

## **BEHAVIORAL ACTIVATION AND THE PREVENTION OF SUICIDAL BEHAVIORS IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER**

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Clinical approaches in treating and preventing suicidal behaviors in patients with borderline personality disorder (BPD) have received limited attention. To stimulate further work in this area, we present a behavioral activation treatment for depression (BATD; Lejuez, Hopko, & Hopko, 2002) that has shown promising results in treating clinically depressed patients and a theoretical conceptualization for why BATD may prove particularly useful in reducing the frequency of suicide-related behaviors and other symptoms characteristic of patients with BPD. We also present theoretical consistencies between BATD and the well-established intervention of dialectical behavior therapy (DBT; Linehan, 1993), which may allow for their practical integration, and conclude with a case study that illustrates the assimilation of these strategies in the treatment of a patient with BPD.

According to the Centers for Disease Control and Prevention (CDC, 1998), suicide was the third leading cause of death for adults aged 15 to 44 years. Demographic predictors include being male; Caucasian; divorced, widowed, or separated; living alone and in an urban area; and unemployment (Fremouw, de Perczel, & Ellis, 1990). Clinical risk factors include inadequate social support, deficient coping strategies, chronic illness, family history of suicide attempts, psychiatric problems, a history of physical or sexual abuse, and previous suicidal attempts (Fremouw et al., 1990). Suicide risk also is associated with certain psychiatric conditions including mood disorders, substance dependence, schizophrenia, and personality disorders (Kaplan & Sadock, 1998). Of the personality disorders, suicidal behaviors are most common among individuals with borderline personality disorder (BPD). The primary objectives of this article are to first outline the magnitude of the suicidality problem among patients with BPD. Second, we

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highlight the remarkable paucity of research that has examined the efficacy and effectiveness of psychosocial interventions in reducing the frequency of suicidal and parasuicidal behaviors among patients with BPD. Third, we outline a brief behavioral activation treatment for depression (BATD; Lejuez et al., 2002) and a theoretical conceptualization for why this intervention may be an uncomplicated and effective means to reduce suicidal behaviors and simultaneously ameliorate other symptoms characteristic of patients with BPD. Finally, we emphasize theoretical consistencies between BATD and the well-established intervention of dialectical behavior therapy (DBT; Linehan, 1993) that may allow for their practical integration and present a case study in which a patient with BPD and suicidal ideation is treated via this combined approach.

### **SUICIDALITY AND BORDERLINE PERSONALITY DISORDER**

The prevalence of BPD is high in both inpatient (19%) and outpatient (11%) mental health settings (Widiger & Frances, 1989), with epidemiological catchment area data estimating that 2% of the population meet criteria for BPD (Swartz, Blazer, George, & Winfield, 1990). Demographic characteristics associated with the disorder include being female, single, younger, of lower socioeconomic status, and residing in an urban area (Swartz et al., 1990). Clinically, BPD frequently co-occurs with a number of Axis I conditions that include mood, anxiety, substance abuse, and eating disorders (Adams, Bernat, & Luscher, 2001). Perhaps the most significant correlate of BPD is the alarming rate of suicidal, parasuicidal, and self-injurious behaviors (Gunderson & Ridolfi, 2001). For example, suicide rates for individuals with BPD range from 9 to 36% and as many as 75% of patients with BPD have a history of at least one parasuicidal or self-injurious behavior (Gunderson, 1984; Soederberg, 2001; Shearer, 1994). Among the suicidal risk factors in patients with BPD, researchers have implicated age, educational level, childhood loss, decreased treatment contact prior to hospitalization, previous suicide attempts, self-mutilation, childhood physical and/or sexual abuse, and increased impulsivity (Brodsky, Malone, Ellis, Dulite, & Mann, 1997).

Given the strong association between suicidal behavior and BPD, several hypotheses address how pervasive characterological disorders may predispose one to engage in suicidal or parasuicidal behavior. Among these alternative viewpoints, patients with BPD: (a) may be more predisposed to mental disorders associated with increased suicidality, (b) may exhibit more pervasive difficulties in relationships and psychosocial adjustment, (c) may be more apt to encounter undesirable life events as a consequence of impulsive and irrational behavior, and (d) may have fewer coping resources to adapt to stressful life events (Kaplan & Sadock, 1998). Despite the significance of suicidal and parasuicidal behaviors and the chronicity and impairment in functioning associated with BPD, assessment and intervention strategies are relatively understudied and underdeveloped compared with other psychiatric disorders (Linehan & Heard, 1999), and very few randomized control trials have targeted maladaptive behavior patterns through psychological intervention (Linehan, 1993, 2001). This situation is problematic

given that self-harm behaviors are among the more complicated clinical factors in treating patients with BPD (Linehan, 1993).

