

Dialectical Behaviour Therapy in the Management of Emotionally Unstable Personality Disorder, Borderline Type: A Clinical Case Study of a Young Indian Woman

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Abstract

Emotionally Unstable Personality Disorder, Borderline Type (EUPD-BT; ICD-10: F60.31), characterised by pervasive emotional dysregulation, chronic emptiness, self-harming behaviour, and unstable interpersonal relationships, presents one of the most complex challenges in clinical psychology practice. This case study documents the comprehensive clinical assessment, diagnostic formulation, and psychotherapeutic intervention of *Miss N.D.*, a 27-year-old unmarried Indian woman referred to the Clinical Psychology Unit following inadequate response to pharmacotherapy. A thorough bio-psychosocial formulation identified an abusive romantic relationship as the primary precipitant, with heightened emotional sensitivity, poor frustration tolerance, and submissive personality traits as predisposing vulnerabilities. A 17-session Dialectical Behaviour Therapy (DBT) programme — spanning seven months — was implemented, targeting three core skill domains: Emotion Regulation, Interpersonal Effectiveness, and Distress Tolerance. Post-intervention outcomes revealed marked improvement in anger management, significant reduction in self-harming behaviour, enhanced interpersonal functioning, and increased psychological well-being. The case illustrates the clinical efficacy of culturally sensitive DBT in an Indian hospital-based outpatient setting and underscores the importance of structured, phased psychotherapeutic intervention for EUPD-BT in young adults.

Keywords: Emotionally Unstable Personality Disorder, Borderline Personality Disorder, Dialectical Behaviour Therapy, DBT, emotion regulation, self-harm, Indian clinical psychology, case study

1. Introduction

Emotionally Unstable Personality Disorder, Borderline Type (EUPD-BT; ICD-10 code F60.31), equivalent to Borderline Personality Disorder (BPD) in DSM-5 nomenclature, is a severe and pervasive mental disorder characterised by an enduring pattern of emotional instability, impulsive behaviour, disturbed self-image, and chaotic interpersonal relationships (World Health Organization, 1992). The disorder is estimated to affect 1.6–5.9% of the general population globally (Leichsenring et al., 2011) and is disproportionately prevalent among

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Published: 21 May 2026

DOI: <https://doi.org/10.70558/IJSSR.2026.v3.i3.301099>

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psychiatric outpatient populations, where it may account for up to 20% of presentations (Zanarini et al., 2000). In India, robust epidemiological data on EUPD-BT remain limited; however, clinical experience and case series suggest it is a frequently encountered, chronically underdiagnosed, and inadequately treated condition — particularly among young women who present with emotional dysregulation in the context of interpersonal and relational stressors (Kumar & Mondal, 2024).

The aetiology of EUPD-BT is best understood through a bio-psycho-social lens. Linehan's (1993) biosocial theory — the theoretical bedrock of Dialectical Behaviour Therapy — proposes that borderline pathology arises from a transactional relationship between a biologically determined heightened emotional sensitivity and a pervasively invalidating environment during development. The resulting individual lacks the skills to regulate emotions, tolerate distress, and navigate interpersonal conflict effectively — deficits that perpetuate the disorder across the lifespan.

Dialectical Behaviour Therapy (DBT), originally developed by Marsha Linehan (1993), is the most empirically validated psychotherapy for EUPD-BT. It integrates cognitive-behavioural change strategies with mindfulness-based acceptance techniques, operating on the central dialectic of *acceptance and change*. Randomised controlled trials have demonstrated DBT's efficacy in reducing suicidal and self-harming behaviour, decreasing psychiatric hospitalisation, and improving psychosocial functioning (Linehan et al., 2006). The present case study illustrates the application of individual DBT across a 17-session, seven-month course in an Indian hospital-based outpatient setting, documenting the clinical process and treatment outcomes in detail.

2. Case Presentation

2.1 Socio-Demographic Profile

Miss N.D. is a 27-year-old unmarried Indian woman from an urban, middle-class nuclear family. She holds a Master's degree in Designing (M.Des.) and was pursuing a fashion designing course at the time of referral. She is the younger of two siblings; her elder sister (32 years) lives independently. Her father (58 years) is a businessman and the primary decision-maker of the household; her mother (53 years) is a homemaker. Family dynamics were characterised by unresolved arguments and a lack of effective conflict resolution strategies. The family was, however, supportive of psychiatric treatment.

