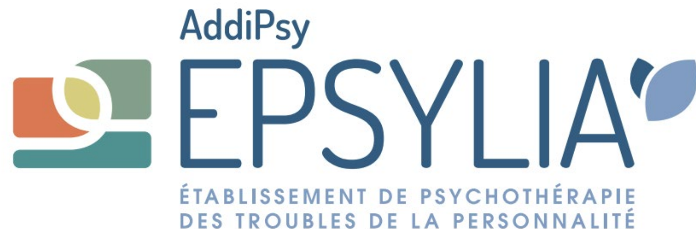
Towards a dimensional trigger-based approach of emotional dysregulation in patients meeting criteria for borderline personality disorder



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Svensk personlighetspsykiatrisk kongress 2026 – *Karolinska Institute, Stockholm, Sweden – May 6-7Th 2026*

Conflit of interest

- None

On Monday…

GPM as a framework for a dimensional, trigger-based approach to emotion dysregulation in borderline personality disorder

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2nd International conference on GPM– Karolinska Institute, Stockholm, Sweden – May 4-5Th 2026

Our dear Mister X…

Mister X, 26

- Referred for diagnostic evaluation for BPD
- Medical history:
  - BPD(reason for referral)
  - ADHD (diagnosed at a specialized center)
  - Adult ASD without ID (diagnosed at a specialized center)
  - BD(diagnosed at a specialized center)
  - Cannabis and alcohol use disorder
  - Bulimia nervosa
  - Complex PTSD (severe childhood trauma)
  - Intimate partner violence
  - DID (recently diagnosed in a private clinic)
- Living situation: In an open relationship, no children. Lives with his girlfriend and another boyfriend in an apartment. Not working. Dropped out of high school due to mental health issues
- Medication: XEROQUEL 600mg, TERCIAN 100mg, TEMESTA 2.5mg

Clinical picture

- Multiple emotional outbursts throughout the day
  - Self-harming and, at times, aggressive behaviors
  - Multiple substance and food-related issues (substances and food)
  - Anger outbursts
  - Recurrent dissociative and paranoid symptoms
- Major interpersonal difficulties
  - Hypersensitivity to rejection and fear of abandonment
  - Difficulties with social cognition
- Post-traumatic symptoms, including hypervigilance and, at times, significant flashbacks

How to treat ?

- ASD Specialist: “ASD must be first”
- BD Specialist: “BD must be stabilized first”
- EMDR Therapist: “We must start by stabilizing the flashbacks”
- Referring Physician: “Above all, BPD must be treated first”…

…

- Patient: “I don’t understand any of this”

Introduction

Some definitions

- Emotions : *« Whole-body phenomena, that include changes in subjective experience, behaviors, and physiology, and that emerges in response to a specific object/situation perceived as relevant for oneself »*
- Emotion regulation can be defined as the way people attempt to influence this phenomenon, using different type of strategies
- Emotional dysregulation: lots of conceptualizations
  - DBT : emotional vulnerability and invalidation
  - MBT : mentalizing deficits
  - Others: *process model of emotion regulation*

Gross & Thompson, 2007; McRae & Gross, 2020; Gross, 2015

Emotional dysregulation and BPD

- First categorical description of ED and its consequences in BPD
  - At least 4/9 criteria: self-harm & suicide, affective lability, impulsive behaviors, anger…
  - These symptoms are therefore often associated with BPD…
  - … Even though we now know that it is a transdiagnostic construct
    - Other PDs: NPD, OCPD, ASPD
    - NDDs : ADHD, ASD
    - (c)PTSD
    - BD
- This makes it hard to distinguish between these disorders,BPD, and true comorbid conditions, even more so given the high rates of comorbidity among these disorders

Carmassi et al., 2022; Sloan et al., 2017; Blay et al., 2024

Need for a dimensional approach

- Categories are useful, particularly because they provide an overarching framework for understanding suffering that patients can often easily grasp…
  - But they are also limited and lack strong support from the data, the latter indicating that these issues should be considered dimensionally

- New dimensional approaches
  - HiTOP (and its super-spectrum emotional dysfunction)
  - ICD-11 & AMPD
  - But : very little implementation in clinical practice, where the categorical approach remains the most widely used

Craddock & Mynors-Wallis, 2014; Haslam et al., 2012; Eaton et al., 2023; Watson et al., 2022