### **TREATING SUICIDE IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER**

Although psychosocial and pharmacological interventions are used with acutely suicidal patients in an inpatient environment, data suggest inpatient hospitalization may be of limited use in deterring future suicidal attempts (van der Sande et al., 1997). As a preferable intervention model, researchers have suggested that long-term outpatient treatment may be most suitable for chronically suicidal individuals (Clark, 1995). In this context, two prevailing theoretical models guide intervention (Pulakos, 1993). First, the crisis-intervention model assumes suicidal feelings are acute and that suicide is preventable. Alternatively, the continuing-therapy model emphasizes the chronicity of suicidal ideation and posits that suicide is not directly preventable, but requires an ongoing treatment effort that emphasizes the incorporation of multiple resources (e.g., mental health practitioners, family, friends). Integrating these models, a significant number of psychosocial interventions have been used to treat BPD, including psychoanalytic/psychodynamic, behavioral, cognitive, family-oriented, group-based, and supportive strategies (American Psychiatric Association, 2001). Results of randomized controlled outcome studies suggest that only psychodynamic and dialectical behavior therapies have demonstrated efficacy in treating BPD (Bateman & Fonagy, 1999; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). In line with these outcome data, the current standard of care for patients with BPD is long-term psychotherapy complemented by symptom-targeted pharmacotherapy (American Psychiatric Association, 2001). Accordingly, psychotropic medications, which include SSRIs, tricyclic antidepressants, MAOIs, anxiolytics, mood stabilizers, and neuroleptic medications also may be utilized to enhance treatment response.

Although advances have been made in treating symptoms of BPD, systematic efforts to develop and validate symptom-specific psychosocial interventions that directly target suicidality or parasuicidality are lacking. Clinical strategies used to address such problems have included no-suicide contracts, family psychoeducation, community interventions, treatment of co-existent psychopathology, intermittent letter contact, remediation of social skills and problem solving deficits, brief psychodynamic therapy, cognitive therapy, and components of dialectical behavior therapy. Linehan's comprehensive literature review (Linehan, 1997) identified only 20 randomized clinical trials of psychosocial and psychotropic intervention studies explicitly designed to reduce rates of suicide and parasuicidal behaviors. Analyses revealed minimal support for the aforementioned clinical strategies, with only four psychosocial intervention studies and one pharmacotherapy study yielding efficacious results when compared to control conditions.

Given the paucity of research examining the utility of psychosocial interventions for suicidality and parasuicidal behavior, the lack of efficacy and effectiveness of many of the existing treatments, and the significance of

self-harm behaviors among patients with BPD, continued development and refinement of psychotherapeutic strategies to prevent suicide is critical. One particularly promising intervention is the empirically validated and widely used treatment approach of DBT. The emotional acceptance and behavioral change model of DBT is a dialectical approach that seeks to balance an understanding and validation of underlying emotional experiences while simultaneously encouraging behavior modification. The behavioral change component of DBT involves decreasing suicidal, therapy-interfering, and quality of life interfering behaviors, and increasing skillful behaviors in the areas of distress tolerance, emotion regulation, and interpersonal relations. Relevant to the suicide component of treatment, skillful behaviors are in part learned to decrease the likelihood of suicidal behavior (i.e., a proactive component). Linehan's protocol (Linehan, 1993) also includes strategies to be used when suicidal behavior is more imminent, including problem solving, conducting a functional (or chain) analysis of suicidal behavior, focusing on negative consequences of suicide, and developing a nonsuicidal behavioral plan (i.e., reactive component).

In line with the prevailing research and theoretical basis of DBT, we present a recently developed behavioral activation treatment for depression (BATD; Lejuez et al., 2002) that may prove useful in reducing the frequency of suicidal, parasuicidal, and self-mutilating behaviors exhibited by patients with BPD. BATD maintains the emotional acceptance and behavioral change philosophy, and similar to DBT, takes a proactive approach to addressing suicidality. Differing from DBT, however, the mechanism of decreasing suicidality is not through direct skill enhancement procedures, but rather through modifying the environment such that patients are increasingly exposed to positive affective experiences via increased frequency of rewarding and healthy behaviors. The behavioral activation rationale is that as rewarding experiences begin to occur more frequently, more positive thoughts and emotions evolve, with subsequent decreases in the likelihood of engaging in incompatible unhealthy acts that include self-harm behaviors. Based on this philosophy, we discuss why BATD may be particularly useful in treating suicidality.

### **BEHAVIORAL ACTIVATION TREATMENT FOR DEPRESSION (BATD)**

BATD is a behavioral treatment based on the concept of matching theory (Herrnstein, 1970). In line with matching theory, BATD is based on the idea that behavior is maintained by its consequences and that human behavior is conceptualized as *choice* behavior. In this context, choice implies the notion that the different contingencies of reinforcement for alternatives in one's environment make one behavior more likely to occur than an alternative behavior. Accordingly, the consequences for a particular behavior are considered in relation to consequences for all other possible instances of behavior. Applied to psychopathology, all behavior is categorized as either "healthy" or "unhealthy." Healthy behavior is defined as overt behaviors that are directed toward improving one's quality of life and/or functioning and are directed toward the attainment of some goal, objective, or reward. Healthy behavior is directly incompatible with unhealthy behavior. Similar

to “healthy” behaviors, unhealthy behavior may be a function of some reward via positive (e.g., sympathy of friend or family member) or negative reinforcement (avoidance of responsibility), but unhealthy behaviors serve to impact one’s functioning or quality of life negatively. Matching theory posits that unhealthy behavior not only should be considered in terms of its direct consequences, but also in terms of the consequences for healthier alternative behavior. Specifically, the relative value of unhealthy behavior compared to healthy behavior is proportional to the relative value of reinforcement obtained for unhealthy versus healthy behavior, with *value* determined by parameters of the reinforcement schedule (including frequency, magnitude, duration, immediacy, and certainty). Logically, if the reinforcement value associated with unhealthy behavior is greater than that of healthy behavior, unhealthy behaviors will more likely occur.