2.2 Chief Complaints

Miss N.D. presented to the K.G.M.U. Adult Psychiatry OPD, independently, reporting the following chief complaints, presented here in the patient's own words (in Hindi, with English translation):

- “Gussa zyada aata hai” — Excessive and poorly controlled anger
- “Rone ka mann karta hai, lagta hai kuch nai kar paungi” — Persistent crying spells and pervasive hopelessness about personal efficacy
- “Khud ko nuksan pohochaati hoon gusse mein” — Deliberate self-injury during states of anger

- “Khalipan lagta hai” — A chronic, distressing subjective sense of inner emptiness

The onset of symptoms was insidious, approximately five years prior to presentation. The course has been fluctuating, with a first continuous episode precipitated by the termination of an abusive romantic relationship. No pharmacological treatment records were available at assessment.

2.3 History of Present Illness

Miss N.D. was reportedly well-adjusted until approximately five years prior to presentation. The precipitating event was the discovery of infidelity and subsequent termination of a three-year emotionally abusive relationship. During the relationship, her partner had engaged in verbal abuse, threats of abandonment, and periodic physical harm when the patient failed to comply with his demands. In response to the chronic fear of abandonment, the patient had progressively abandoned her own goals and career preferences to appease her partner, a pattern consistent with the *frantic efforts to avoid real or imagined abandonment* described in DSM-5 BPD criteria (American Psychiatric Association, 2013).

Following the breakup, she developed progressive irritability, anger outbursts directed at family members and friends, prolonged crying spells (escalating to 1–2 episodes daily), and self-harming behaviour including head-banging, punching walls, and deliberate starvation for up to two days. These acts were ego-syntonic in the context of acute distress — the patient reported that self-injury temporarily reduced internal distress. Sleep became fragmented with delayed onset, though appetite was largely preserved except during altercations. Interpersonal functioning deteriorated significantly; she made few new friendships and experienced conflict within the family home. Academic performance, however, remained adequate.

2.4 Personal and Background History

Antenatal, natal, and postnatal history was unavailable. Childhood and adolescent development were unremarkable; there was no history of physical or sexual abuse, substance use, behavioural disorder, or academic difficulty. The patient had studied up to post-graduation level. There was no past psychiatric history and no family history of psychiatric illness.

2.5 Pre-Morbid Personality

Pre-morbid temperament was characterised by a generally calm, cheerful, and responsible disposition. However, several premorbid personality traits of clinical significance were identified: low frustration tolerance in response to criticism; difficulty asserting personal needs; a tendency to form attachments rapidly but sustain them poorly; and heightened sensitivity to interpersonal rejection. These traits were present before the onset of illness, represent the diathesis upon which the precipitating stressor acted.

3. Assessment and Diagnostic Formulation

3.1 Mental Status Examination (MSE)

On mental status examination, Miss N.D. presented as an average-built, young adult female with adequate personal hygiene and appropriate grooming. Her gait, psychomotor activity, and

speech were within normal limits. Affect was euthymic with a congruent range of emotional expression. Thought flow was normal; thought form was relevant and coherent. Thought content revealed intact self-awareness regarding her behavioural difficulties and a genuine desire for change. There were no perceptual abnormalities, formal thought disorder, or psychotic features. Concentration and memory — immediate, short-term, and long-term — were intact. Abstract thinking was preserved. Insight was rated at *Grade IV* (aware of illness and desirous of help but with incomplete understanding of its psychiatric nature). Personal judgment was impaired, as evidenced by self-harming behaviour; social judgment was intact.

3.2 Psychometric Assessment

3.2.1 Sixteen Personality Factor Questionnaire (16PF)

The 16PF was administered to delineate the patient's personality profile. The Motivational Distortion (MD) score of 5 (average range) confirmed the reliability of the profile.

The clinically salient findings demonstrated high apprehension and insecurity, emotional sensitivity, elevated tension and frustration, low frustration tolerance, emotional instability, submissive and dependency traits, social withdrawal and inferiority feelings and maladaptive coping tendencies

3.2.2 SCID-II Personality Questionnaire

On the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II), Miss N.D. met the diagnostic threshold for Borderline Personality Disorder, scoring 3 (clinically significant) on six of the nine diagnostic criteria, exceeding the cut-off of five criteria. The endorsed items were: (i) unstable and intense interpersonal relationships; (ii) markedly and persistently unstable self-image and goals; (iii) impulsivity in personally damaging domains; (iv) recurrent self-harming behaviour; (v) affective instability with episodic dysphoria; and (vi) inappropriate, intense anger with difficulty controlling it.

