leeds, 1998), with one dysfunctional memory network linking into many others and seldom if ever linking to adaptive memory networks. Therefore, in such cases of disorders of extreme stress, the standard EMDR instruction at the start of reprocessing of saying "Just let whatever comes up, to come up" is not necessarily a good idea. These clients tend to live in chaos and may have a list of a "top hundred" disturbing memories instead a list of "top 10." In many clients with BPD, if the clinician simply follows the spontaneous associative process, too much material can easily be activated without leading to effective reprocessing. Variations on standard reprocessing guidelines have been proposed by several authors (Gelinas, 2003; Korn, 2009; Leeds, 2009; Paulsen, 1995) that somewhat resemble the original EMDR (Shapiro, 1989)—which returned to target after every set of BLS—by using short association chains. After only two or three sets of BLS or as soon as one or two new (negative) memories arise by spontaneous association, return to target, and ask "What is different?" (to avoid an automatic response of "The same").

Repeated use of interweaves to activate adaptive information. Deliberate activation of adaptive information, also known as *interweaves* (Leeds, 2009) or cognitive interweaves (Shapiro, 2001), can be repeatedly introduced before subsequent sets of BLS when needed to address ineffective reprocessing. The therapist can introduce some elements of a positive change in beliefs, for example, "What would help you to think better about yourself?" To assist the client in moving toward reflective thinking, mentalization, and realization, when returning to target, the therapist can ask one of the following questions: "What do you understand about this experience now?" "What do you think about this experience now?" "What are you aware of now that you were not aware of then?" During reprocessing with clients with PTSD from a single or limited number of experiences, linking of adaptive information and realization often happen spontaneously. During reprocessing with clients with disorders of extreme stress, it is possible to actively promote the linking of adaptive information and realization that, because of a limited early exposure to adaptive experiences, may not take place otherwise.

Actively exploring for secondary emotions that can disrupt reprocessing. Another way to enhance effective reprocessing is to assist the client to deal with the *secondary emotions* that frequently emerge in those with BPD. These secondary emotions are related to negative judgments or beliefs that are activated as consequence of a primary emotional state (see Leeds, 2009, p. 164; Shapiro, 2001, pp. 192–193). For example, when the patient experiences rage, he or she can think "I am bad (just like the angry abuser was)." The belief "I am bad" is associated with *secondary feelings of shame*. This secondary emotion can disrupt the reprocessing. Such disruptions can be indicated by statements such as "Nothing is coming," by sudden somatic symptoms, by excessive talking, by increasing anxiety, or by overwhelming increases in the client's level of emotional activation.

Following each set of BLS, after making the standard inquiry ("What are you noticing now?") and listening to the client's verbal report, each time the therapist observes a decrease in the fluency of associations, it can be useful to make an additional inquiry to identify possible inner conflicts such as an affect or dissociative phobia: "What else is happening with you now?" This can help to identify relevant information and the need for a further intervention. It can also help the client to gain perspective and acquire a metacognitive stance. Depending on the specific situation, several possible interventions may help the client to recover the "mindful stance" needed for effective reprocessing. Examples include "Don't judge anything that comes," "Your own rage was not the cause of the mistreatment that your . . . (the abuser) caused with emotional abuse," "Do you really need this emotion now?" (sometimes clients believe they need to cling to an old emotion), "Allow yourself to feel *all* your feelings," or "Let it out . . . it's ok."

The centrality of an adequate therapeutic alliance. Throughout the desensitization phase, clinicians should remain attentive to moments of misattunement and relational issues. As noted earlier, the most central factor to support structured reprocessing for clients with BPD is a well-grounded, calm, firm, and supportive therapist who has a strong enough therapeutic relationship with the client. From this point of departure, various technical interventions can be very useful, but these same interventions can also be completely ineffective in the absence of an adequate therapeutic alliance.

Ending the Session. The standard EMDR procedural steps and principles for reprocessing to individuals with PTSD without BPD or DESNOS are oriented toward striving for a completed session. However, when offering reprocessing to individuals with BPD, it is better to do a modest amount of good work and finish with an incomplete session than to push to try to complete reprocessing on a specific target (Leeds & Mosquera, 2012). Indeed, when working with clients with BPD, it is often prudent or necessary to bring sessions to a close when technically incomplete. When sessions are incomplete, therapists may consider a series of steps toward closure. These include inquiry into the client's level of emotional and somatic activation; interventions for self-soothing, grounding, and presentification; session review with an emphasis on "mentalization"; brief installation of metacognitive statements reflecting any gains; and suggestions for homework or rehearsal of self-care.

Early, partial installation to support noticing change and mentalization. After assuring that the client is feeling well oriented, emotionally in control, and able to reflect on the session, the therapist can inquire about the client's sense of gain, insight, or realization from the session. Then the therapist can consider briefly "installing" any achievement or realization that happened during the session or any needed resource(s) that could help the patient to deal with the memory. Such brief installations typically involve only two or three sets of BLS and should not press for a Validity of Cognition of 7. The statement reflecting achievement or realization should, of course, be realistic. For example, if the client requests to install the preferred statement, "That this didn't happened," that would not be acceptable. But the therapist can propose an alternative more adaptive statement of possibility: "Some day I will be over this . . . some day this will not hurt me," or any other healthy possibility that the patient might actually believe at that moment.

Reevaluation

Most targets will only be reprocessed to completion after several sessions. During the reevaluation phase which opens subsequent sessions, it is essential to "check one's work" by inquiring about the client's experiences following the previous session as well as inquiring into the specific target from the previous session. In deciding how to proceed, it is important not to lose focus and it is essential to avoid "target hopping" (D. Mosquera, 2012b). The patient might bring different issues to work on at every session, but it is important to find a balance between acknowledging current concerns while maintaining a focus and keeping on track with well-selected targets (Leeds & Mosquera, 2012). It is important to have in mind a clear yet flexible therapeutic plan because these patients often function in a very chaotic way.

Conclusions

EMDR is a promising therapy for clients with BPD, but its application requires several adaptations of the standard EMDR procedures, which were originally developed for simpler cases of PTSD. The subgroup of clients with BPD who show more prominent features of structural dissociation will be better approached with interventions for dealing with structural dissociation (Gonzalez & Mosquera, 2012). Clinical experience suggests that many clients with BPD need only limited amounts of stabilization intervention and only minor modifications in standard EMDR procedures to safely access and reprocess traumatic material such as those described in this article. A central issue in developing and organizing safe and effective EMDR treatment plans for clients with BPD is the development of the conceptual, perceptual, procedural, and intersubjective skills clinicians need for pacing the work through

each of the eight phases of EMDR. The development of these skills requires advanced specialty education, training, and consultation. Previously published cases (Brown & Shapiro, 2006; Wesselmann & Potter, 2009) and a forthcoming case series (Mosquera, Gonzalez, & Leeds, 2014) document positive results from the application of EMDR as described in this article. We believe that further research is warranted to examine the principles that have been enumerated in this summary. For example, individuals screened to meet criteria for BPD could be randomly assigned to a similar number of treatment sessions with DBT or with EMDR therapy based on these principles.

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