One may question how the apparently marginal level of reinforcement provided by unhealthy behaviors can be greater than that provided by healthy behaviors. In line with matching theory, the answer to this question depends upon a contextualistic understanding of reinforcement value. As one example, BPD-related behaviors may begin because of immediate and certain positive consequences, even though the resulting magnitude and duration of negative consequences may be quite severe. Indeed, self-medication through substance use or an aggressive response to conflict may in the long-term result in significant impairment in social or occupational functioning, yet the behavior may be highly valued because the temporary relief and consequences are certain and immediate (e.g., emotional avoidance, control of others). In contrast, whereas healthy behavior may have the potential for producing a high magnitude and duration of reinforcement, the presence of delay and uncertainty reduce the value of the reinforcement. For instance, attempts at relationship building via identification and engagement in prosocial behaviors may be neither immediately rewarding nor guaranteed. For a more *impulsive* individual with BPD, unhealthy behaviors may therefore seem far more valuable given the certainty and immediacy of reinforcement for these actions.

Considering that unhealthy behaviors generally create more significant life problems as they persist, one might predict that the value and corresponding frequency of such behaviors would decrease over time with a resultant increase in healthy behaviors. Given the chronic nature of personality disorders, this hypothesis clearly is unsubstantiated. Explicated within the framework of matching theory, one explanation for why healthy behaviors do not become more valuable than unhealthy behaviors is that previous engagement in unhealthy behavior may restrict sources of reinforcement for newer healthier behaviors. For example, if a patient with BPD has strained relationships with friends and family because of aggressive behavior, substance abuse, and/or suicidal or parasuicidal actions, these individuals may be reluctant to reinitiate contact even if the patient has begun to reduce these behaviors and engage in more healthy behavior (Coyne, 1976). Thus, healthy behavior may not produce much reinforcement initially and may need to occur more regularly and with minimal initial reward until trust is reestablished. So although the reinforcement value of BPD-related behaviors, including those related to suicidality, may be

somewhat small in absolute terms, the reinforcement value may be considerably larger when considered in relative terms.

An additional explanation for the persistence of unhealthy behaviors may relate to reinforcement obtained through certain environmental contingencies. This process further reduces the salience, immediacy, and certainty of reinforcers for healthy behavior, continuing the pattern of inappropriate characterological behaviors. Illustrated in the example of an individual with BPD who engages in self-injurious acts, reinforcement of this unhealthy behavior may involve an avoidance of emotional distress and/or immediate attention received from members of his/her social system. The immediacy of these consequences inhibits the individual from exploring alternative, healthier approaches to obtain the same result. The target of treatment, therefore, is to assist the individual in developing an environment (i.e., life experiences) in which the likelihood of obtaining reinforcement in a healthier manner increases. The challenge in this approach is to help the individual learn that reinforcement may be obtained via engagement in a wide range of behaviors, and to become aware of factors such as immediacy and certainty that affect the value of a reinforcer. In all cases, it is vital to consider the specific reinforcing aspects of unhealthy behaviors.

### **USING THE BRIEF BEHAVIORAL ACTIVATION TREATMENT WITH SUICIDAL PATIENTS**

At its core, BATD is based on the premise that systematically increased activity is a necessary precursor toward the reduction of parasuicidal, suicidal, and self-harm behavior. This philosophy is consistent with data demonstrating that increasing activity (i.e., response-contingent reinforcement) and establishing reasons for living function to increase resiliency and ward against depressive symptoms in general (Jacobson et al., 1996; Hopko, Lejuez, & Hopko, in press; Hopko, Lejuez, LePage, Hopko, & McNeil, 2003; Lejuez, Hopko, LePage, Hopko, & McNeil, 2001) and suicidal behavior specifically (Malone et al., 2000). Although providers need to understand the basic underlying theory behind the approach, implementation is relatively easy for providers and patients, as it does not include complex strategies that may be difficult to comprehend or implement.

As outlined in the treatment manual (Lejuez et al., 2002), initial sessions should aim to assess the function of self-harm behavior, establish rapport with the patient, and introduce the treatment rationale. Consistent with Linehan's (1993) concept of emotional validation, patients are presented with the notion that although treatment will require a significant commitment, their chances of overcoming parasuicidal and self-harm behaviors are improved when the environment is supportive of healthy behavior and attempts to limit self-harm behavior. To develop such an environment, patients are encouraged to communicate with family and friends about their desire to gradually increase healthy behaviors and decrease self-harm behaviors. Patients are instructed to request that family and friends NOT focus on self-harm behaviors or symptoms, but rather on the patient's efforts to engage in healthy alternatives. This is not to say that patient's statements about suicide are ignored. On the contrary, both therapist and family mem-

bers should continually assess the imminence of suicidal/parasuicidal behavior, and if these behaviors do occur, appropriate strategies should be followed (Linehan, 1993). It is made clear at the outset of BATD, however, that the patient, therapist, and family members agree that the patient will work to solve problems in a manner that does not include parasuicidal, suicidal, or self-harm behaviors. Formalized behavioral contracts are helpful in this regard, outlining specific ways family and friends can assist the patient in creating a healthy environment and how crisis situations will be addressed. Family members or friends may write down how they will avoid rewarding self-harm gestures, what the patient can do as an alternative (i.e., healthy behavior), and how the family member or friend will attend to these instances of healthy behavior.