Consequences

- The various conditions associated with ED can have very different psychopathological and interpersonal implications
- Thus, it seems reductive to directly link ED to BPD, and it may even lead to potential important consequences
  - Impaired therapeutic relationship due to lack of epistemic epistemic correspondence
  - Missing key issues may lead to treatment drop-out/resistance (e.g., ASD, PN)
  - Delays in prescribing medication and/or failure to prescribe medication (e.g., ADHD, BD)

Blay et al., 2023; Blay et al., 2024; Campbell et al., 2009; Richter et al., 2023; Bemmouna et al., 2022

Development of our trigger-based approach

- To propose a simple, trans-diagnostic, and process-oriented model to assist clinicians in their daily practice, particularly those who do not specialize in the management of ED and who continue to rely on a categorical approach
- Based on triggers (the specific factors that cause ED in each disorder) and interpersonal styles.
- Why these two aspects?
    - Because they are the most variable between patients
    - Because they are the most likely to reflect underlying psychopathology, while the others (NSSI, impulsive behaviors, SA…) are much more behavioral in nature
- But if we want to use triggers as differentiating factors, we need to understand how and why they may differentially develop

Blay et al., 2024

Developmental perspective

Emotions

- Emotions cannot be reduced to physiological responses…
  - Appear in a **relevant situation**, leading to an **attention focus on the important aspects of that situation**, an **evaluation of those aspects in relation to one's objectives and goals**, and ultimately **physiological and behavioral activation**
- … Thus, their regulation cannot be reduced to the ability to modulate this activation
  - A dynamic set of **extrinsic and intrinsic processes** responsible for r**egulating, evaluating, and modifying the intensity and timing of emotional responses**, which individuals use to achieve their **goals** while taking **social expectations** into account.

