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Protocol Development of Sage: A Novel Conjoint Intervention for Suicidal and Self-Injuring People With Borderline Personality Disorder and Their Significant Others

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Borderline personality disorder (BPD) is associated with several destructive behaviors, including suicide and nonsuicidal self-injury. The devastating effects of BPD impact individuals with BPD, their relationships, and the mental health of significant others (SOs), which research suggests may be suboptimal. Few BPD interventions incorporate SOs into treatment, despite research suggesting that both emotion dysregulation and relationship dysfunction contribute to the maintenance of BPD. Incorporating SOs into treatment presents an opportunity to optimize BPD outcomes, while dismantling emotional and relational factors that maintain BPD and improving SO mental health. This paper describes the development of Sage, a 12-session conjoint psychotherapy intervention delivered to individuals with BPD who engage in suicidal and nonsuicidal self-injurious behavior, or have suicidal ideation, and their SOs. It is designed to simultaneously target BPD pathology, relationship functioning, and SO mental health. Sage is a time-limited cognitive-behavioral intervention that is primarily informed by cognitive-behavioral conjoint therapy for posttraumatic stress disorder (Monson & Fredman, 2012) and dialectical behavior therapy (Linehan, 1993, 2015). This paper describes the development of the intervention, including key skills taught, logistical issues that were encountered in its delivery, and relevant solutions. Future directions in the development and testing of Sage are described.

Borderline personality disorder (BPD) is a debilitating illness associated with a range of destructive and distressing behaviors. Approximately 84% of individuals with BPD engage in nonsuicidal self-injury (NSSI) or suicidal behaviors (Soloff et al., 2002), 75% attempt suicide at least once (Goodman et al., 2017), and 10% die by suicide (Paris & Zweig-Frank, 2001). Despite the life-threatening nature of BPD, leading treatments, such as dialectical behavior therapy (DBT; Linehan 1993, 2015) and psychodynamic therapies (Cristea et al., 2017), are long (e.g., 12 months or longer), resource intensive (e.g., weekly individual and group therapy, as well as 24-hour access to skills coaching; Linehan, 1993, 2015), and difficult to access (e.g., wait-lists ranging from months to years; Vandyk et al., 2019). Furthermore, 41%–47% of individuals do not show clinically significant change following leading treatments (Woodbridge et al., 2022).

The devastating effects of suicide and NSSI impact not only the individual with BPD but also their significant others (SOs). Distressed, volatile, and dysfunctional interpersonal relationships are part of the diagnostic criteria of the disorder (American Psychiatric Association, 2013). Individuals with BPD have intimate relationships characterized by lower relationship satisfaction and support, as well as increased conflict, criticism, distress, dissolution, and violence (Beeney et al., 2018; Bouchard et al., 2009; Hill et al., 2011; Lazarus & Cheavens, 2017; Navarro-Gómez

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et al., 2017). Perhaps unsurprisingly, SOs of those with BPD also exhibit elevated mental health problems (e.g., depression, anxiety, grief, burden, disempowerment; Bailey & Grenyer, 2013) and describe suicidal and self-injuring behaviors of their partners as a major stressor (Greer & Cohen, 2018)—however, 62.3% of SOs express a desire for mental health support and being unable to access it (Lawn & McMahon, 2015). Undeniably, frontline BPD treatments do not wholly neglect relationship problems. Indeed, these interventions incorporate skills training for individuals with BPD to navigate relationships more effectively, may discuss the way individuals with BPD relate to others, and may occasionally bring SOs into treatment to involve them in treatment planning or execution (e.g., Bateman & Fonagy, 2004; Linehan, 1993; Yeomans et al., 2015)—however, these interventions are ultimately individually delivered treatments that may conceptualize SOs as facilitators to BPD treatment but not core clients in and of themselves. Consequently, SOs are not routinely or predictably incorporated into treatment, the relationship between people with BPD and their SOs is not comprehensively addressed, and SOs' own personal mental health needs are not directly targeted. Therefore, there is an imminent need for interventions for suicidal and self-injuring people with BPD that are more efficient and optimized in addressing *individual* BPD outcomes, while simultaneously addressing *relationship-level* and *SO* outcomes. This paper describes the development of a brief intervention delivered to people with BPD and their SOs that is designed to simultaneously target BPD symptoms, relationship functioning, and SO mental health.

Emotional and Interpersonal Theories of BPD

Seminal theories of BPD ontology and development emphasize the centrality of either emotional (Linehan, 1993; Sauer-Zavala & Barlow, 2014) or interpersonal (Fonagy & Luyten, 2009; Gunderson & Lyons-Ruth, 2008) disturbances. Linehan's biosocial theory argues that all behavioral and interpersonal sequelae of BPD are the result of a biological vulnerability to disrupted emotion processes combined with a fundamental problem modulating them (i.e., emotion dysregulation). Similarly, Sauer-Zavala and Barlow emphasize the high degree of negative affectivity and neuroticism that underlies its clinical presentation. In contrast, the interpersonal hypersensitivity theory proposes that the central feature of BPD is an inherent biological tendency to interpersonal hypersensitivity. This hypersensitivity shapes caregiver interactions across development, leading to disturbed adult attachment characterized by intolerance of aloneness, fears of abandonment, and rejection sensitivity (Gunderson & Lyons-Ruth, 2008). The failed mentalization theory (Fonagy & Luyten, 2009) similarly proposes that disturbed infant–caregiver relationships result in fundamental deficits in mentalization (i.e., a poor capacity to read the mental states of self and others).

Each of these theories offer valuable information about the processes underlying the development of BPD but empirical support is mixed for all of them—for example, some evidence indicates that BPD is characterized by core emotion dysregulation components, such as heightened emotional reactivity (i.e., changes in emotional intensity from baseline following provocation; Linehan, 1993; e.g., Chapman et al., 2015; Gratz et al., 2019), whereas others suggest the opposite (e.g., Herpertz et al., 2000; Pfaltz et al., 2015), or no differences compared to control groups (e.g., Kuo et al., 2016; Kuo & Linehan, 2009). Moreover, several studies suggest that BPD may not be characterized by deficits in emotion regulation across self-report and physiological indices (e.g., Chapman et al., 2009; Kuo et al., 2016). Evidence supporting a solely interpersonal model of BPD is also inconsistent: Some findings suggest that, relative to control groups, BPD is associated with significant interpersonal impairments in areas like mentalization (e.g., Baez et al., 2015; Rifkin-Zybutz et al., 2021), whereas others suggest that individuals with BPD may exhibit superior mentalization (e.g., Scott et al., 2011) or no differences in mentalization at all (e.g., Schilling et al., 2012).

Emotional-Interpersonal Theories of BPD

Theories that exclusively emphasize emotional or interpersonal processes in BPD are limited because they fail to account for the bidirectional influence of each other. Indeed, studies suggest that emotion dysregulation occurs in the context of interpersonal distress in BPD—for example, one study showed that individuals with BPD exhibit higher emotional reactivity relative to controls, but only in response to negative interpersonal situations that provoke feelings of disappointment (Houben et al., 2018). Some studies have used both interpersonal and noninterpersonal stressors to elicit emotional reactivity in BPD and showed that interpersonally themed stressors elicit higher reactivity in BPD compared to control groups but noninterpersonal stressors do not (Elices et al., 2012; Sauer et al., 2014). These studies suggest that the relationship dysfunction that characterizes BPD may present a key context in which emotion dysregulation emerges for this group.

Research also shows that other BPD symptoms like suicidal behavior and NSSI may be both emotionally and interpersonally driven. NSSI in BPD can serve both

emotion regulatory functions (Sadeh et al., 2014) and interpersonal ones, such as communicating distress (Brown et al., 2002; Klonsky, 2007). Interpersonal stressors, such as perceived abandonment and rejection, prompt up to 73% of the most lethal suicide attempts in BPD (Brodsky et al., 2006), and are more related to the decision to attempt suicide in BPD relative to other disorders (Brown et al., 2002; Kelly et al., 2000). These findings suggest that both interpersonal and emotional processes, rather than one or the other, may be central components of the disorder.