Once efforts have been made to reduce reinforcement for unhealthy behavior, patients are instructed to engage in a weekly self-monitoring exercise to examine already occurring daily activities. The primary goals of this assignment are to (a) provide a baseline measurement by which to compare progress following behavioral activation, (b) make the patient more cognizant of the quality and quantity of his/her activities, and (c) provide some ideas with regard to identifying potential activities to target during treatment. Following this monitoring, the emphasis shifts to identifying a person's values and goals (i.e., reasons for living) within a variety of life areas that include family, social, and intimate relationships; education, employment/career; hobbies/recreation; volunteer work/charity; physical/health issues; and spirituality. Behaviors and activities are then generated through a collaborative effort by the patient and therapist to facilitate movement toward these goals. In addition to activities associated with major life areas, a suicidal patient may be asked to list activities that provide relief and distraction from suicidal thoughts.

Following this exercise, an activity hierarchy is constructed in which 15 activities are rated ranging from "easiest" to "most difficult" to accomplish. The process of generating a hierarchy of adaptive behaviors aimed at replacing activities and situations that reliably trigger parasuicidal or suicidal behaviors is in itself a useful exercise in promoting adaptation and in devaluing reinforcers for parasuicidal, suicidal, and self-harm behavior. Using a master activity log and behavioral checkout to monitor progress, the patient moves through the hierarchy in a progressive manner, moving from the easier behaviors to the more difficult. For each activity, the therapist and patient collaboratively determine what the *final goal* will be in terms of the frequency and duration of activity per week. These goals are recorded on the master activity log that is kept in the possession of the therapist. *Weekly goals* are recorded on a behavioral checkout form that the patient brings to therapy each week. At the start of each session, the behavioral checkout form is examined and discussed, with the following weekly goals being established as a function of patient success or difficulty. Rewards are identified on a weekly basis as incentive for completing the behavioral checkout. Earlier sessions that include an explanation of the treatment rationale, rapport building, and activity and goal selection may take as long as one hour. Over time, as the patient becomes more skilled at monitoring, the length of treatment sessions may be reduced to 15 to 30 minutes.

**THE POTENTIAL UTILITY OF BATD FOR PATIENTS WITH BPD**

The fundamental objective of BATD is to engender healthier behavior patterns by extinguishing maladaptive behaviors, such as suicidal and parasuicidal behaviors and systematically exposing patients to activities or behaviors that will increase the likelihood of experiencing response-contingent positive reinforcement. As such, BATD is designed to encourage patients to work toward modifying overt behavior that is more directly in their control, rather than trying to rid themselves of maladaptive cognitions or aversive emotions that are perceived as more difficult to change. To the extent that reinforcing overt behaviors are identified and engaged in, unhealthy behaviors that include suicidal, parasuicidal, and self-harm gestures lose their reinforcement value and decrease in frequency. Indeed, recent data show that BATD may be an effective and parsimonious treatment for major depressive disorder in outpatient and inpatient settings, as well as a successful adjunct to pharmacotherapy (Hopko et al., 2003; Lejuez et al., 2001).

In addition to being used to alleviate depressive symptoms, it is conceivable that BATD may greatly enhance the psychosocial treatment of patients with BPD. First, the high comorbidity of depression and BPD and the finding that BPD patients report stable depressive symptoms and feelings of hopelessness even with a year of DBT treatment (Linehan et al., 1991) suggests that despite the comprehensive approach of DBT, adjunct psychosocial treatment strategies such as BATD may be needed to better address depressive symptomatology. Although Linehan (1993) acknowledges the importance of environmental change and a structured natural environment that will promote reinforcement of behavior, the emphasis is more on teaching patients problem solving, communication, and social skills in addition to facilitating exposure (to aversive events) and developing contingency management strategies. DBT does not include a structured yet ideographic method of assessing decreases in response-contingent reinforcement of healthy behavior, identification of potentially rewarding behaviors, or a systematic method of assisting patients to engage in behaviors that increase the likelihood of obtaining life goals. As such, although patients may be well equipped with the skills to successfully negotiate various behaviors, activities, and interactions, they may lack direction in terms of specific life areas in which change is desired, where to begin with behavioral change, as well as when to move forward with more difficult behaviors. The importance of this process is highlighted within the BATD protocol in that patients begin with behaviors that are easier to achieve, likely to result in immediate reinforcement, and thus more conducive to continued treatment commitment and depressive symptom alleviation. Different from the DBT model, therefore, a more concentrated effort is placed on structuring therapy to go beyond skills training and reinforcement within the therapeutic setting to methodically working toward increasing response-contingent positive reinforcement in the natural environment.

Second, given the behavioral dysregulation and impulsivity associated with BPD (Linehan, 1993), the systematic method of the protocol toward identifying and increasing healthy behaviors may provide some much needed structure in the life of the patient. In the most optimal case, the se-



lected behaviors will include both those that the patient already is doing and others that are easily mastered, thereby providing the immediacy and certainty of reinforcement that often is lacking from healthy behaviors selected by patients without the structure of the program. Indeed, individuals in treatment often believe they must make large-scale life changes and take on insurmountable goals. Consequently, patients find themselves only focusing on activities (e.g., exercising, saving money, re-engaging broken relationships) for which the benefits may not occur until some time in the distant future. When a patient's only alternative to engaging in impulsive actions such as suicide-related behaviors, substance abuse, or promiscuity, and the feeling of momentary relief that may accompany these behaviors, is the abstract concept of achieving some longer-term, work-intensive goal, it is unlikely that they will succeed. Therefore, although more difficult behaviors that provide less immediate and certain reinforcement should be included in the patient's activity hierarchy, these goals should only be attempted following more preliminary successes in the program.