Barret et al., 1987; Thompson, 1994; Gross et al., 2015

Process model of emotion regulation

McRae & Gross, 2020

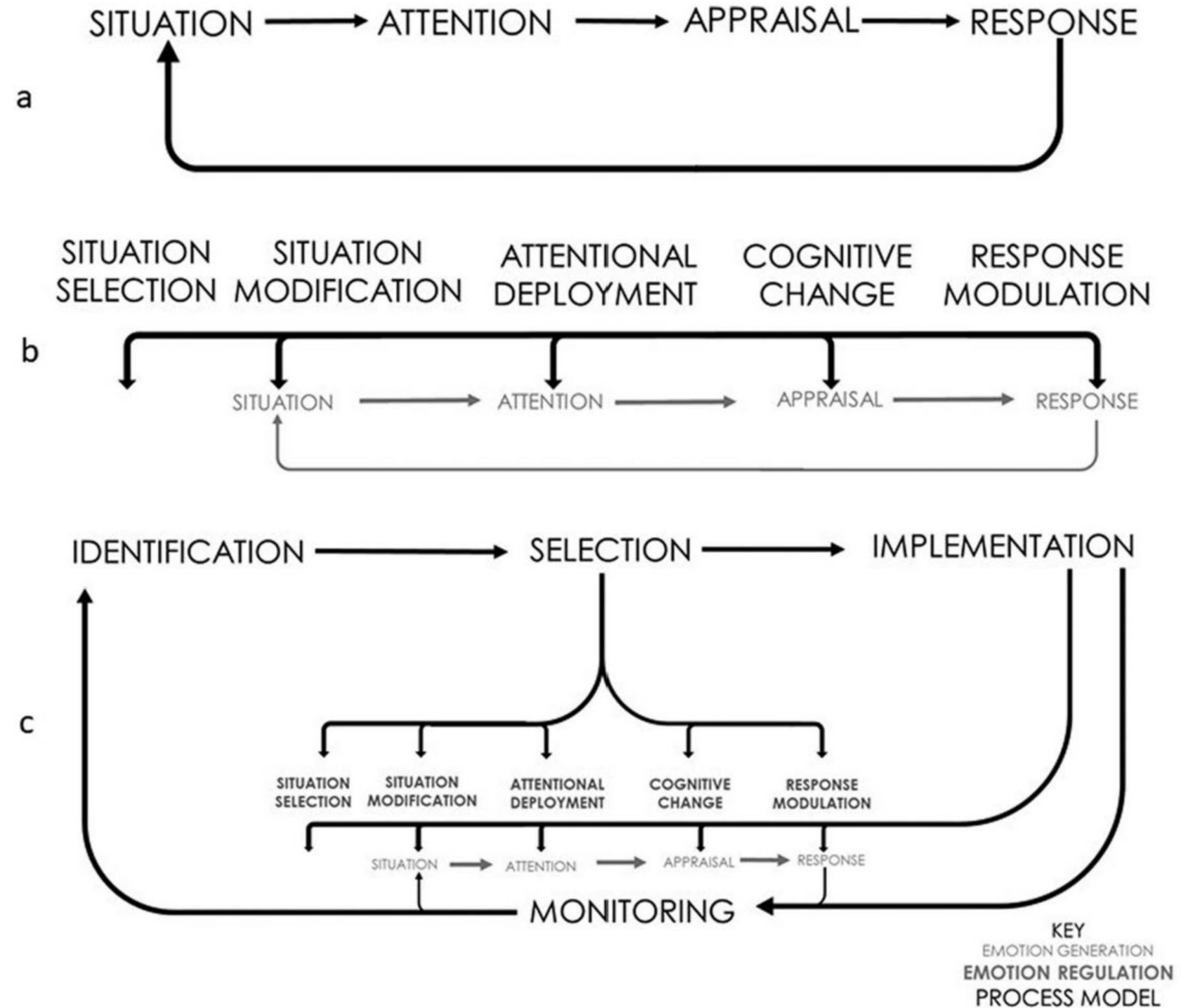


Figure 1. A sequential model of emotion generation (a), the five families of strategies that can be used to regulate emotions, organized by the stage of emotion generation in which they first intervene (b), and the process model of emotion regulation, outlining four stages by which emotion regulation strategies are enacted (c). Figures are modified from Uusberg et al. (2019). Feedback arrows indicate that all three stages are constantly iterating cycles.

Development of emotion regulation

- A complex and ongoing process
  - During the first few months, regulation is solely external
  - Gradual acquisition of internal regulation
    - Emergence of intrapsychic strategies: redirecting attention, cognitive reappraisal
    - Flexibility: adapting strategies to the context, using multiple strategies
    - Integration of social norms and well-being goals
  - Of course, this is highly dependent on the type of environment in which the individual develops -> attachment
    - Contingent, congruent, and marked parental mirroring
- Emotional regulation becomes problematic when an individual's ER patterns disrupt short- and/or long-term developmental goals
  - Interference with the achievement of short- and/or long-term well-being goals
  - Hinder developmental expectations regarding appropriate behavior
  - Conflict with sociocultural norms regarding emotion-related communication and behavior.