The Borderline Interpersonal-Affective Systems Model

To address the lack of integration between emotional and interpersonal theories of BPD, members of our team recently proposed the borderline interpersonal–affective systems (BIAS) model. The BIAS model suggests that, within close relationships, both intrapersonal (e.g., cognitive, emotional) and interpersonal (e.g., communication) processes interact to maintain BPD pathology (Fitzpatrick et al., 2021). Specifically, histories of conflictual relationships lead individuals with BPD to develop a sensitivity to perceived threat in relationships that, in turn, leads to heightened emotional reactivity and difficulties communicating in stressful interpersonal situations. The model also delineates SO intrapersonal and interpersonal processes that may contribute to BPD maintenance. Specifically, SOs are posited to have their own relational histories that influence their interactions with their loved one with BPD. These histories can include negative beliefs about the relationship, individuals with BPD, and themselves as the result of ongoing conflicts that may lead SOs to be emotionally reactive to people with BPD and, in turn, communicate ineffectively with them. SOs' emotional and communication problems transact with that of individuals with BPD's to escalate emotion dysregulation and conflict, which may culminate in individuals with BPD engaging in destructive behaviors, like suicidal behaviors or NSSI. Increased care or decreased conflict from the SO in response to destructive behavior can inadvertently reinforce it. The BIAS model also suggests that these transactional patterns can contribute to both people in a dyad's mental health difficulties, as well as relationship dysfunction (Fitzpatrick et al., 2021). Based on this model, improving BPD, relationship dysfunction, and SO mental health requires incorporating SOs into BPD treatments to target each member of the dyad's beliefs, emotions, and communicative patterns, as well as the transaction between the two.

Existing Dyadic BPD Interventions

Despite the implications of the BIAS model and the research it is predicated on, a review by Fitzpatrick and colleagues (2019) showed that few BPD treatments incorporate SOs, target their mental health, or address relationship dysfunction. Kamalabadi et al. (2012) compared the efficacy of a 14-session couple intervention informed by dialectical behavior therapy (CDBT; Fruzzetti, 2006; Fruzzetti & Payne, 2015) to a wait-list control in 30 Iranian couples wherein one partner had BPD. Those with BPD in the CDBT group reported greater improvements in BPD, anxiety, psychosomatic symptoms, and social functioning, and both partners reported greater improvements in relationship functioning, compared to those on the wait-list—however, although this intervention targeted relationship functioning, SO mental health outcomes were not reported, making it difficult to ascertain the extent to which it was targeted.

Kirby and Baucom (2007) investigated a couple-based intervention for 10 couples wherein one member had emotion dysregulation (but not necessarily BPD) and had recently graduated from a DBT skills training program. The intervention was delivered over 16, two-hour sessions in a group format. DBT graduates reported large pre- to 6-month follow-up effect size improvements in negative affect and emotion dysregulation, moderate effect size improvements in depression and self-efficacy for changing emotions, small effect size improvements in anger, no improvements in relationship satisfaction or anxiety, and small effect size decreases in positive affect. Partners reported large pre- to 6-month follow-up effect size improvements in self-efficacy for changing emotions, small effect size improvements in relationship satisfaction, anxiety, positive affect, and emotion dysregulation, and no improvements in negative affect. These results suggest that this intervention may be helpful in addressing some elements of BPD pathology (emotion dysregulation), as well as relationship functioning and SO mental health—however, it was not specifically designed for those who have BPD and/or engage in suicidal or self-injurious behavior. In fact, DBT graduates were required to be in individual therapy and to have abstained from suicidal or NSSI behavior for at least 6 months to participate. Given the scarcity of available BPD interventions, and the high rates of suicidal and NSSI behavior in BPD (Goodman et al., 2017), conjoint interventions that directly target BPD—including suicidal and NSSI behavior—alongside partner and relationship outcomes are still needed.

In sum, theory and research suggest that relationship dysfunction and SO thoughts, feelings, and behaviors may play a critical role in the maintenance of BPD, and interventions that jointly target BPD, relationship dysfunction, and SO mental health may optimize and broaden BPD treatment outcomes—however, no interventions to date have been developed that conjointly target BPD (including suicidal and NSSI behavior), relationship dysfunction, and SO mental health. Given this gap in BPD treatment offerings, members of our team developed Sage. Named after a plant that thrives by connecting and interacting with its ecosystem (Beck et al., 2012), Sage is a brief intervention delivered to people with BPD and their SOs that simultaneously targets BPD symptoms (i.e., BPD symptom severity; self-injurious and suicidal behavior frequency, and suicidal ideation), relationship functioning (i.e., frequency/-severity of relationship conflict), and SO mental health (i.e., SO depression, anxiety, emotion dysregulation, shame, negative emotion, positive emotion, posttraumatic stress disorder [PTSD] symptoms, and substance use symptoms; see Clinicaltrials.gov identifier #NCT04737252 for a full list of study outcomes in current trials). This paper provides an overview of the development of Sage. We first review key Sage components, followed by a description of logistical considerations in its delivery. We conclude by discussing key future directions for clinical practice and research.

Sage

Sage is a conjoint psychotherapy for individuals with BPD who engage in suicidal behavior and NSSI, or have high suicidal ideation, and their SOs. It is a time-limited, 12-session intervention informed by cognitive-behavioral conjoint therapy (CBCT) for PTSD (Monson & Fredman, 2012) and DBT (Linehan, 1993, 2015). Sage has some overlap with Fruzzetti's (2006) CDBT approach to treating high-conflict couples with emotion dysregulation in his self-help book and described for clinicians in some book chapters (e.g., Fruzzetti & Payne, 2015). These two interventions have somewhat different theoretical bases, with Fruzzetti's approach grounded in Linehan's (1993) biosocial theory and Sage based on the BIAS model (Fitzpatrick et al., 2021). Both models encourage interventions that emphasize communication and emotion regulation training—however, given the cognitive conceptualization included in the BIAS model, a major difference in Sage are the cognitive interventions designed to reduce interpersonal threat sensitivity in addition to its communicative and emotion regulatory targets. Further, unlike Sage, CDBT is not protocolized and its delivery has not been precisely delineated. CDBT authors also note that severe life-threatening behaviors may preclude involvement in CDBT and instead require individual therapy to manage (e.g., Fruzzetti & Payne, 2015). Conversely, in developing Sage, our goal was to construct a manualized, stand-alone, brief intervention for people with BPD and their partners that includes targeting severe life-threatening behavior. Moreover, as CDBT is a dyadic extension of DBT, it explicitly draws on many DBT-based techniques and components to form its basis, including dialectical philosophy, chain analysis, mindfulness, phone coaching, therapist consultation teams, and a DBT-like treatment hierarchy (Fruzzetti & Payne, 2015). Although Sage draws on DBT elements of emotion regulation and distress tolerance training, it does not presume or require prior DBT training in order to implement. There is minimal empirical data supporting CDBT (Kamalabadi et al., 2012).

In Sage, the first session is 90 minutes long and the second session is ideally scheduled within the same week as the first to intensively monitor and intervene early on safety concerns. Subsequent sessions are weekly and last 75 minutes. Sessions are grouped into three phases based on the core tenets of the BIAS model. In Phase 1 ("Orientation and Safety"), dyads are oriented to the intervention and provided with psychoeducation. Dyads are provided with skills to modulate intense emotions, reduce suicide and NSSI risk, and manage severe conflict. Phase 2 ("Communication and Emotion Regulation") focuses on identifying, expressing, and regulating emotions dyadically, as well as building effective communication. In Phase 3 ("Cognitive Interventions and Termination"), dyads learn about negative beliefs that exacerbate emotion dysregulation and relationship dysfunction. They are taught strategies to collectively challenge negative beliefs about emotions, themselves, and others that theoretically maintain interpersonal threat sensitivity, emotion dysregulation, and destructive behaviors. Finally, Phase 3 addresses dyads' goals for the future, relapse prevention, and intervention termination.

