

Walking on the Eggshells through the lens of DBT: A Case Report with Borderline Personality Disorder

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Abstract:

Borderline personality disorder is a severe mental illness and this is the result of biological and social predispositions. The core symptoms of Borderline personality disorder are inability to maintain interpersonal relationship, poor self-image, affective instability and reckless behaviors. Dialectical Behavior Therapy (DBT) is an evidence-based intervention and is widely regarded as the gold-standard treatment for Borderline Personality Disorder. Despite its effectiveness, relapse to baseline levels of functioning is common in BPD. Owing to the paucity of case studies with long-term follow-up, the present study aims to examine and sustain the long-term therapeutic gains achieved through DBT. In view of the robust empirical support for DBT, the present study implemented DBT with a 21-year-old unmarried female presenting with symptoms of low mood, irritability, self-harm, aggressive behavior, interpersonal conflicts, reduced appetite, and disturbed sleep. The intervention comprised 17 weekly DBT sessions. Outcome measures included the Borderline Symptom List-23 (BSL-23), Beck Depression Inventory-II (BDI-II), and Hamilton Anxiety Rating Scale (HAM-A). Post-intervention findings demonstrated a marked reduction in borderline symptom severity, as well as significant improvement in depressive and anxiety symptoms.

Keywords: Dialectical behaviour therapy, Borderline personality disorder,

Introduction:

Borderline Personality Disorder (BPD) is a serious psychiatric condition characterized by a complex interplay of maladaptive personality traits, behavioral patterns, and clinical symptoms. Historically, BPD has been conceptualized as a polymorphic disorder, marked by significant heterogeneity in its presentation and blurred diagnostic boundaries with other mental health disorders. Contemporary research increasingly supports the view that BPD represents a central dimension of personality dysfunction, encompassing features that are shared across personality disorders and varying primarily in terms of severity rather than distinct diagnostic categories.^[1] Dialectical Behavior Therapy (DBT) aims to help individuals build a life

they find meaningful and worth living. It focuses on increasing motivation to change problem behaviors, teaching effective coping skills, and helping clients apply these skills in daily life with environmental support. DBT is delivered through individual therapy, skills training sessions, phone coaching, and therapist consultation meetings.^[2] Dialectical Behaviour Therapy was developed by Dr Marsha Linehan^[3]. Although DBT is widely used in the treatment of Borderline Personality Disorder, there is a scarcity of case studies that include long-term follow-up. Given the waxing and waning course of BPD, the present study aims to examine the sustainability of therapeutic gains through long-term follow-up.

Brief Clinical Background:

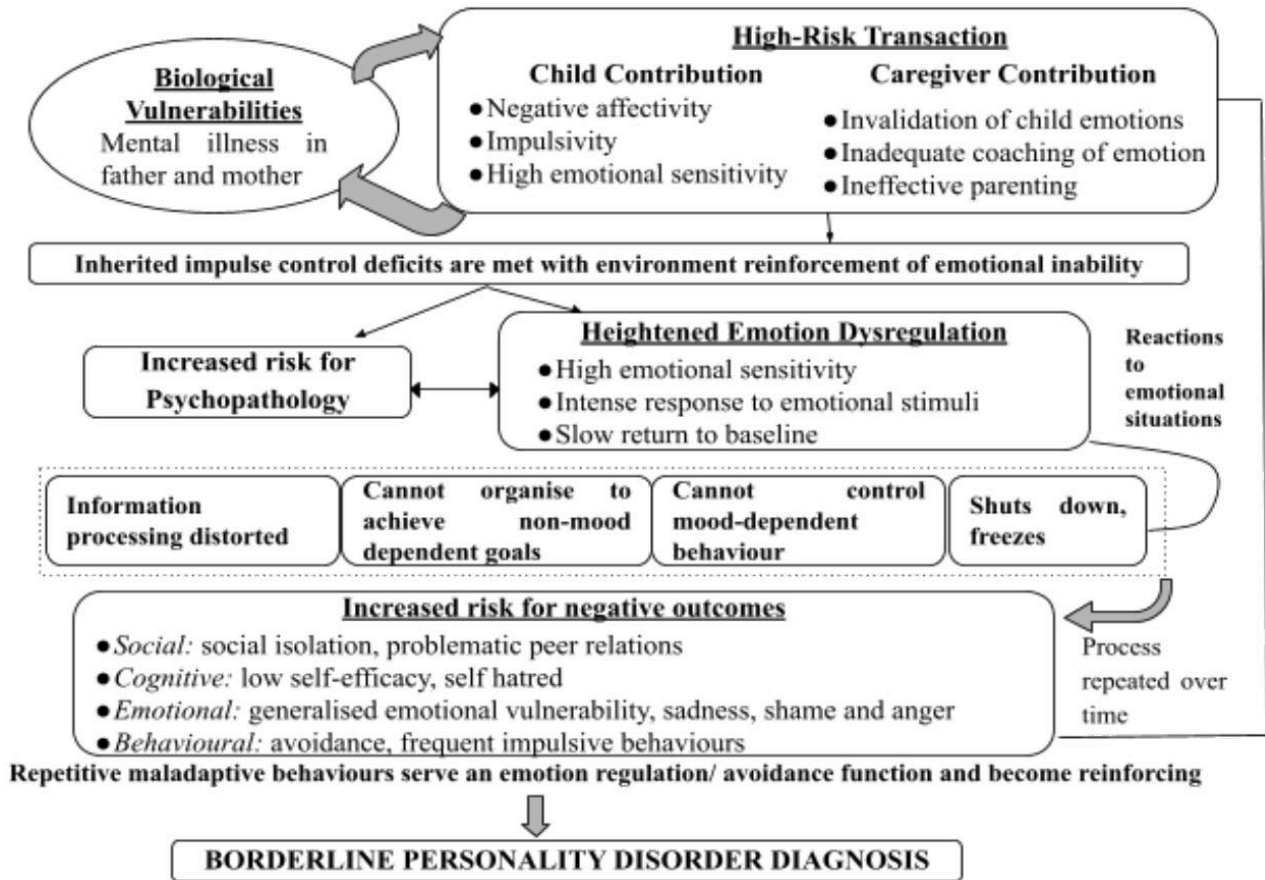
Index patient, Ms. AH, 21 year old unmarried female, graduate came by herself to the OPD with chief complaints of low mood, irritability, self-harm, aggressive behaviour, poor concentration, loss of appetite and disturbed sleep. History suggested that after having break-up with her boyfriend she began experiencing a persistent low mood throughout the week, often triggered by intrusive memories of past sexual abuse. She describes significant fatigue, which has impacted her ability to focus on academic tasks. The client reports pervasive feelings of worthlessness and expresses passive suicidal ideation, stating that she feels she does not deserve to live. In addition to these mood disturbances, the client has engaged in self-harm behavior and has exhibited aggressive behavior towards her partner, which has caused significant interpersonal strain. She also experiences frequent irritability and difficulty regulating her emotions, leading to conflicts within her family and her relationship with her partner. She finds herself preoccupied with negative thoughts about herself, contributing to disturbed sleep and markedly reduced appetite, with food intake limited to once a day. Due to the severity and persistence of these difficulties, the client sought psychological treatment. Ms. AH started using substance when she was around 16 years old. She was introduced to it by her peers. Whenever she feels anxious or low, she used to smoke cigarettes which instantly gave her relief. She noticed a shift in her mood from becoming more irritable when engaged in substance use. This slowly led to use of cannabis and alcohol as well. It had an impact on her biological functioning causing her disturbance in sleep and appetite.

During her early years, her father worked abroad and was often away from home, though she shared a close bond with him at the time. Over the years, this relationship grew distant, especially as she became more aware of the emotional abuse her father directed toward her mother. The household environment was marked by frequent conflict and instances of domestic violence. The client's mother struggled with episodes of severe depression. In her childhood and adolescence, the client displayed introverted behavior and was generally cooperative with others. She maintained a few close friendships and got along well with most people. However, during adolescence, she began struggling with body image issues and insecurities about her physical appearance. She was emotionally bullied by her peers, which further contributed to her feelings of self-doubt. At home, she felt largely ignored, with her mother often dismissing her emotional struggles. Over time, this lack of emotional validation led the client to withdraw and stop opening up to others.