McRae & Gross, 2020; Cole et al., 2019; Debbané, 2022; Blay et al., 2024

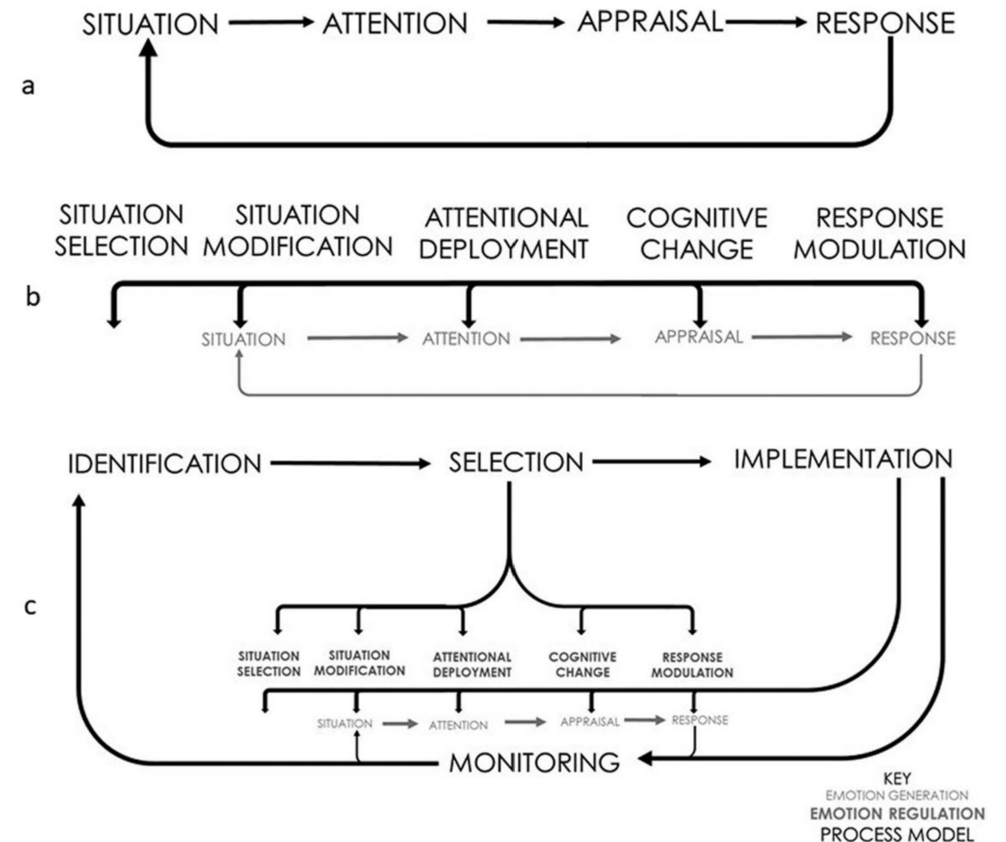
ED as a context-dependant construct

- It therefore appears that DE should not be reduced to the presence of overly intense or prolonged negative emotions.
- Degree of ED seems to depend more on the context in which emotions arise and on how the individual balances their well-being goals with the realities of their environment
- While certain regulatory patterns and/or attachment styles may be adaptive in the immediate context, they can become maladaptive in the long term as the environment changes
  - Ex : NPD, expressive suppression, et humiliation

Cole et al., 2019; 1994; Debbané, 2022; Blay et al., 2024; 2024

Why these specificities?

- Different biological and neurocognitive backgrounds
  - Ex : ASD and difficulties in filtering relevant situations, ADHD and fluctuations in attention
- Different environment
  - Ex : OCPD and over-controling, moralizing or compulsive environment