Phase 1: Orientation and Safety

The first phase of Sage has three primary goals: (a) orienting the dyad to the intervention, (b) building motivation to change, and (c) establishing intrapersonal and interpersonal safety. This phase lasts for three sessions. Session 1 focuses on orientation, motivation building, and management of imminent safety concerns until Sessions 2 and 3, where safety is extensively addressed (see Table 1 for a sample session-by-session outline). Key interventions include orientation, dyadic safety planning, trust discussions, and development of skills to manage intense emotion and conflict, each of which is described below.

Table 1
Sage Session Content and Practice Assignments

Session by phase	Central content	Practice assignment
Phase 1: Orientation and Safety		
1. Orientation	– -Psychoeducation on BPD, emotion dysregulation, relationships – Intervention rationale and goals	– Write letter to partner about impact of BPD, things they appreciate in their partner, and hopes for intervention
2. Personal Safety	– Review letters, discuss implications for formulation – Develop dyadic safety plan	– Daily trust discussions – Review safety plan and implement as needed
3. Personal and Relationship Safety	– Distraction-based skills for reducing intense emotions – Skills for de-escalating conflict	– Daily trust discussions – Monitor for signs of high-intensity emotions – Distraction-based skills – Time-out skills
Phase 2: Communication and Emotions		
4. Communication Skills	– Paraphrasing and channel checking – Psychoeducation about emotional avoidance "cycles"	– Daily trust discussions – Paraphrasing and channel checking – Catching and disrupting emotional avoidance
5. Identifying and Feeling Emotions	– Psychoeducation about emotions and avoidance – Skills for approaching emotions	– Daily trust discussions – Tracking and identifying emotions – Approaching emotions – Catching and disrupting emotional avoidance
6. Expressing Emotions and Reducing Invalidation	– Skills for sharing emotions – Skills to validate emotions and reduce invalidation	– Daily trust discussions – Sharing and validating emotions – Catching and disrupting emotional avoidance
7. Acting on Emotions	– Distinguishing between experiencing and acting on emotions – Introduce I-FEEL skill to dyadically determine if, when, and how to act on emotions	– Daily trust discussions – I-FEEL skill – Catching and disrupting emotional avoidance
8. Impact of Beliefs on Emotions	– Psychoeducation on impact of beliefs – Practice sharing beliefs and paraphrasing – Introduce theme of beliefs about emotions	– Sharing and paraphrasing thoughts with paraphrasing and validation as appropriate – Reading and discussion on beliefs about emotions
Phase 3: Beliefs and Planning for the Future		
9. Beliefs About Emotions	– Introduce UNSTUCK skill and practice – Introduce theme of beliefs about self	– UNSTUCK on beliefs about emotions – Reading and discussion on beliefs about self
10. Beliefs About Self	– UNSTUCK on beliefs about self – Introduce theme of beliefs about others	– UNSTUCK on beliefs about self – Reading and discussion on beliefs about others
11. Beliefs About Others	– UNSTUCK on beliefs about others	– UNSTUCK on beliefs about others – Write a letter to partner about progress and hopes for future
12. Planning for the Future	– Reflect on progress and areas for continued growth – Develop maintenance plan	– Review skills as needed – Refer to plan for maintaining progress, continued growth

Note. BPD = borderline personality disorder.

Orientation

Orientation to Sage begins by providing dyads with psychoeducation on BPD and the interplay between emotion dysregulation and relationship dysfunction in maintaining it. Three primary areas that the BIAS model purports maintain BPD (Fitzpatrick et al., 2021) are presented as the targets of Sage: (a) emotional processes (by teaching dyads to identify, tolerate,

regulate, and express painful emotions), (b) relationship processes (by teaching dyads to communicate with each other in ways that enhance relationship functioning), and (c) unhelpful beliefs that lead to emotion dysregulation and relationship dysfunction (by teaching dyads to collaboratively challenge negative beliefs, and develop adaptive alternatives). Psychoeducation is presented collaboratively and clinicians begin to build a preliminary case conceptualization with the dyad regarding the interplay of their cognitive, emotional, and communicative patterns, and how these patterns maintain BPD over time. To consolidate psychoeducation, further inform case conceptualization, and bolster motivation for the intervention, dyads are asked to write a letter to each other after the first session about their experience of BPD, emotion dysregulation, relationship dysfunction, and their interplay within their relationship, as well as their hopes for the intervention. This letter is shared and discussed in the next session.

In this phase, the dyad is also oriented to intervention expectations, including its structure (e.g., the phases, policies regarding late cancellation) and the importance of completing homework. The clinician and dyad work together to develop behaviorally specific BPD and relationship-focused goals. If suicidal behavior, NSSI, or intimate partner violence are present, then goals focused on eliminating these behaviors are prioritized.

Dyadic Safety Plans

In addition to assessing and managing suicide risk within each session, dyadic safety plans are created as early as possible in the intervention to establish a plan for how it will be handled moving forward. In building these safety plans, the dyad is guided to collaboratively brainstorm "red flags" that they may each notice that signal potential risk for NSSI or suicidal behavior in the person with BPD; helpful ways for the dyad to communicate with each other about increases in risk; strategies the dyad can engage in independently or together to manage their painful emotions; and places or people to visit or contact for distraction or help. This dyadic safety plan provides individuals with BPD with concrete steps on how they can independently manage suicide risk, while simultaneously offering SOs agreed-upon strategies to mitigate risk but avoid shouldering responsibility for keeping people with BPD alive, and care for themselves in these stressful crises. We find that SOs experience this information as relieving as they often express helplessness and confusion regarding how they "should" respond in crises.

Trust Discussions

In our experience, trust in individuals with BPD's relationships is often damaged by past destructive behaviors including suicide attempts, and SOs experience a great deal of hypervigilance, fear, and anxiety about individuals with BPD's safety. The goal of trust discussions is to begin to repair this trust and reduce chronic fear in SOs by providing them with regular and predictable feedback regarding the individuals with BPD's safety. The regularity of feedback also reduces the need for SOs to "police" the behavior of individuals with BPD, which can inadvertently reinforce suicidal behaviors if it occurs after NSSI or suicidal episodes, or promote unhelpful interaction patterns in the dyad (i.e., one member acting becoming overly responsible for the other's safety). Inspired by the trust discussion developed for behavioral couple therapy for substance use disorders (Klostermann & Fals-Stewart, 2008), the Sage trust discussion instructs individuals with BPD to express their commitment to their SOs to abstaining from suicidal behavior and NSSI for the next 24 hours. Individuals with BPD, rather than the SO, are asked to initiate the trust discussion to promote agency in managing their safety and accountability for repairing trust. They are also encouraged to be honest about their level of commitment; if they cannot commit to abstaining from suicidal behavior and NSSI for the next 24 hours, they are asked to express this lack of commitment, and dyads are directed to refer to their safety plan to collaboratively decide how to manage the risk. If individuals with BPD are committed to safety, each member of the dyad expresses gratitude to the other for their commitment and support. Research also supports the importance of increasing positive interactions while also decreasing negative interactions to improving relationship functioning (e.g., Gottman & Levenson, 1999; Hilpert et al., 2013). Therefore, in the trust discussion, each dyad member is also instructed to share one thing that the other one did for them in the past 24 hours that they appreciated. These communications function to build positivity and increase attention to information that is inconsistent with the individual with BPD's sensitivity to interpersonal threat.