Baseline assessment and outcome measures tools:

1. Borderline symptom List-23^[4]
2. Beck Depression Inventory^[5]
3. Hamilton Anxiety Rating Scale^[6]

Case conceptualization and formulation using Dialectical Behaviour Therapy Model for BPD^[7]



Case formulation

Ms. AH presents with a longstanding difficulties in emotional and social functioning from early childhood. She displayed a temperament marked by being emotionally sensitive, reacting intensely, suggestive of a biological vulnerability. She was raised in an environment where emotional expressions were frequently misunderstood and dismissed. She describes her father as emotionally unavailable and her mother as inconsistent as sometimes nurturing, but often critical and invalidating. Emotional expressions like crying or expressing fear were labeled as "attention-seeking" or "overreacting" which led to doubt herself and suppressed her emotions. Over time, Ms. AH internalized the belief that her emotions were inappropriate or wrong, making it difficult for her to trust her internal experiences or communicate them effectively to others. The intense emotional responses evoked negative reactions from caregivers (e.g., withdrawal, criticism) which further invalidated her experiences. This reinforced her emotional reactivity and taught her to either suppress her emotions or express them in extreme forms to be heard. This dynamic continues in her present interpersonal relationships, where she shifts between clinging and pushing people away, often fearing abandonment while simultaneously testing the commitment of others.

She uses maladaptive coping strategies such as harming herself, impulsive messaging, or binge drinking to manage her distress. These behaviors provided temporary relief, but reinforced her sense of being out of control and unworthy of care. This also maintained her difficulty in regulating emotions and seeking validation which lead to intense interpersonal conflicts. The recent escalation of symptoms followed a sexual assault brought great distress. This triggered overwhelming feelings of fear, shame,

confusion, and helplessness, and reactivated her core fears of abandonment, loss of control, and worthlessness. The past trauma also increased her engagement in self-injurious behaviors, emotional outbursts, and social withdrawal as a means of coping with the unresolved emotions.

This longstanding biological vulnerability was aggravated with a recent incident which she was sexually assaulted by a friend while under the influence of a substance that occurred a month ago. She reported frequent mood fluctuations between irritability and sadness. Her emotional distress began to affect her day-to-day functioning. She reported difficulty regulating her emotions, frequent crying spells, and a persistent sense of emotional numbness. She also noticed a marked decline in her ability to concentrate and focus on tasks. She found herself forgetting academic deadlines, struggling to complete assignments, and feeling overwhelmed by tasks that were previously manageable. There was a noticeable decline in her self-care behaviors. The client reported reduced motivation to engage in personal hygiene, grooming, and daily routines. She described feeling exhausted to carry out basic tasks. She also reported social withdrawal, from friends and peers, and a disinterest in previously enjoyed activities. Rumination about the incident, Self-blame and guilt, social withdrawal, unprocessed traumatic experiences, lack of perceived support from significant others often maintains her emotional distress and interpersonal conflicts.

Goals of treatment (Table-1)

Initial Phase	Middle Phase	Final Phase
Building a trusting and collaborative relationship with the client	Behavioural Activation	Post-Intervention assessment
Psychoeducating the client	Distress Tolerance Skills	Reflect back on the process of therapy and its benefits
Orienting to the therapeutic process	Mindfulness	Inclusion of Mindfulness in daily routine.
	Emotion Regulation	

Course of treatment

Initial Phase (Sessions 1-3)

The session focused on conducting necessary baseline assessments. The client was introduced to the structure of therapy, duration of sessions nature of schedule and confidentiality. She was hesitant about sharing the information initially, but when responded with reflective statements and unconditional positive regard, made her gradually open up about her traumatic experiences. In the following sessions, the client was psychoeducated about the importance of adhering to the psychotherapy and willingness to continue the sessions. She was introduced to the Cognitive Model, about how our thoughts, feelings and behaviours influence each other in our life. Examples from her experiences were discussed in the session. This brought insight into how at times, she acts only based on how she feels, which hampers the interpersonal relationships. Additionally, she was also introduced to the Dialectical Behaviour Therapy by discussing the core skills of DBT. She was able to comprehend how certain experiences in life were relatable to the model presented. She reported she felt understood and hopeful about the therapeutic process.

Middle Phase of therapy(sessions 4-14)

Behaviour activation

The client had poor biological functioning indicating disturbed sleep with only 3 hours of sleep and having meals once in a day. This was impacting her mood and energy throughout the day. Therefore, behavioural activation was introduced. An activity schedule prioritizing biological regulation: eating two to three small meals daily (e.g. a breakfast, dinner), establishing a bedtime routine (e.g. 10-minute reading before bed), and low-effort tasks (e.g. 10-minute exercise) which progressed to value-driven activities (e.g., journaling). The activity schedule was also monitored daily to review any difficulties in following the schedule.

The Patient reported she often end up feeling low triggered by her own rumination of the past. This demotivated her to follow the schedule daily. The importance of following the schedule, how it fosters a sense of mastery and pleasure was discussed in the sessions. The completed activities of the day were discussed and how it impacted her feelings of being productive and elevated the mood. This made her hopeful about continuing the activity schedule. She was also encouraged to do the journaling to help with her rumination. These content were discussed in the session.