3.3 Provisional Diagnosis

On the basis of the clinical interview, mental status examination, psychometric findings, and behavioural observations, a provisional diagnosis of *Emotionally Unstable Personality Disorder, Borderline Type (ICD-10: F60.31)* was made. The diagnosis was supported by: persistent disturbance in self-image and interpersonal functioning; self-harming behaviour; extreme and rapid mood shifts; low frustration tolerance; and the characteristic pattern of intense but short-lived relationships. The diagnosis was arrived at only after ruling out mood disorders (no sustained euphoria, no pervasive anhedonia), anxiety disorders (no free-floating or situational panic), psychosis (no hallucinations or thought disorder), and organic pathology.

3.4 Bio-Psychosocial Formulation

A comprehensive bio-psychosocial formulation was developed, drawing on Crowell, Beauchaine, and Linehan's (2009) developmental biosocial model. The formulation integrated predisposing vulnerabilities, precipitating stressors, perpetuating maintaining factors, and protective resources across biological, psychological, and social domains.

Table 1: Bio-Psychosocial Formulation of Miss N.D.

Domain	Predisposing	Precipitating	Perpetuating	Protective
Biological	Female sex; poor emotional modulation	—	Poor impulse control	Above-average intelligence; absence of medical illness
Psychological	Heightened emotional sensitivity; low frustration tolerance	Low distress tolerance (abusive relationship)	Poor coping style; poor self-esteem; unclear self-image	Motivation for treatment; fair insight (Grade IV)
Social	Lack of reliable interpersonal relationships	Abusive relationship with male partner	Ongoing conflict within the family unit	Supportive family; seeking treatment independently

4. Management Plan and Rationale for DBT

4.1 Rationale for Psychotherapeutic Referral

Miss N.D. was referred to the Clinical Psychology Unit following inadequate symptomatic relief from pharmacological management alone. Her primary presenting difficulties were emotional dysregulation, self-harming behaviour, and unstable interpersonal relationships are targets that respond specifically and substantially to skills-based psychotherapy. She was highly motivated for treatment, had Grade IV insight, and demonstrated the capacity for active collaborative engagement — all positive prognostic indicators for psychotherapy.

4.2 Selection of Dialectical Behaviour Therapy

DBT was selected as the treatment modality on the basis of strong empirical evidence for its efficacy in EUPD-BT (Linehan et al., 2006; Cristea et al., 2017), and its theoretical alignment with the patient's formulation. Specifically, DBT's core dialectic — that the patient must simultaneously *accept herself as she is* while also *changing maladaptive patterns* — directly addresses the central tension in EUPD-BT between self-invalidation and the need for change. The modular, skills-based format allowed the therapist to tailor the intervention to the patient's specific deficits: emotion regulation, distress tolerance, and interpersonal effectiveness.

The treatment was structured as follows: **17 individual sessions** of one hour each over a period of **seven months**. This stepped-care structure promoted skill consolidation and gradual reduction of therapeutic dependency.

4.3 Therapeutic Goals

Short-Term Goals	Long-Term Goals
Reduce frequency and intensity of anger outbursts	Achieve acceptance of past traumatic experiences
Decrease self-harming behaviour to zero	Develop robust, adaptive coping skills
Improve distress tolerance in crisis situations	Increase stress tolerance across diverse life contexts
Improve emotion regulation skills	Stabilise and enrich interpersonal relationships
Enhance interpersonal effectiveness	Develop a coherent, positive self-concept