Skills to Manage Intense Emotions and Conflict

The final task of Phase 1 is to teach dyads skills to manage and reduce intrapersonal and interpersonal destructive behavior (e.g., NSSI/suicide attempts and high-intensity conflict). For the former, skills are informed by Linehan's (2015) DBT distress tolerance module and involve distraction-based strategies (e.g., slowed breathing, splashing cold water on the face)

to reduce intense emotions, decrease problematic numbing and/or dissociation, and avoid engaging in destructive behavior. Both members of the dyad complete homework designed to sensitize them to signs of emotions that are too high or too low (i.e., dissociation), and implement these skills in such instances. Dyads are also taught a "time-out" skill to de-escalate and disengage from highly conflictual interactions, which is derived from a long tradition of behavioral therapy for couples (Jacobson & Margolin, 1979). The specific skill instructions were derived from CBCT for PTSD (Monson & Fredman, 2012) and integrated with distraction-based strategies. For the time-out skill, dyads are provided with step-by-step instructions to disengage from conflict, utilize skills to reduce intense emotion or dissociation/emotional disengagement, focus on identifying ways to improve communication, and resume their communication under more moderate emotional circumstances. Instructing dyads to return to difficult conversations following a time-out encourages healthy communication over habitual avoidance of difficult, conflict-prone topics (e.g., Monson & Fredman, 2012).

Phase 2: Communication and Emotion Regulation

The goal of Phase 2 is to promote emotion regulation and effective communication. Because effective emotional communication serves an emotion regulatory function, and emotion regulation facilitates communication, these goals are synergistic (e.g., Dixon-Gordon et al., 2015).

Communication Skills

One of the first targets in Phase 2 involves ensuring that each member of a dyad can demonstrate understanding of each other's communications. Paraphrasing is thus emphasized, which involves one member of the dyad expressing themselves in short, clear phrases, and the other member of the dyad summarizing these statements and checking with the first member for accuracy before responding with their own perspective. This skill serves multiple functions. First, it prevents conflict by "slowing down" and de-escalating communications. Second, it provides an interpersonal emotion regulation opportunity by helping each member of a dyad feel heard and understood. Third, it builds empathy in dyads by helping them understand each other's perspectives (e.g., Monson & Fredman, 2012). Consistent with the interpersonal threat sensitivity that theoretically characterizes BPD (Fitzpatrick et al., 2021), individuals with BPD are particularly likely to interpret information as rejecting, critical, or threatening (Foxhall et al., 2019; Miano et al., 2013). Paraphrasing helps to combat such cognitive biases by increasing the saliency of accurate information that is being presented by SOs.

Linehan (1993) suggests that individuals with BPD were often exposed to invalidation in early life wherein their emotional expression was punished, dismissed, or trivialized. Such invalidation theoretically teaches people with BPD to either avoid emotions or to become more extreme in their emotional reactions to receive support or understanding. Accordingly, research suggests that invalidating responses escalate emotional distress (Greville-Harris et al., 2016; Shenk & Fruzzetti, 2011), whereas validating statements regulate it (Vangronsveld & Linton, 2012). Therefore, in Phase 2, dyads build on paraphrasing skills by learning to validate each other's emotional expressions. Dyads are also sensitized to the nature of invalidation, even if accidental and seemingly benevolent (e.g., "It's not so bad"), which may elicit emotion dysregulation and communication breakdowns. In our experience, this education is particularly critical as both members of the dyad frequently invalidate each other in attempts to reduce each other's distress, inadvertently making it worse. Validation functions both as a strategy that enhances communication, as well as promotes interpersonal emotion regulation.

Finally, consistent with other CBCT interventions (e.g., Monson & Fredman, 2012), dyads are educated about two different purposes of communication: to share one's experience or solve problems. Dyads learn about how communicating with each other when they have different goals (sharing vs. solving) can lead to invalidation, misunderstanding, and conflict. They therefore learn skills to "channel check" with each other, wherein they share or inquire about the goals of an interaction (i.e., to be heard vs. to receive advice or solutions). In our experience, SOs frequently offer solutions to individuals with BPD in an attempt to quickly eradicate their distress—however, such solving attempts are often inadvertently invalidating and counterproductive, leading to escalations in distress and conflict. This strategy therefore helps to reduce the likelihood of invalidation and enhance effective communication.

Emotion Regulation Skills

All of the above communication skills are inherently emotionally regulating—however, explicit emotion regulation skills are also emphasized in Phase 2. Research shows that BPD is characterized by elevated avoidance of inner emotional states (i.e., experiential avoidance), and that suicidal behavior and NSSI can reflect a maladaptive attempt to regulate or escape emotions (e.g., Chapman et al., 2005, 2011). Therefore, avoiding

emotion may reduce it in the short term but elicits greater emotion dysregulation in the long term by inhibiting the building of distress tolerance (e.g., Chapman et al., 2011). Moreover, although less research has examined SOs of people with BPD, research in other disorders (e.g., Campbell et al., 2017), as well as our anecdotal experience implementing Sage, suggests that SOs frequently avoid experiencing or expressing negative emotions to prioritize and mitigate the negative emotions of those with BPD. Such behavior not only fosters experiential avoidance within the SO but also accommodates it within those with BPD. Consequently, consistent with frontline BPD interventions, such as DBT (Linehan, 1993, 2015), Sage is predicated on the notion that promoting adaptive emotion regulation for those with BPD and their SOs involves building greater emotion tolerance in oneself and others, while down regulating highly intense emotions that are likely to lead to destructive outcomes (i.e., Phase 1 skills). Further, dyadic research shows that sharing emotions (including negative ones) is associated with enhanced intimacy and closeness (Lippert & Prager, 2001; McKinnon & Greenberg, 2017), and high levels of emotional avoidance may inhibit effective communication and intimacy in relationships (Wiebe et al., 2017). Therefore, promoting emotional identification, sharing, and expression is a critical Phase 2 component as it serves the interrelated goals of enhancing emotion regulation and relationship functioning.

Accordingly, early on in Phase 2, dyads receive education about emotions and their components, and are asked to practice identifying them. Dyads then learn skills to tolerate emotions at low to moderate intensities without acting on emotional urges (for high-intensity emotional states, dyads are directed to Phase 1 strategies). Next, dyads practice effectively *expressing* identified emotions to each other. Theory suggests that individuals with BPD inaccurately express emotions during periods of distress, which elicits defensiveness, rejection, or invalidation from SOs, and increases emotion dysregulation over time (Fruzzetti & Fantozzi, 2008). Identifying emotions accurately therefore promotes emotion regulation and effective communication. To this end, dyads are also sensitized to the importance of identifying and expressing primary, rather than secondary, emotions, wherein expressing the latter (e.g., anger) may function to facilitate the avoidance of the former (e.g., shame; Linehan, 1993, 2015). When one member of a dyad expresses emotions, the other is shaped to paraphrase and validate it, which serves interpersonal emotion regulatory functions, builds emotional tolerance, and promotes connection and intimacy (Lippert & Prager, 2001; McKinnon & Greenberg, 2017).

The final skill for Phase 2 provides a decision-making framework to identify the most effective way to respond to emotions and associated behavioral urges. This skill was developed to navigate the common dilemma articulated by Linehan (2015) of when to experience emotion and its associated urge to combat experiential avoidance, and when to disengage and distract from it. The acronym I-FEEL (Identify emotion, Feel emotion, Express emotion, Express validation and paraphrase [for the one listening to the emotion], Look at your options) is presented to dyads to help them approach rather than avoid emotions, while collaborating with each other to decide on how to effectively respond to them.

Throughout Phase 2, dyads learn about the role of emotional avoidance in maintaining emotion dysregulation and relationship dysfunction and work to identify their unique dyadic emotional avoidance patterns—for example, dyads may identify the tendency for an individual with BPD to withdraw emotionally from their SO when upset, and their SO to inadvertently reinforce such emotional avoidance by increasing expressions of care and concern. Alternatively, dyads may identify a tendency for the individual with BPD to avoid a primary emotion, such as sadness or fear, by expressing a secondary emotion, such as anger, to their SO, which elicits defensiveness from the SO and, subsequently, inadvertent invalidation and conflict. Dyads practice "catching" their unique emotional avoidance patterns and disrupting them using Phase 2 strategies.