Time	Activities	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
10:00	Wake up							
10 am - 11 am	Post wake up activities	✓	✓	✓	✓		✓	✓
11 am - 12 pm	Read a novel	✓						
12:30 - 1 pm	Breakfast					✓		
1 pm - 2 pm	Relax & Chill	✓	✓	✓				✓
2 pm - 3 pm	Study Session		✓					
3 pm - 4 pm	Hobbies (Painting)							
4 pm - 5 pm	Exercise	✓	✓		✓		✓	
5 pm - 6 pm	Freshen up	✓	✓					
6 pm - 7 pm	Study Session	✓	✓			✓	✓	
7 pm - 8 pm	Time to you	✓	✓	✓				
8 pm - 9 pm	Dinner	✓	✓				✓	
9 pm - 10 pm	Journalling	✓	✓	✓		✓		✓
10 pm - 11 pm	Reading	✓						
11 pm - 12 am	Get ready for sleep							

Distress Tolerance skills

When she feels overwhelmed with emotions, she engages in self-harming behaviour (cutting), which resulted in a relief. The triggers for the self-harm impulses were identified. It often triggered by interpersonal conflicts with partner and family members. When she feels she has no control over the situation or when she perceives that partner abandoned her or stops giving attention to her as usual. She was introduced to one of the distress tolerance skills (STOP skill - Stop, Take a step back, Observe, and Proceed mindfully) [8]. This helped her in reducing the self harm urges in the following weeks. Socratic questioning was done to facilitate more awareness into the triggers, consequences of the act etc. The client was encouraged to ask these similar questions once she feels regulated. TIPP (Temperature, Intense Exercise, Paced Breathing, Progressive Relaxation) skills were also introduced to utilize when experiences intense emotions[8]. It was explained about TIPP’s role in quickly calming physiological arousal, demonstrating each component in-session: splashing cold water on the face for Temperature, doing 30 seconds of jumping jacks for Intense Exercise, practicing 4-6 second breathing cycles for Paced Breathing, and tensing/relaxing shoulders for Progressive Relaxation. However, emotional intensity and

shame made her resist TIPP during crises. An inconsistency in following and practicing the skills were discussed in the sessions. She reported being overwhelmed about not feeling better, However, there was little initiation from the client's side in putting the efforts. The client was acknowledged and validated about her feelings and why it hinders the process

Mindfulness skills

Mindfulness was introduced to her to help her with the rumination as it reminds her of the past experiences. It was aimed to help her to identify and separate judgemental thoughts which fuels her overwhelming emotions.

Emotional Mind and Reasonable Mind and how it contributes to Wise Mind were explained to her. What skills were introduced to her to help her be more mindful in the moment to moment experiences.

Techniques:An exercise 'Focus on a single object' was done in the session. The exercise aimed to improve attention and maintain the focus on whatever one is observing. She was asked to observe a pen in front of her. She was given instructions to begin looking at the object, exploring the surfaces with eyes, then try to imagine the different qualities it possess. Following questions were asked to her in the session

- What does the surface of the object look like?
- Is it shiny or dull? Is it smooth or rough?
- Does it have multiple colors or just one colour ?
- Is it bendable or rigid? What else do you notice about the way it feels?

Another exercise 'Thought Defusion' was done in the session to help the client recognize and focus on her thoughts, emotions, and physical sensations. She was asked to visualize the thoughts either as picture or words, floating away from the client without analyzing them^[8].

The client reported some difficulty in visualizing it. With gradual practice, she was able to do it most of the times.

Emotion regulation Skills

The goal aimed to identify and label emotions accurately as most of the time she feels confused about why she felt an emotion at one time. She could not identify whether she did an action out of anger or sadness. The session mainly focused on helping her identifying primary emotions and secondary emotions. She was encouraged to use feeling words when she experienced a certain emotion using I statements. (For eg: I feel angry, I felt disappointed). It was also discussed how emotions help us to survive, remember people and situations, cope in daily life, communicate with others, avoid pain and to seek pleasure, biological mechanisms behind it and the importance of acknowledging and accepting the way she feels.