Finally, several aspects of the treatment are especially appealing in that they are quite amenable to use with BPD patients and their families. As with its use in other protocols, behavioral contracting that targets self-harm behavior provides a useful framework for facilitating discussion with family members and friends regarding their role in the development and maintenance of the problem, and gives guidance for future interactions that involve self-harm behaviors. The values assessment and goal selection provides the patient with a positive focal point and is an excellent reminder of reasons for living. This component of treatment also provides an excellent opportunity for the therapist to validate the patient's needs, goals, and desires and may be an important means by which to develop a patient's self-image and identity, which many BPD patients have difficulties forming (Linehan, 1993). As mentioned previously, the hierarchical nature of the weekly activities allows the patient to experience a sense of accomplishment early in the treatment after achieving a few simple and relatively easy goals, and to avoid feelings of failure and of being overwhelmed by unrealistic expectations. This feature of the treatment may prove useful in initial facilitation of self-management skills, which is an important target to be addressed in therapy (Linehan, 1993). Continued efforts toward increasing self-management involve the structured monitoring system utilized in the treatment. The structured feature of the master activity log and weekly checkouts assists with setting limits on impulsive behaviors and thus also help with behavioral regulation, while the flexibility of the type and number of goals set each week gives the patient a sense of control and autonomy within the overall structure. Finally, when suicidal or parasuicidal behaviors are part of the presenting problem, incompatible behaviors (e.g., asking for assistance with disputing maladaptive cognitions when distressed, taking time out when involved in a negative interpersonal interaction, engaging in self-care behaviors such as exercising, journaling, going to church, meditating, etc.) can be directly targeted in the weekly goal setting assignment, as well as rewards for exhibiting these behaviors (e.g., treating oneself to a nice dinner if all weekly goals are met).

### **CASE ILLUSTRATION**

Jennifer was a 25-year-old, single, Hispanic female who was a full-time college student. At intake, she reported several symptoms of depression that included suicidal ideation, dysphoric mood, avolition, difficulty concentrating on schoolwork, fatigue, excessive sleep, and feelings of low self-worth and hopelessness. Jennifer reported having depressive symptoms and suicidal ideation from a very young age but indicated that she did not receive any mental health treatment prior to beginning college at the age of 18. At that time, Jennifer experienced time management difficulties, problems with interpersonal relationships, and high levels of academic stress. In response to these stressors, she began engaging in daily bingeing and purging behaviors that included vomiting and excess laxative use. These behaviors continued for several months until she sought treatment at a local eating disorders clinic. Treatment lasted approximately 5 months and consisted of psychoeducation, group therapy, and nutritional guidance. Following treatment, Jennifer reported a termination of her purging, but not bingeing behavior. Since this initial therapy experience, Jennifer had seen numerous outpatient mental health providers for the treatment of ongoing relational problems and depressive symptoms (including significant suicidal ideation). Treatment included several years of primarily insight-oriented therapy together with trials of various antidepressant medications. Jennifer was admittedly resistant throughout psychotherapy and generally noncompliant with pharmacotherapy.

The most serious episode of depression occurred in the fall of 1999 when Jennifer began a combined baccalaureate/master's program that was academically rigorous. She reportedly felt unable to perform at a level equivalent to her classmates and indicated that her grades were unacceptable, a situation that intensified maladaptive cognitions based on a core belief that she was a failure. In March 2000, Jennifer experienced an escalation of suicidal thoughts and attempted suicide by swallowing approximately 200 pills of Prozac (believing this to be a lethal dose). After becoming ill, Jennifer went to the hospital and was admitted for psychiatric evaluation and treatment. Following a 1-year leave of absence, she returned to school to earn her baccalaureate. Jennifer presented to our outpatient clinic in May 2002, indicating that she was seeking treatment due to the progressive worsening of her affective symptoms, suicidal ideation, unstable relationships, and increasing demands associated with academic responsibilities. Although she did not report any suicide attempts subsequent to her first, she was experiencing recurrent fantasies of death and hopelessness about her future. Thus, the potential for another suicide attempt was a significant therapeutic concern.

### **ASSESSMENT**

Jennifer was well-groomed and neatly dressed. Speech rate was rapid, with excessive detail and tangentiality that frequently made it difficult to conduct the interview. Although there was no evidence of perceptual distortions, Jennifer displayed an extremely rigid pattern of thought, expressed as "all or none" thinking and behavior (e.g., individuals in her social network were ei-

ther extremely supportive or reprehensible). Although she reported significant suicidal ideation, Jennifer denied any specific plans or intent to harm herself. She appeared to be of average to above-average intellect and her insight generally was adequate, although she did not appear to recognize her responsibility in the damage/termination of several significant interpersonal relationships.

Jennifer was assessed with two semi-structured interviews [Structured Clinical Interview for DSM-IV Axis I Disorders (First, Spitzer, Gibbon, & Williams, 1996) and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (First, Spitzer, Gibbon, Williams, & Benjamin, 1997)]. Results indicated that she met diagnostic criteria for recurrent major depressive disorder, binge-eating disorder, and obsessive-compulsive personality disorder. Although Jennifer initially was given a rule-out for borderline personality disorder (BPD), it became apparent in the early stages of therapy that she did meet the criteria and associated features of BPD. Among these symptoms were intense and unstable interpersonal relationships marked by alternating extremes of idealization and devaluation, affective instability, unstable self-image, a pattern of sabotaging personal goals and accomplishments at the moment they are about to be realized, suicidal ideation and behavior, and impulsivity with respect to eating. Prior to commencing with therapy, the patient was asked to complete the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), on which she scored a 47 (severe depression).