Phase 3: Cognitive Interventions and Termination

The BIAS model contends that those with BPD selectively attend to signs of interpersonal threat and interpret interpersonal information as threatening. They also hold negative beliefs about emotions that can contribute to emotional reactivity or avoidance (Bateman & Fonagy, 2004; Bradley & Westen, 2005). SOs are also purported to hold negative beliefs about themselves, those with BPD, or their relationship (e.g., "She can't handle emotions, so I better not upset her"; "I'm hurtful to my loved one with BPD") that contribute to either emotional reactivity or avoidance, and exacerbate communication problems over time (Fitzpatrick et al., 2021). The goal of Phase 3 is therefore to encourage greater awareness of, and cognitive flexibility about, the dyad's beliefs that contribute to the maintenance of BPD, emotion dysregulation, and relationship dysfunction.

Phase 3 begins with basic psychoeducation about beliefs, including the difference between beliefs and emotions, and the role of beliefs in eliciting various

emotions and communication behaviors. Dyads are asked to practice identifying, sharing, and paraphrasing beliefs to consolidate this work. Next, to encourage cognitive flexibility, dyads practice examining their beliefs to identify inaccurate or unhelpful beliefs that may contribute to emotion dysregulation and relationship dysfunction. Dyads are encouraged to approach this exercise collaboratively in order to promote empathy for each other's experiences and tolerance for alternative perspectives. Beliefs that they determine to be inaccurate or unhelpful are then challenged, using the UNSTUCK intervention adapted from CBCT for PTSD (Monson & Fredman, 2012). This procedure involves helping dyads to collaboratively ask each other Socratic questions to understand one of their beliefs and alternative ways of thinking using paraphrasing and validation. Together, dyads then select one or more of the more helpful or balanced beliefs that they generated and discuss how it impacts their emotions. Dyads also design behavioral plans to further consolidate these new, balanced beliefs and create opportunities for natural exposures to additional evidence that might support them—for example, a behavioral plan might involve instructing an individual with BPD to express a painful emotion to another person to test the belief that nobody cares about how they feel.

Cognitive Themes

In CBCT for PTSD, dyads learn to progressively utilize UNSTUCK exercises to address seven cognitive themes that are particularly relevant to trauma survivors (Monson & Fredman, 2012). Similarly, we found that focusing UNSTUCKs on particularly relevant cognitive themes provided structure that facilitated uptake of the exercise and elucidated beliefs that were particularly relevant to the maintenance of BPD. Drawing on research demonstrating that individuals with BPD have potent negative beliefs about their emotions, themselves, and other people (Bradley & Westen, 2005), cognitive interventions using UNSTUCKs focus on these three themes. For each theme, dyads receive information about how that theme may apply to people with BPD and their SOs. They are then asked to use paraphrasing to identify beliefs within the theme that may be relevant to them, and then challenge these beliefs using UNSTUCK.

For each theme, dyads are taught about the role of the early environment—including the particularly potent role of an early invalidating environment (Linehan, 1993)—in fostering unhelpful beliefs. For beliefs about emotions, the clinician facilitates a conversation between the dyad to identify beliefs about emotions being inherently "bad" (e.g., "My SO would love me more if I didn't have emotions" or "My loved one with BPD's emotions is dangerous") or "good" (e.g., "I couldn't be in a relationship with someone who expected me to decrease the intensity of my emotions"), and helps the dyad understand how these beliefs facilitate emotional avoidance, emotional reactivity, and communication problems. For beliefs about oneself, the clinician facilitates a dialogue about negative self-beliefs that may be relevant to people with BPD and their SOs, such as "If my SO saw the real me, they wouldn't love me"; "My SO can't possibly love me and be upset with me at the same time"; "I can't handle my SO's emotions"; or "If [the person with BPD] kills themselves, it's my fault." Finally, for the theme of beliefs about other people, conversations between the clinician and dyad focus on negative beliefs about others. For many people with BPD with trauma histories, these beliefs often involve perceiving others as untrustworthy, cruel, or malicious. In this case, clinicians and dyads frequently discuss the validity of these beliefs in historical contexts (e.g., in early, abusive environments), while emphasizing how they may be counterproductive and exacerbate communication problems and emotion dysregulation in the current relationship context. SOs may also hold these beliefs, but frequently articulate fragilizing beliefs about the person with BPD (e.g., "They can't handle distress") that lead to accommodation of emotional avoidance and ineffective communication. The dyad practices challenging each belief theme in and outside of session using the UNSTUCK exercise.

The final task of Phase 3 is termination, relapse prevention, and planning for the future. The clinician guides the dyad to identify areas of progress and growth, skills that they found particularly helpful, plans for maintaining skills use, signs that additional skills are needed, and areas of growth for the future. For homework, dyads discuss these points further using their communication skills and write each other a letter that shares what they have learned during Sage, what the other member of the dyad has done during this time that has been helpful for them, and what they look forward to in their future together. These letters are read to each other in the last session and contrasted with the letters that dyads wrote at the beginning of the intervention to highlight areas of growth and areas that may require further attention. They also serve to promote intimacy, build positivity and gratitude in both members of the dyad for the work that they have done together, and increase hope for the future.

Logistical Considerations

In developing Sage, we encountered several logistical issues related to delivering a dyadic intervention

to a complex, dysregulated, and high-risk population of people with BPD and their SOs. Below we describe the particularly central decisions that were made to address these issues.

Balancing Risk Assessment and Management With Content Delivery

First, in developing Sage, we faced the challenge of balancing the delivery of content that we believe will ultimately reduce suicide or NSSI risk in the long term, with the necessity of attending to short-term issues of imminent risk management and relationship crises, including violence. DBT uses a treatment hierarchy to address this clinical dilemma wherein life-threatening issues (e.g., suicide and NSSI) are prioritized over therapy-interfering issues (e.g., coming late, homework nonadherence, abusive remarks to therapists), which in turn are prioritized over quality-of-life-interfering issues (e.g., depression, anxiety; Linehan, 1993). Following this format, life-threatening issues take priority in Sage, and clinicians spend as much time as necessary to adequately address imminent risk while still striving to cover the session content. We have found that Sage content is typically highly relevant to these life-threatening issues and clinicians can usually weave intervention content together with suicide risk assessment and management to balance short-term risk management with longer-term intervention strategies.

In addition, immediately before each session, we ask individuals with BPD to complete a brief (i.e., 30-second) questionnaire regarding their current suicide risk and engagement of life-threatening behavior over the past week. The questionnaire provides the therapist with a brief "snapshot" of information that they can use to determine how much time to allocate to suicide and NSSI risk assessment and management in session. These questions do not replace a full risk assessment, which the therapist would still conduct if suicide risk is elevated, but they allow the clinician to quickly home in on areas of concern and minimize time lost to assessment.

Progression Through Sage

We have found that the most common barrier to improvement in Sage involves dyads not practicing skills outside of session. In such cases, we typically found that poor goal consensus contributed to this lack of skill uptake. If dyads and clinicians lack goal consensus (e.g., they do not agree that reducing suicidal behavior or NSSI is a goal, or do not agree that both members of the dyad must practice skills), then they are destined to experience the intervention as a poor fit, practice skills only superficially, or not practice them at all, making Sage unlikely to be effective. Poor goal consensus is also a robust predictor of poor therapeutic outcomes (Tryon et al., 2018). Furthermore, the three Sage phases are designed to build upon one another—for example, expressing and experiencing challenging emotions (Phase 2) requires that dyads can mitigate and address suicide and NSSI risk or de-escalate intense conflict (Phase 1). Moreover, challenging difficult beliefs as a dyad (Phase 3) requires that dyads effectively communicate with each other and minimize unhelpful communication behaviors (Phase 2) during the exercises. Therefore, dyads must acquire some bare minimum of skills from one phase before they can be expected to benefit from the next.