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Evaluation

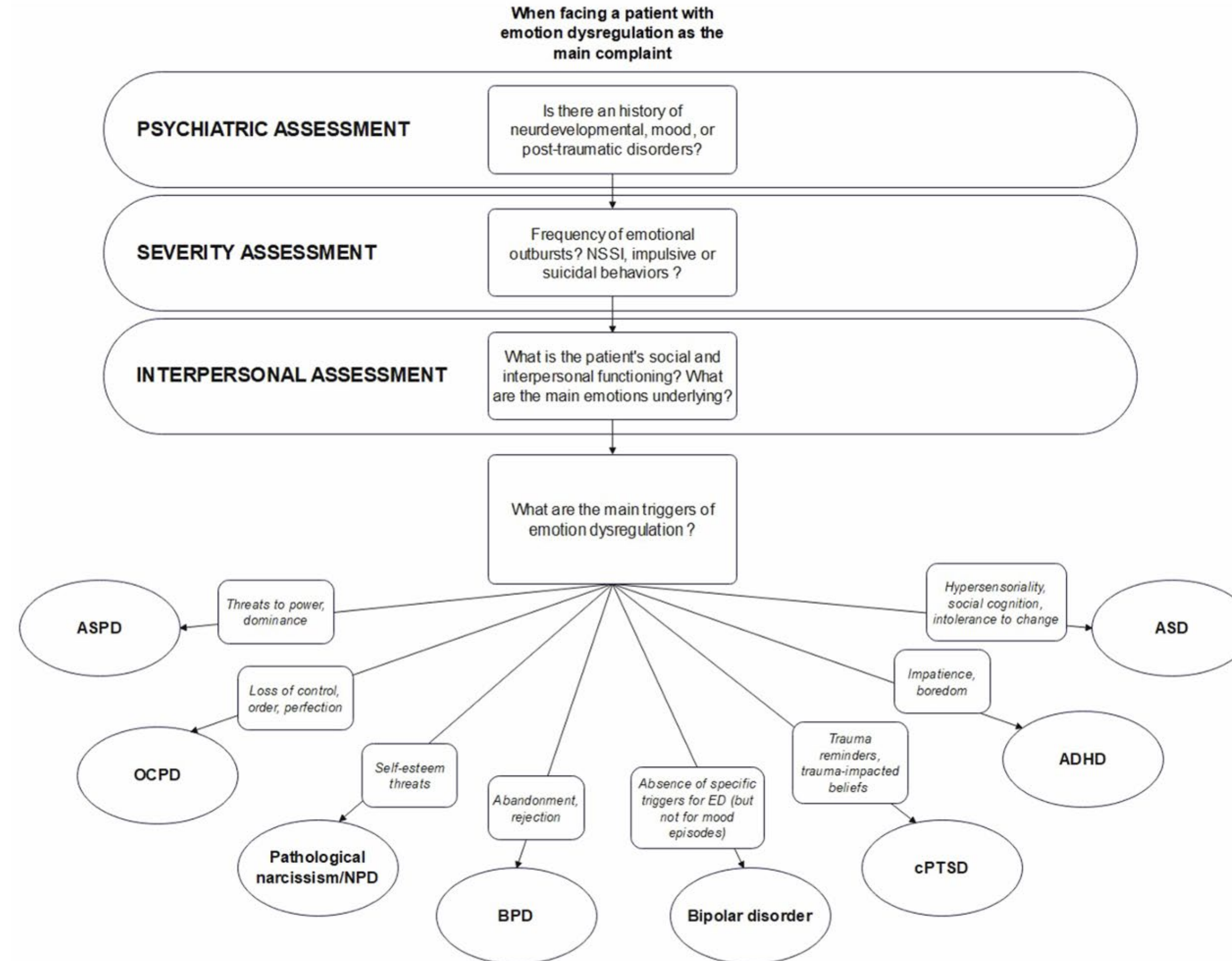

FIGURE 1

Sumary of our processual approach. ADHD, attention deficit hyperactivity disorder; ASD, autism spectrum disorder; BPD, borderline personality disorder; cPTSD, complex post-traumatic stress disorder; NPD, narcissistic personality disorder; OCPD, obsessive-compulsive personality disorder.

TABLE 1 Summary of specific triggers and interpersonal styles.

Disorder		Trigger	Interpersonal style
Personality disorders	**Borderline personality disorder**	Real or imagined rejection and abandonment	Intense and unstable patterns of idealization and devaluation, emotional and identity dependency toward others
	Narcissistic personality disorder/ Pathological narcissism	Real or imagined self-esteem threats	Dependency on external admiration, validation or reassurance to regulate self-esteem, arrogancy and devaluation towards others, victimization
	Obsessive-compulsive personality disorder	Internal or external threat to perfection, order, or control	Tendency to overcontrol others' behaviors, or to avoid relationships because of fear of not meeting other's expectations. Relegation of relationships after one's productivity and effort.
	Antisocial personality disorder	Threats to power and dominance over others	Tendency to manipulate, lie, and exhibit aggressiveness toward others. Relations are marked by dominance and intimidation, with a lack of concern and remorse. Others are seen as ways to reach personal gains.
Other disorders	**Bipolar disorder**	No specific triggers for ED (autonomous variations), but not for mood episodes.	Euthymic bipolar patients have more stable relationships than BPD patients, but may present alterations linked with impulsivity, persistent depressive symptoms and neurocognitive impairments.
	Complex post-traumatic stress disorder	Reminders of traumatic events and trauma-impacted beliefs about self and relationships	Severe emotional detachment, tendency to avoid relationships, mistrust, feeling of worthlessness
	Autism spectrum disorder	Difficulties in filtering environmental stimuli (including sensory), cognitive rigidity (notably intolerance to change)	Lack of understanding of social norms, lack of willingness to enter in relations, lack of understanding non-verbal communication and social reciprocity
	Attention deficit hyperactive disorder	Impatience, boredom	Too talkative and excitable, impulsivity and novelty seeking leading to logistical and organizational issues

Applied to M. X

- History : everything
- Severity
  - Emotional outbursts at least once a day, often several times a day, primarily involving anger
  - Self-harming behaviors at least once a week (cutting arms and thighs, punching walls), multiple visits to the emergency room, 3 suicide attempts in the past year
  - Rare but serious acts of aggression toward others (hitting his girlfriend and another friend, hitting his mother)
- Interpersonal functioning
  - No close friends, just a few acquaintances. Complex relationship with the mother; no relationship with the father; no siblings.
  - Interest in peers varies but expresses desire to form more connections. Significant difficulty in understanding others' perspectives.
  - Conflictual relationship with a partner, linked to a major fear of abandonment.
  - Underlying emotions: anger and fear
- 2 main triggers
  - Fear of abandonment and rejection
  - Traumatic reminders and cognitive disorsions (father's violence and homeless period)

Treatment

TABLE 2 Summary of general and specific therapeutic interventions in terms of psychoeducation, narrative work, and goal setting.