#### CASE CONCEPTUALIZATION

Rigidity of thought and avoidance behavior initially were perceived as the core factors contributing to Jennifer's depressed mood and impaired social and academic functioning. Excessive rigidity interfered with her ability to efficiently problem solve, make good decisions, and engage in proactive behaviors that might prevent emotional dysregulation. For example, she often avoided initiating or completing behaviors (i.e., social interaction, homework) because she was convinced that consequences would not be concomitant with her excessively high standards. Such avoidance behaviors together with a poor tolerance of uncertainty produced a low level of access to positive reinforcers and rewarding experiences. This lack of positive experiences contributed to diminished self-efficacy, maintenance of depressive and angry affect, and increased suicidal ideation.

During the early stages of treatment, it became apparent that additional factors were interfering with functioning and the progression of psychotherapy. In conducting the functional analysis component of BATD, several maladaptive and self-destructive behaviors were related to a "desire" to maintain depressive symptoms. For example, if Jennifer was starting to feel or anticipate improvements in therapy, the frequency and intensity of expressions of suicidality and bingeing and purging behaviors increased. If she did not approve of the process of therapy sessions (e.g., increasing level of structure, not enough perceived sympathy) Jennifer again would increase binge eating behavior and experience rapid fluctuations in mood. In addition, during one session she admitted feeling comfortable being depressed

and felt scared to succeed in any aspect of her life. Furthermore, as initial sessions progressed, problems with interpersonal relationships became more and more apparent (i.e., a pervasive cycle of idolizing and devaluing important people in her life). Therefore, in addition to avoidance and rigidity problems described above, it was apparent that inadequate distress tolerance, periodic feelings of invalidation, and discomfort with change also were associated with the maintenance of BPD and depressive symptoms.

#### COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

Jennifer initially was presented with the theory, metaphor, and intervention consistent with Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), a philosophy integrated within the BATD and DBT protocols. As utilized in the context of BATD, this element is central toward addressing a patient's verbal behavior as it relates to attempts to "control" emotional states and the potential exacerbation of symptoms associated with such an exercise. Along with the emotional acceptance and behavioral change philosophy, several other aspects of treatment rationale were presented to Jennifer, including the notion that BATD could be used to structure her time better, the idea that value assessment and activity and goal selection might assist in developing a more stable sense of self, and the concept that active participation in behaviors and activities might allow for increased contact with positive reinforcers, less inclination toward unhealthy (e.g., suicidal) behaviors, and a more regulated, positive mood state. Based on reconceptualization of the case following increased awareness of borderline personality features, in addition to being treated with the full BATD protocol (Lejuez et al., 2002), specific treatment components were included from Linehan's Dialectical Behavior Therapy (Linehan, 1993). An advanced graduate student trained in both BATD and DBT conducted psychotherapy via weekly sessions over the course of 12 weeks. The patient was not medicated during psychotherapy.

The two initial sessions included an explanation of the BATD treatment rationale, identification of Jennifer's values and goals within various life domains, and activity and goal selection. Fourteen activities were identified and rated from "easiest" to "most difficult" to accomplish. These activities included already occurring behaviors, activities designed to accomplish long-term goals, and activities determined to facilitate a sense of pleasure or accomplishment. Several situations that elicited anxiety and avoidance behaviors also were targeted. For example, routine activities related to personal hygiene and work-related tasks (e.g., exploring career options, applying for employment) that were avoided due to fears of "imperfection" and failure were directly confronted via engagement in these tasks, with a focus on decatastrophizing and becoming more accepting of imperfections. Previously rewarding activities that the patient had discontinued (e.g., participation in church activities, engagement in social events) and health-related activities (e.g., exercise classes, modifying sleep behavior) also were incorporated. Importantly, efforts were made to modify maladaptive eating behaviors with methods such as bringing lunch to work/school, eating dinner at home, eliminating junk food, and reducing the duration and fre-

quency of time associated with eating behaviors. Finally, improving the quality of Jennifer's social system also was addressed via increasing contact with old friends, re-establishing relationships within the church, increasing positive communications/comments to others (i.e., reducing conflict with family members), as well as increased utilization of DBT skills described below. Using the master activity log and behavioral checkout to monitor progress, the patient was encouraged to move progressively through the activity hierarchy. Consistent with previous treatment experiences, initial compliance was minimal. Jennifer's compliance substantially improved after several weeks, however, in part due to increased acceptance of the BATD treatment rationale, expression of reward and satisfaction following completion of assigned activities, and incorporation of skills training and management strategies designed for patients with BPD (Linehan, 1993).