Effective implementation of Sage thus requires (a) that dyads and clinicians have goal consensus and a shared understanding of the problem (including commitment to attempting to reduce or refrain from suicide attempts and/or NSSI) and (b) that dyads are willing to implement skills they learn. Progressing through the intervention if these basic conditions are not met is unlikely to be helpful and may in fact be harmful by increasing the saliency of distressing or vulnerable issues in dyads' relationships without the mastery of skills to manage them. Therefore, we designed Sage so that the dyad does not automatically progress to the next phase but instead has a conversation with the clinician toward the end of each phase with respect to whether continuing to the next phase is appropriate. Decisions to progress to the next phase are based on whether clinicians and clients have goal consensus and clients have demonstrated adequate attempts to implement Sage skills (as well as dyads' desire to continue and motivation to do so). In its current form, the number of sessions that fall within each phase are fixed, as is session-by-session protocol content. This has allowed uniformity in the intervention being tested, helped clinicians remain adherent to the treatment manual amid the seeming chaos and confusion that can present for participants with BPD and their partners, and allowed our team to identify areas in need of revision when such adherence was overly challenging or ill fitting to the dyads—however, following adequate testing, we envision adaptations of Sage in the future that allow providers to expand or contract time spent in each phase based on case formulation and dyad needs.

Maintaining a Dyadic Frame

Finally, consistent with many dyadic therapies (Gurman et al., 2015), Sage is designed to maintain a dyadic frame and conceptualize the relationship as "the client," as much as possible. When individuals with BPD present with high levels of emotion dysregulation,

chaos, or suicide risk, it can be tempting for the clinician to inadvertently begin to conceptualize them as "the patient" and their SOs as simply present to support their intervention. In such cases, clinicians may find themselves speaking more to the individual with BPD while SOs silently watch, or only involving SOs in conversations about how they can support the individual with BPD, rather than asking them to share their own emotional reactions and perspectives. Given that the BIAS model suggests that BPD pathology is maintained within interpersonal *transactions* (Fitzpatrick et al., 2021), treatment of BPD pathology in Sage requires that the beliefs, emotions, and behaviors of both members of the dyad receive attention. Sage clinicians are therefore explicit at the outset of the intervention that they will not "keep secrets" or substantively communicate with one member of the dyad without the other (e.g., talking by phone to a SO about how to "handle" a conflict with someone with BPD)—however, in some rare emergencies, we may break the dyadic frame and intervene on an individual basis, such as high-risk situations when there is not time to involve SOs or unique instances when our case conceptualization or clinical judgment would suggest that their involvement may increase safety concerns (e.g., reports of intimate partner violence).

Who Is Sage For?

Related to the above point, a central question in the development of any intervention is "Who is this for?" Given the comorbidity and complexity inherent in the BPD diagnosis, we have deliberately designed Sage to accommodate a wide and diverse array of dyads. Therefore, a more useful question may be to examine who Sage may *not* be for. In its early stage of testing, we have excluded dyads wherein both members have BPD or engage in suicidal or self-injurious behaviors/elevated suicidal ideation—however, people with BPD are more likely than controls to partner with people who also have personality disorders (Bouchard et al., 2009). We believe that the dyadic frame of Sage is well equipped for dyads with dual BPD as both members of a dyad are expected to practice all skills to support themselves and each other. Therefore, an important future direction will be to test the efficacy of Sage in such dual-diagnosis contexts. In addition, in our early phases of testing, dyads with severe past-year violence against each other are excluded. Given the high rates of intimate partner violence in the relationships of people with BPD (Gonzalez et al., 2016; Hines, 2008; Weinstein et al., 2012), including such dyads and targeting this, would improve the generalizability of Sage. Moreover, in the current phase of testing, we have limited dyads to romantic relationships based only on research suggesting that intimate relationships are particularly impaired in BPD (Hill et al., 2008)—however, many individuals with BPD do not have a romantic partner (Tomko et al., 2014), or may have a partner who is unwilling to participate in the intervention. Such individuals may still benefit from Sage, and its future iterations will therefore include nonromantic relationships (e.g., family, friends). Beyond these parameters, we argue that Sage is likely insufficient for dyads that may have needs that would significantly interfere with uptake of the intervention or require inpatient or medical treatment, including instances wherein individuals have a severe and unmanaged psychotic disorder, eating disorder, or substance use disorder (note that we allow individuals with psychotic symptoms, eating disorders, and substance use disorders into our current trial testing Sage if they are not severe). Moreover, although we are currently testing Sage in couples wherein one member is suicidal or engages in suicidal/self-injurious behavior, we believe Sage would be highly applicable to couples wherein this is not the case, as Phase 1 content may emphasize relationship safety before proceeding to address the key drivers of BPD pathology in the later phases.

Possible Unanticipated Outcomes

Ultimately, our assertions regarding who Sage is and is not for, and its anticipated benefits, are untested and speculative. Indeed, it is possible that Sage is unhelpful or even iatrogenic in ways that we have not yet anticipated, such as instances wherein SOs experience high levels of psychopathology to a degree that interferes with the individual with BPD learning skills and foments conflict in the relationship. Moreover, for dyads that are characterized by a high level of emotional avoidance, facilitating communication about challenging issues in their relationship that may not be quickly solvable may elicit high levels of conflict or relational distress. We proffer that Sage's dyadic design, which centers the relationship as the primary client, makes it well equipped to address the mental health needs of either member of the dyad, and that the long-term health of relationships requires building the capacity to engage with, rather than avoid, difficult topics, which is a central focus of Sage—however, these assumptions and many others that we have outlined here require rigorous empirical testing in the years to come before they can be offered with confidence. Engaging such rigorous testing presents its own challenges in a dyadic intervention context because, relative to tests of individual interventions, dyadic intervention trials virtually double participants who also have interdependent data. Relative to individual intervention designs or observational dyadic designs,

dyadic clinical trial research presents an extensive range of issues, such as timing assessments to link dyad members' data, confidentiality issues, scheduling individual eligibility assessment appointments for each member of the dyad, and managing linked data. A fulsome discussion of these issues is beyond the scope of this paper but have been offered elsewhere in the literature (e.g., Christensen et al., 2005; Sprenkle, 2012).

Conclusions

Developed in line with the BIAS model (Fitzpatrick et al., 2021) and evidence indicating that emotion dysregulation occurs in the context of interpersonal distress in BPD (e.g., Elices et al., 2012; Houben et al., 2018), Sage aims to optimize treatment for people living with BPD and their SO by jointly targeting BPD pathology, relationship dysfunction, and SO mental health. To date, very few BPD interventions incorporate SOs into treatment or target relationship dysfunction (Fitzpatrick et al., 2019), despite research suggesting that relationship dysfunction may be a key context in which emotion dysregulation emerges and contributes to the maintenance of other BPD symptoms, including suicidal behavior (Brodsky et al., 2006). Therefore, incorporating SOs into treatment not only presents an opportunity to support them but also improve upon individually focused treatments for BPD, which suffer from low rates of remission and clinically significant change (Woodbridge et al., 2022). By structuring Sage as a brief psychotherapy intervention that can be delivered remotely, Sage may address length and resource-related barriers that limit the access of leading BPD interventions (Vandyk et al., 2019)—however, the development and testing of Sage is in its early stages. Testing the efficacy of Sage on its own (currently underway) and against standard care to determine whether it optimizes BPD outcomes, relationship dysfunction, and SO mental health is needed.

The destructive and life-threatening nature of BPD and its devastating effects on interpersonal relationships calls for novel interventions that optimize mental health outcomes for people living with BPD and their SOs. Sage represents an exciting dyadic BPD intervention that not only addresses BPD symptoms but the relational context in which they exist.

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author.

Baez, S., Marengo, J., Perez, A., Huepe, D., Font, F. G., Rial, V., Gonzalez-Gadea, M. L., Manes, F., & Ibanez, A. (2015). Theory of mind and its relationship with executive functions and emotion recognition in borderline personality disorder. *Journal of Neuropsychology, 9*, 203–218.