Recognizing the emotion was encouraged by asking questions to herself about what happened that led to experience a certain emotion, why does she think the situation happened to identify the potential causes, and how does it made her feel emotionally and physically to identify primary and secondary emotions and how it impacts her body, and what was the urge to do as a result of how she felt, and the consequences of the actions as well. She had difficulty in realizing that her feelings were disproportionate to the situation. However, by acknowledging and validating that her way of experiencing emotions intensely is valid, but at times, it results in causing harm to herself and the people around her. Gradually, she accepted this part of herself. An emotional record was given to her to identify and recognize her

emotions during the following weeks.

There were certain thoughts which makes her cognitively vulnerable to experience emotions intensely. The trigger thoughts identified were ‘No one is ever going to love me’ ‘People always hurt me.’ These trigger thoughts were balanced with the emotions by examining the evidences that supports both sides of an emotionally stimulating event. She was encouraged to ask the following questions to herself during a distressing situation. (What happened, what did I think and feel, what evidence supports how you think and feel, what evidence contradicts how you think and feel, what is more accurate way to think and feel about this situation, what can she do to cope with this situation in a healthy way?). After examining the evidence, she was encouraged to trigger thoughts were replaced by coping thoughts to soothe herself when she is in a distressing situation. A list of coping thoughts was given to the client and she chose one which is helpful for her. For eg: (‘These are just my feelings, eventually they will go away’, ‘Mistakes happen, nobody is perfect’). Opposite Action Skill was taught to her to regulate her emotions rather than acting it out. She was asked to identify the emotion and the the urge or emotion driven behaviour, then doing the opposite action. She had noticed the change in her body language, but it took her lot of time to engage in a opposite action. Therefore, mindfulness was encouraged to use to do it without any judgment.

Termination Phase of Therapy (Sesions :15-17)

During this Phase post intervention assessment was done (Table-2). Experiences of the patient during therapy was discussed. Patient reported the potential benefits of therapy as she reported there was reduction in the urges of self-harm and she was able to regulate her emotions with the help of adaptive coping skills such as TIPP and STOP skills. Therapist emphasized the importance of Mindfulness Skill in her daily routine to sustain the gains of therapy. She was advised to come for followup at 6 months and 1 year.

Measures of Progress

Measures	Pre intervention assessment score	Post intervention (Immediate after therapy)assessment score	Post ntervention assessment score at 6 months	Post intervention assessment score at 1 year
Borderline symptom list-23	1.086/ Moderate	0.95/ Mild	1.04/moderate	1.04/moderate
Beck Depression Inventory-II	23/Moderate	17/Mild	15/Mild	16/ Mild
Hamilton Anxiety Rating Scale	26/Moderate to severe	14/ Mild to Moderate	24/ Moderate to severe	25/ Moderate to severe

Outcome of Treatment

The client has a better understanding of her condition, able to understand the reasons, triggers and urges she experiences frequently. She has improved in communicating her feelings to the significant people in

life. Her self harming tendencies has significantly reduced to zero at present. She is able to identify her emotions and chooses adaptive coping strategies and utilizing the distress tolerance skills. At 6 months and 1 year follow-up sustainability of gains was there in terms of depressive symptoms and with mild fluctuation in borderline symptom severity and anxiety but patient didn't return the baseline level so trends towards improvement was there.

Discussion:

Dialectical Behaviour Therapy is widely implied in the management of Borderline Personality Disorder. Generally Pharmacological treatment is provided with DBT to reduce the acute symptoms like bouts of suicidal acts and impulsivity. People get immediate relief with the help of pharmacological treatment and it is very much evidenced that sometime after few sessions of psychotherapeutic intervention patients discontinue the treatment so very few studies are there which are reflecting the treatment outcome with long-term follow-up. This study aims to provide standard treatment with 1 year follow-up to monitor the long-term gains. The present study reports sustainability of long term gains in terms of depressive symptoms and Borderline symptom severity. These findings are consistent with the study conducted with Eighteen randomized controlled trials involving 1,755 participants, predominantly women, supported the effectiveness of Dialectical Behavior Therapy for Borderline Personality Disorder. The studies primarily examined self-injurious behavior, suicidal ideation, emergency service utilization, and hospital admissions. Both standard and short-term DBT were associated with small to moderate reductions in suicidality, with effects maintained for up to 24 months post-treatment. Additionally, DBT significantly improved overall psychopathology and depressive symptoms in individuals with BPD^[9].

Conclusion:

The present study demonstrates that DBT is effective in sustaining long-term therapeutic gains in individuals with Borderline Personality Disorder, particularly in reducing borderline symptom severity, self-harm urges, and depressive symptoms.

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