Elements from Linehan's *Skills Training Manual for Treating Borderline Personality Disorder* (1993b) were simultaneously incorporated into each session to facilitate movement through the BATD treatment protocol. Most importantly, each session was structured in terms of time and content to reduce therapy-interfering behaviors. The master activity log and behavioral checkout form always were reviewed first, and Jennifer promptly was redirected if attempting to avoid the process of discussing behavioral assignments. Increased efforts also were made to validate Jennifer's emotional and behavioral experiences as she engaged in assigned activities. If assignments were not adequately completed, the therapy session length was reduced and an adverse consequence was introduced within the session (in this case, writing the positive and negative consequences of not engaging in homework tasks). Emotional regulation training also was introduced to reduce emotional lability and encourage healthy (e.g., social) behaviors regardless of current emotional state. Distress tolerance strategies were included with a focus on "improving the moment" through cognitive restructuring and engagement in problem solving strategies. For example, a rule was instituted whereby if Jennifer engaged in therapy-interfering behaviors (i.e., straying off task and talking excessively about a current "crisis"), she was directed to stop and think of at least one way she could actively work toward resolving the problem. This solution was then incorporated into the behavioral checkout form. Distress tolerance strategies also were highly emphasized as they pertained to developing a more stable social system. Jennifer was reinforced with verbal praise when she remained focused and proactive during sessions, following completion of assigned activities, and when she reported utilization of emotion regulation and distress tolerance skills in the natural environment.

Treatment progress was assessed by monitoring scores on the BDI-II. As indicated in Figure 1, Jennifer's total score initially rose for the first 4 weeks, and then dropped significantly below pretreatment levels. As Jennifer indicated,

The first several weeks I wasn't completing the activities. Then I got to a point where I was doing them more frequently and its been going better the last few weeks. . . . At the beginning of treatment, I remember feeling like there wasn't enough time to talk about everything I was used to talking about in sessions. The

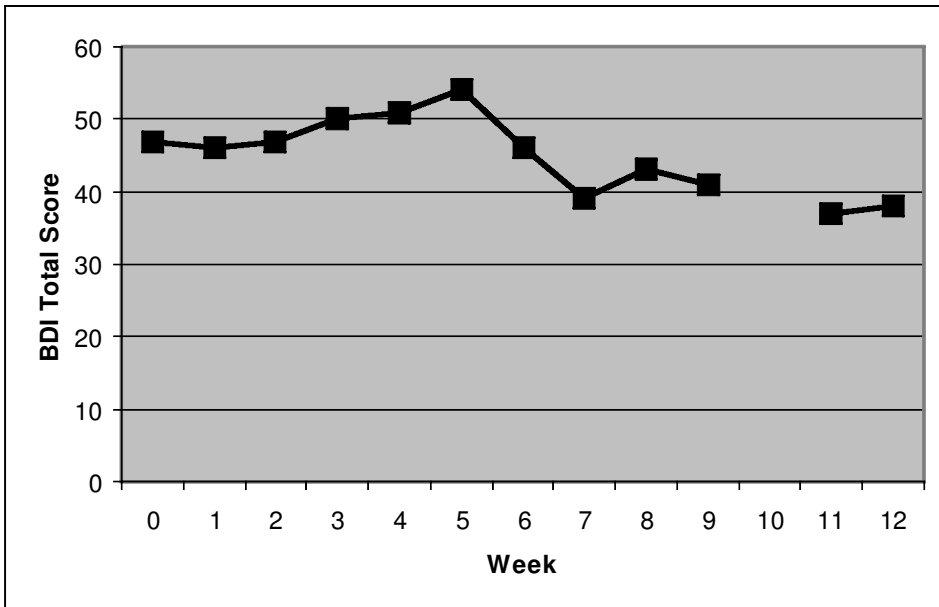


FIGURE 1. BDI-II Scores from Pretreatment to Week 12 of BATD.

*Note.* The BDI Score Ranges from 0-63.

The scale in this graph was truncated due to the absence of scores in the lower ranges.

sessions were more structured and I didn't have time to just vent. I really hated that... Now I realize that "venting" just for the purpose to vent is not helpful. In fact, it makes me feel worse.

Given Jennifer's narrative, initial increases in depressive symptomatology likely were a product of noncompliance and attempts to engage in therapy interfering behaviors. As presented in Figure 1, increased compliance from Sessions 5 through 12 resulted in a BDI-II decrease from 54 to 38. Considering Jennifer's history of attempting suicide and ongoing suicidal ideation, specific attention was also given to Item 9, "Suicidal Thoughts or Wishes." From pretreatment to Week 5, Jennifer consistently expressed thoughts of killing herself through personal narrative and the BDI-II suicide item (i.e., she repeatedly responded "2" on the 0-3 Likert Scale). Between Sessions 6 to 12, however, Jennifer's narrative and scores on the suicide item progressively indicated less pervasive thoughts of committing suicide (i.e., over the last several sessions she responded "0" to Item 9).

I used to wish it [the suicide attempt] had worked. I used to think about what I should have done instead of taking the pills, like getting a gun or not going to the hospital so that no one knew about the attempt and trying [to kill myself] again later. I don't think about those things much at all now. I guess its because we've been working on things that have helped my mood and I'm not ruminating about negative things as much.

Therefore, although her total score continued to indicate significant depressive symptoms, overall reductions in her total (and suicide item) scores were clinically meaningful in terms of improving the quality of her life. In addition, the decrease of suicidal ideation and depressive symptoms allowed us to focus much more on impairments in social and occupational functioning, for example, by increasing effort toward identifying and seeking employment in a field of interest. Jennifer also has been more able to participate in DBT modules, such as interpersonal skills training, which we in large part attribute to positive experiences obtained through engaging in assigned behaviors and developing more adaptive emotional regulation and distress tolerance skills.