Bailey, R. C., & Grenyer, B. F. (2013). Burden and support needs of carers of persons with borderline personality disorder: A systematic review. *Harvard Review of Psychiatry, 21*, 248–258.

Bateman, A. W., & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders, 18*, 36–51.

Beck, J. L., Connelly, J. W., & Wambolt, C. L. (2012). Consequences of treating Wyoming big sagebrush to enhance wildlife habitats. *Rangeland Ecology and Management, 65*, 444–455.

Beeney, J. E., Hallquist, M. N., Clifton, A. D., Lazarus, S. A., & Pilkonis, P. A. (2018). Social disadvantage and borderline personality disorder: A study of social networks. *Personality Disorders, 9*, 62–72.

Bouchard, S., Sabourin, S., Lussier, Y., & Villeneuve, E. (2009). Relationship quality and stability in couples when one partner suffers from borderline personality disorder. *Journal of Marital and Family Therapy, 35*, 446–455.

Bradley, R., & Westen, D. (2005). The psychodynamics of borderline personality disorder: A view from developmental psychopathology. *Development and Psychopathology, 17*, 927–957.

Brodsky, B. S., Groves, S. A., Oquendo, M. A., Mann, J. J., & Stanley, B. (2006). Interpersonal precipitants and suicide attempts in borderline personality disorder. *Suicide and Life-Threatening Behavior, 36*, 313–322.

Brown, M. Z., Comtois, K. A., & Linehan, M. M. (2002). Reasons for suicide attempts and nonsuicidal self-injury in women with borderline personality disorder. *Journal of Abnormal Psychology, 111*, 198–202.

Campbell, S. B., Renshaw, K. D., Kashdan, T. B., Curby, T. W., & Carter, S. P. (2017). A daily diary study of posttraumatic stress symptoms and romantic partner accommodation. *Behavior Therapy, 48*, 222–234.

Chapman, A., Rosenthal, M., & Leung, D. (2009). Emotion suppression in borderline personality disorder: An experience sampling study. *Journal of Personality Disorders, 23*, 29–47.

Chapman, A. L., Dixon-Gordon, K., Butler, S. M., & Walters, K. N. (2015). Emotional reactivity to social rejection versus a frustration induction among persons with borderline personality features. *Personality Disorders, Theory, Research, and Treatment, 6*, 88–96.

Chapman, A. L., Dixon-Gordon, K. L., & Walters, K. N. (2011). Experiential avoidance and emotion regulation in borderline personality disorder. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 29*, 35–52.

Chapman, A. L., Specht, M. W., & Cellucci, T. (2005). Borderline personality disorder and deliberate self-harm: Does experiential avoidance play a role?. *Suicide and Life-Threatening Behavior, 35*, 388–399.

Christensen, A., Baucom, D. H., Vu, C. T. A., & Stanton, S. (2005). Methodologically sound, cost-effective research on the outcome of couple therapy. *Journal of Family Psychology, 19*, 6–17. https://doi.org/10.1037/0893-3200.19.1.6.

Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of psychotherapies for borderline personality disorder: A systematic review and meta-analysis. *JAMA Psychiatry, 74*, 319–328.

Dixon-Gordon, K., Bernecker, S. L., & Christensen, K. (2015). Recent innovations in the field of interpersonal emotion regulation. *Current Opinion in Psychology, 3*, 36–42.

Elices, M., Soler, J., Fernández, C., Martín-Blanco, A., Portella, M. J., Pérez, V., Alvarez, E., & Pascual, J. C. (2012). Physiological and self-assessed emotional responses to emotion-eliciting films in borderline personality disorder. *Psychiatry Research, 200*, 437–443.

Fitzpatrick, S., Liebman, R. E., & Monson, C. M. (2021). The borderline interpersonal–affective systems (BIAS) model: Extending understanding of the interpersonal context of

borderline personality disorder. *Clinical Psychology Review, 84* 101983.
Fitzpatrick, S., Wagner, A. C., & Monson, C. M. (2019). Optimizing borderline personality disorder treatment by incorporating significant others: A review and synthesis. *Personality Disorders: Theory, Research, and Treatment, 10*, 297–308.
Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology, 21*, 1355–1381.
Foxhall, M., Hamilton-Giachritsis, C., & Button, K. (2019). The link between rejection sensitivity and borderline personality disorder: A systematic review and meta-analysis. *British Journal of Clinical Psychology, 58*, 289–326.
Fruzzetti, A. E. (2006). *The high-conflict couple: A dialectical behavior therapy guide to finding peace, intimacy, and validation*. New Harbinger.
Fruzzetti, A. E., & Fantozzi, B. (2008). Couple therapy and the treatment of borderline personality and related disorders. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (pp. 567–590). Guilford Press.
Fruzzetti, A. E., & Payne, L. (2015). Couple therapy and borderline personality disorder. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (pp. 606–634). The Guilford Press.
Gonzalez, R. A., Igoumenou, A., Kallis, C., & Coid, J. W. (2016). Borderline personality disorder and violence in the UK population: Categorical and dimensional trait assessment. *BMC Psychiatry, 16*, 180.
Goodman, M., Tomas, I. A., Temes, C. M., Fitzmaurice, G. M., Aguirre, B. A., & Zanarini, M. C. (2017). Suicide attempts and self-injurious behaviors in adolescent and adult patients with borderline personality disorder. *Personality and Mental Health, 11*, 157–163.
Gottman, J. M., & Levenson, R. W. (1999). What predicts change in marital interaction over time? A study of alternative medicine. *Family Process, 38*, 143–158.
Gratz, K. L., Richmond, J. R., Dixon-Gordon, K. L., Chapman, A. L., & Tull, M. T. (2019). Multimodal assessment of emotional reactivity and regulation in response to social rejection among self-harming adults with and without borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment, 10*, 395–405.
Greer, H., & Cohen, J. N. (2018). Partners of individuals with borderline personality disorder: A systematic review of the literature examining their experiences and the supports available to them. *Harvard Review of Psychiatry, 26*, 185–200.
Greville-Harris, M., Hempel, R., Karl, A., Dieppe, P., & Lynch, T. R. (2016). The power of invalidating communication: Receiving invalidating feedback predicts threat-related emotional, physiological, and social responses. *Journal of Social and Clinical Psychology, 35*, 471–493.
Gunderson, J. G., & Lyons-Ruth, K. (2008). BPD's interpersonal hypersensitivity phenotype: A gene–environment–developmental model. *Journal of Personality Disorders, 22*, 22–41.
Gurman, A. S., Lebow, J. L., & Snyder, D. K. (Eds.). (2015). *Clinical handbook of couple therapy*. Guilford Press.
Herpertz, S. C., Schwenger, U. B., Kunert, H. J., Lukas, G., Gretzer, U., Nutzmann, J., Schuerkens, A., & Sass, H. (2000). Emotional responses in patients with borderline as compared with avoidant personality disorder. *Journal of Personality Disorders, 14*, 339–351.
Hill, J., Pilkonis, P., Morse, J., Feske, U., Reynolds, S., Hope, H., Charest, C., & Broyden, N. (2008). Social domain dysfunction and disorganization in borderline personality disorder. *Psychological Medicine, 38*, 135–146.
Hill, J., Stepp, S. D., Wan, M. W., Hope, H., Morse, J. Q., Steele, M., Steele, H., & Pilkonis, P. A. (2011). Attachment, borderline personality, and romantic relationship dysfunction. *Journal of Personality Disorders, 25*, 789–805.
Hilpert, P., Bodenmann, G., Nussbeck, F. W., & Bradbury, T. N. (2013). Predicting relationship satisfaction in distressed and non-distressed couples based on a stratified sample: A matter of conflict, positivity, or support? *Family Science, 4*, 110–120.
Hines, D. A. (2008). Borderline personality traits and intimate partner aggression: An international multisite, cross-gender analysis. *Psychology of Women Quarterly, 32*, 290–302.
Houben, M., Claes, L., Sleuwaegen, E., Berens, A., & Vansteelandt, K. (2018). Emotional reactivity to appraisals in patients with a borderline personality disorder: A daily life study. *Borderline Personality Disorder and Emotion Dysregulation, 5*, 18.
Jacobson, N. S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles*. Brunner/Mazel.
Kamalabadi, M. J., Ahmadi, S. A., Etemadi, O., Fatehizadeh, M., Bahrami, F., & Firoozabadi, A. (2012). A study of the effect of couple dialectical behavioral therapy on symptoms and quality of marital relationships and mental health of Iranian borderline personality couples: A controlled trial. *Interdisciplinary Journal of Contemporary Research in Business, 3*, 1480–1487.
Kelly, T. M., Soloff, P. H., Lynch, K. G., Haas, G. L., & Mann, J. J. (2000). Recent life events, social adjustment, and suicide attempts in patients with major depression and borderline personality disorder. *Journal of Personality Disorders, 14*, 316–326.
Kirby, J. S., & Baucom, D. H. (2007). Treating emotion dysregulation in a couples context: A pilot study of a couples skills group intervention. *Journal of Marital and Family Therapy, 33*, 375–391.
Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*, 226–239.
Klostermann, K., & Fals-Stewart, W. (2008). Behavioral couples therapy for substance abuse. *Journal of Behavior Analysis of Offender and Victim Treatment and Prevention, 1*, 81–92.
Kuo, J. R., Fitzpatrick, S., Metcalfe, R. K., & McMain, S. (2016). A multi-method laboratory investigation of emotional reactivity and emotion regulation abilities in borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 50*, 52–60.
Kuo, J. R., & Linehan, M. M. (2009). Disentangling emotion processes in borderline personality disorder: Physiological and self-reported assessment of biological vulnerability, baseline intensity, and reactivity to emotionally evocative stimuli. *Journal of Abnormal Psychology, 118*, 531–544.
Lawn, S., & McMahon, J. (2015). Experiences of family carers of people diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing, 22*, 234–243.
Lazarus, S. A., & Cheavens, J. S. (2017). An examination of social network quality and composition in women with and without borderline personality disorder. *Personality Disorders, 8*, 340–348.
Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.
Linehan, M. M. (2015). *DBT skills training manual* (2nd ed.). Guilford Press.
Lippert, T., & Prager, K. J. (2001). Daily experiences of intimacy: A study of couples. *Personal Relationships, 8*, 283–298.
McKinnon, J. M., & Greenberg, L. S. (2017). Vulnerable emotional expression in emotion focused couples therapy: Relating interactional processes to outcome. *Journal of Marital and Family Therapy, 43*, 198–212.
Miano, A., Fertuck, E. A., Arntz, A., & Stanley, B. (2013). Rejection sensitivity is a mediator between borderline personality disorder