Disorder		Psychoeducation	Narrative work	Goal setting
Every disorder (General interventions)		Focusing on the concept of ED, using DBT, MBT, or other evidence-based conceptualizations.	Focusing on the early signs of emotion dysregulation in childhood, and on the mismatch between the patients' needs and what the environment provided.	Focusing on providing emotion regulation guidelines and learning chain analysis.
Other disorders	**Bipolar disorder**	Focusing on depressive and manic episodes characteristics, on the differences between mood and emotion, and on the importance of medication.	Focusing on the early signs of the disorder (e.g., severe depressive episodes in adolescence) and on the link with family history.	Focusing on the equilibration, tolerance, and adherence to medication (notably through the development of a transparent therapeutic relationship), but also on the importance of overall life hygiene and self-monitoring of symptomatic relapses.
	Complex post-traumatic stress disorder	Focusing on the three dimensions of PSTD and their biological underpinnings, on the disturbance of self-organization symptoms, and on the construction of an individualized trauma-model (encompassing typical reviviscences triggers, maladaptive avoidance, and escape behaviors)	Focusing on *how and why* disturbance of self-organization symptoms appeared, with for example the use of the traumatic invalidation model.	Focusing on the access and conduction of specific trauma-focused psychotherapy (e.g., EMDR, TF-CBT, DBT-PTSD, MBT-PTSD), with possibly a special emphasis on motivation to change, skills-assisted exposure, and radical acceptance.
	Autism spectrum disorder	Focusing on social cognition, hyper-sensoriality, and intolerance to change issues, and on how these symptoms may be linked with ED.	Focusing on the notion of neurodevelopmental disorder and on the exploration of symptoms throughout patient's history (e.g., childhood, adolescence, and adulthood).	Focusing on social cognition learning, with also an emphasis on the treatment framework (low-noise location, no unexpected changes in agenda) and on cognitive flexibility.
	Attention deficit hyperactive disorder	Focusing on hyperactivity and inattention symptoms, with a clear emphasis on their neurobiological underpinnings and on their link with ED. Also provide psychoeducation on medication.	Focusing on the notion of neurodevelopmental disorder and on the exploration of symptoms throughout patient's history (e.g., childhood, adolescence, and adulthood), with also a clear emphasis on the link between ADHD symptoms and socio-educative issues.	Focusing on the importance of psychostimulant medication equilibration, tolerance, and adherence, but also of psychotherapy (notably through cognitive rehabilitation and development of compensating strategies).

Applied to M. X

- First and foremost:
  - Discussing the reasons behind multiple diagnoses+++ and the importance of a multidimensional approach focused on what is causing the disability (i.e., ED)
  - Emphasizing the therapeutic relationship and setting shared goals
- Individual sessions = 2 therapists
  - Individual GPM for:
    - Managing emotional crises
    - Narrative work
    - Life outside of treatment, particularly social fabric
  - EMDR for flashbacks
- Group = 3 groups
  - Psychoeducation on BPD
  - Psychoeducation on trauma
  - DBT for skills training

After 1 year

- Good therapeutic relationship, good investment in care
- Significant reduction in emotional outbursts and self- and other-directed aggressive behaviors
- Improvement in flashbacks
- No further mention of DID, ASD, or BD
- Stabilization of the romantic relationship, improvement in the relationship with the mother

But… Continued substance use. Still significant social isolation. No employment.

To be continued…

Thank you for your attention.

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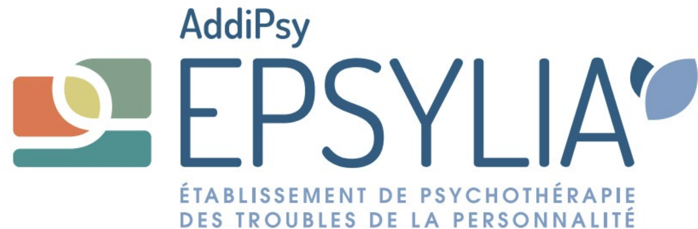

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