## COMPLICATIONS

One of the complications in treating Jennifer was her initial resistance toward engaging in practice exercises, which partially was a function of her fears of imperfection and inadequacy, and uncertainty about the rationale and potential effectiveness of BATD, as well as emotional reactivity that inhibited goal-directed therapy. In addition to fostering a more committed and motivated attitude toward therapy (Miller & Rollnick, 2002), this initial resistance was addressed via increased focus on relationship building, development of a more trusting and validating environment, brief cognitive strategies surrounding core fears, and training in emotion-regulation strategies. Although these components typically are not provided as part of the BATD protocol, their integration was perceived as necessary given the patient's ambivalence toward therapy and the impact of core fears and emotional reactivity in impeding progress with activation exercises. A second complication involving the application of behavioral activation techniques was in the form of other self-sabotaging and therapy-interfering behavior, particularly with respect to eating behaviors. For example, as previously noted, if she began to feel or anticipate improvements in her mood, the frequency and intensity of binges increased, with subsequent increases in dysphoria due to her perceived lack of control and concerns about her physical appearance. This was addressed through the utilization of aversive contingencies, such as using therapy time to have her write the positive and negative consequences of engaging in the maladaptive behavior. At other times, when Jennifer's symptoms decreased or she completed her weekly tasks, she would attempt to ruminate verbally about perceived past failures and hypothetical future failures. As an example, an excerpt follows:

Therapist: I'm really proud of the work you've done. It looks like you've accomplished most of your activities and goals for the week.

Jennifer: Yeah, but it doesn't matter because I just feel like I'm going to fail at this at some point, just like I always do. Like when I lost the weight. Everyone was so happy and told me how good I looked and then I started eating again and gained the weight back. All I know is that I've gained so much weight since then and I feel so stupid because why didn't I just keep on eating healthy food and exercising then? I wouldn't have ever gotten fat. I don't know why I always FAIL...

These behaviors clearly were not consistent with the proactive approach we were advocating and often led to monologues about things that Jennifer had done wrong in her past that subsequently no longer were in her power to change. Similarly, she would focus excessively on negative events, or “crises” of the week. This tendency was addressed by *immediately* terminating in-session verbal behavior that was not goal-oriented and explaining the rationale for doing so. In addition, if she felt that she really needed to discuss a negative event, a rule was instituted whereby she had to think of at least one way to address the event through overt behavior change and utilization of learned skills, and to add this to her activity list for the following week.

Although the application of contingency management procedures to verbal behavior is not a formal component of the BATD protocol, it was these kinds of modifications that were necessary to better address the uniqueness of Jennifer’s behavioral problems. Considering the increased complexity and added challenges that Axis II problems create for the practitioner, flexibility in the provision of BATD strategies will indeed be necessary to a greater or lesser degree pending patients’ ideographic needs. In the present case, Jennifer’s presenting problems necessitated an increased focus on therapy-interfering behaviors, acceptance and validation of emotional experiences, development of distress tolerance strategies, and in-session verbal contingency management. These DBT components and fundamental behavioral strategies were essential in allowing Jennifer to participate and fully benefit from the BATD treatment, and as outlined, these methods reasonably may be adapted within the framework of BATD.

## **SUMMARY**

Although empirical studies are necessary to support the hypothesis, theoretical and practical foundations of BATD may make it a viable treatment alternative for BPD patients exhibiting suicide-related behaviors. To date, only minimal consideration has been given to formulating novel strategies that may decrease self-harm behaviors. Given the paucity of data examining psychosocial treatment for suicidality, and preliminary data that support the efficacy of the BATD approach among depressed individuals (Hopko et al., 2003; Lejuez et al., 2001), the utility of these strategies as a treatment component for patients with BPD may be a worthwhile area of investigation. Among the strengths of BATD is its structured yet ideographic approach that allows treatment to be tailored to the unique needs of patients while incorporating boundaries and consistency that may provide much needed stability in the lives of patients with BPD. In addition, the uncomplicated administration of BATD relative to interventions such as DBT, which require significant time and expertise to administer, suggest the BATD intervention may be a less complex and more portable method, and one that might be more practical as it relates to clinical practice in the era of managed care. As mentioned, BATD also is used to accomplish treatment objectives not specifically addressed in DBT such as a more refined focus on modifying a patient’s natural environment to promote response-contingent reinforcement of healthy behavior through identification of life goals and values and systematic activation of overt behaviors. It is this process that is proposed to



decrease the value of alternative, nonhealthy, self-harm, and suicidal behaviors.

To be sure, there also are several potential limitations of the BATD treatment. First, the treatment does not explicitly incorporate intervention components known to be effective among patients with BPD, including validation strategies, teaching mindfulness and distress tolerance skills, or other problem solving, communication, and social skill training methods. Second, the more time-limited strategy of BATD is inconsistent with the more intensive psychotherapy traditionally provided to patients with BPD. Third, given these differences, many empirical questions remain as to whether the provision of BATD can effectively ameliorate specific symptoms of BPD. Among these questions is whether the value assessment and subsequent engagement in value-consistent overt behavior are beneficial toward developing/restoring self-image, if BATD techniques can facilitate increased emotional regulation, and whether reductions in suicidal/parasuicidal behavior observed via adherence to the protocol would be greater than that achieved with conventional DBT. As demonstrated in the case study, however, BATD and DBT are not incompatible, with the integration of these protocols not only being feasible, but also resulting in decreased depressive symptoms and suicidal ideation in a patient with a complex clinical presentation. Theoretical consistencies between the two approaches and this preliminary finding suggest that further systematic exploration of the environmentally based BATD strategy (with and without adjunct DBT strategies) in the treatment of suicidality and related BPD symptoms is warranted.

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