features and facial trust appraisal. *Journal of Personality Disorders, 27*, 442–456.
Monson, C. M., & Fredman, S. J. (2012). *Cognitive-behavioral conjoint therapy for PTSD: Harnessing the healing power of relationships*. Guilford Press.
Navarro-Gómez, S., Frías, Á., & Palma, C. (2017). Romantic relationships of people with borderline personality: A narrative review. *Psychopathology, 50*, 175–187.
Paris, J., & Zweig-Frank, H. (2001). The 27-year follow-up of patients with borderline personality disorder. *Comprehensive Psychiatry, 42*, 482–487.
Pfaltz, M. C., Schumacher, S., Wilhelm, F. H., Dammann, G., Seifritz, E., & Martin-Soelch, C. (2015). Acoustic emotional processing in patients with borderline personality disorder: Hyper- or hyporeactivity? *Journal of Personality Disorders, 29*, 809–827.
Rifkin-Zybutz, R. P., Moran, P., Nolte, T., Feigenbaum, J., King-Casas, B., Fonagy, P., & Montague, R. P. (2021). Impaired mentalizing in depression and the effects of borderline personality disorder on this relationship. *Borderline Personality Disorder and Emotion Dysregulation, 8*(1), 15.
Sadeh, N., Londahl-Shaller, E. A., Piatigorsky, A., Fordwood, S., Stuart, B. K., McNiel, D. E., Klonsky, E. D., Ozer, E. M., & Yaeger, A. M. (2014). Functions of non-suicidal self-injury in adolescents and young adults with borderline personality disorder symptoms. *Psychiatry Research, 216*, 217–222.
Sauer, C., Arens, E. A., Stopsack, M., Spitzer, C., & Barnow, S. (2014). Emotional hyper-reactivity in borderline personality disorder is related to trauma and interpersonal themes. *Psychiatry Research, 220*, 468–476.
Sauer-Zavala, S., & Barlow, D. H. (2014). The case for borderline personality disorder as an emotional disorder: Implications for treatment. *Clinical Psychology, 21*, 118–138.
Schilling, L., Wingenfeld, K., Löwe, B., Moritz, S., Terfehr, K., Köther, U., & Spitzer, C. (2012). Normal mind-reading capacity but higher response confidence in borderline personality disorder patients. *Psychiatry and Clinical Neurosciences, 66*, 322–327.
Scott, L. N., Levy, K. N., Adams, R. B., Jr., & Stevenson, M. T. (2011). Mental state decoding abilities in young adults with borderline personality disorder traits. *Personality Disorders: Theory, Research, and Treatment, 2*, 98–112. https://doi.org/10.1037/a0020011.
Shenk, C. E., & Fruzzetti, A. E. (2011). The impact of validating and invalidating responses on emotional reactivity. *Journal of Social and Clinical Psychology, 30*, 163–183.
Soloff, P., Lynch, K., & Kelly, T. (2002). Childhood abuse as a risk factor for suicidal behavior in borderline personality disorder. *Journal of Personality Disorders, 16*, 201–214.
Sprenkle, D. H. (2012). Intervention research in couple and family therapy: A methodological and substantive review and an introduction to the special issue. *Journal of Marital and Family Therapy, 38*, 3–29. https://doi.org/10.1111/j.1752-0606.2011.00271.x.
Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2014). Characteristics of borderline personality disorder in a community sample: Comorbidity, treatment utilization, and general functioning. *Journal of Personality Disorders, 28*, 734–750.
Tryon, G. S., Birch, S. E., & Verkuilen, J. (2018). Meta-analyses of the relation of goal consensus and collaboration to psychotherapy outcome. *Psychotherapy, 55*, 372–383.
Vandyk, A., Bentz, A., Bissonette, S., & Cater, C. (2019). Why go to the emergency department? Perspectives from persons with borderline personality disorder. *International Journal of Mental Health Nursing, 28*, 757–765.
Vangronsveld, K. L., & Linton, S. J. (2012). The effect of validating and invalidating communication on satisfaction, pain and affect in nurses suffering from low back pain during a semi-structured interview. *European Journal of Pain, 16*, 239–246.
Weinstein, Y., Gleason, M. E. J., & Oltmanns, T. F. (2012). Borderline but not antisocial personality disorder symptoms are related to self-reported partner aggression in late middle age. *Journal of Abnormal Psychology, 121*, 692–698.
Wiebe, S. A., Johnson, S. M., Burgess Moser, M., Dalgleish, T. L., & Tasca, G. A. (2017). Predicting follow-up outcomes in emotionally focused couple therapy: The role of change in trust, relationship-specific attachment, and emotional engagement. *Journal of Marital and Family Therapy, 43*, 213–226.
Woodbridge, J., Townsend, M., Reis, S., Singh, S., & Grenyer, B. F. (2022). Non-response to psychotherapy for borderline personality disorder: A systematic review. *Australian and New Zealand Journal of Psychiatry, 56*(7), 771–787.
Yeomans, F. E., Clarkin, J. F., & Kernberg, O. F. (2015). *Transference-focused psychotherapy for borderline personality disorder: A clinical guide*. American Psychiatric Publishing Inc.

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