5. Therapeutic Intervention: The DBT Process

5.1 Initial Phase (Sessions 1–2): Assessment, Psychoeducation, and Chain Analysis

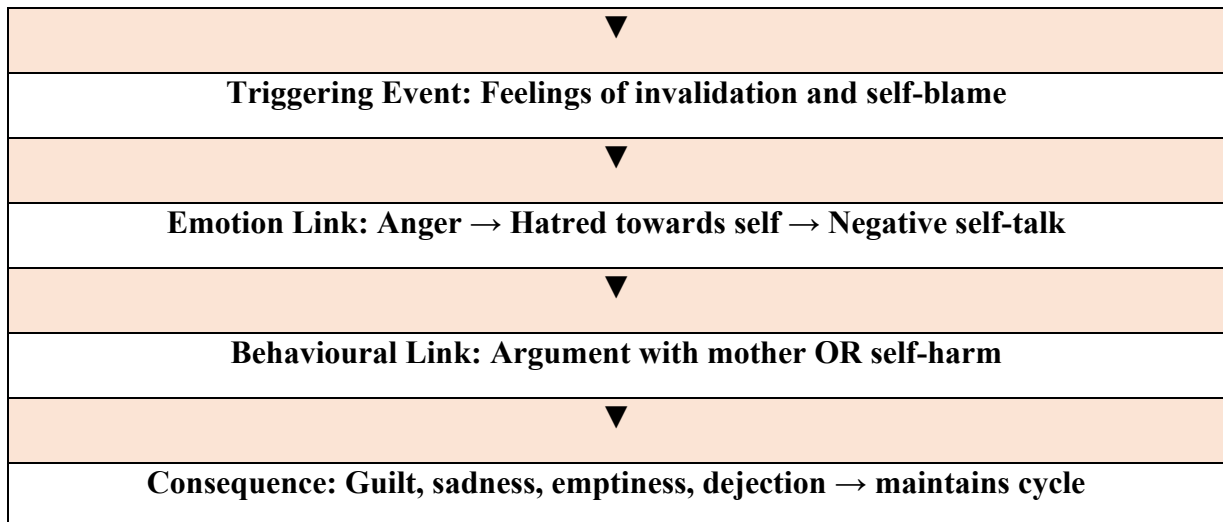
The initial phase was dedicated to establishing therapeutic rapport, conducting psychometric assessment, and providing psychoeducation. The patient presented with a complex clinical picture: intense emotional reactivity, impulsive self-harm, prolonged crying spells, and profound difficulty tolerating memories of her abusive relationship. She began weeping during her account of the relationship and exhibited notable difficulty tolerating the associated affect — a direct in-session demonstration of her core deficit in distress tolerance.

A **biosocial model of EUPD-BT** was presented to the patient in the second session, framing her emotional sensitivity not as a character flaw but as a biologically based vulnerability that interacted with an invalidating relational environment. This psychoeducational reframe was therapeutically significant: the patient experienced considerable relief at understanding the developmental logic of her difficulties, and her motivation consolidated.

Behavioural chain analysis — a core DBT assessment tool — was employed to map the antecedent-response-consequence chains that maintained problematic behaviours. Two prototypical chains were identified:

Figure 1: Behavioural Chain Analysis — Chain 1 (Self-Harm Pathway)

Vulnerability Factor: Memories of emotional abuse by ex-boyfriend
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5.2 Intermediate Phase I — Emotion Regulation Skills (Sessions 3–7)

Emotion dysregulation was identified through chain analysis as the primary maintaining mechanism for most presenting problems. The intermediate phase commenced with a **cost-benefit analysis** of the patient's current maladaptive coping strategies (rumination, social isolation, emotional expression through arguments, self-harm), making the consequences explicit and collaboratively motivating the patient toward skill acquisition.

Self-Destructive Coping Strategy	Possible Costs
Spending a great deal of time thinking about past pain, mistakes, and problems.	You miss good things that might be happening now and then regret missing those things, too; depression about the past
Isolating myself to avoid the possible pain.	You spend more time alone and, as a result, feel even more depressed
I take out my painful feelings out on others through arguments.	It leads to poor interpersonal relationships contributing to loneliness; feeling bad about hurting other people.
I engage in self-harming behaviour.	Scarring; disfigurement; shame; physical pain.

Three core emotion regulation techniques were taught and practised across this phase: (i) Check the Facts — challenging emotional reactions against the objective facts of a situation to reduce cognitively mediated emotional amplification; (ii) Opposite Action — acting in a direction opposite to the action urge associated with an emotion that does not fit the facts (e.g., engaging socially when the urge is to withdraw from sadness); and (iii) Problem Solving — addressing situational triggers of negative emotion directly when the facts themselves constitute the problem.

Situation	Emotion	Action Urge	Opposite Action
The friend not speaking to her; no contact for 5 days over an argument	Sadness, Gloomy, Disturbed.	Crying spells and social withdrawal	Get active and busy, communicate more with friends and family

The patient maintained structured emotion monitoring records as homework assignments, logging the situation, emotion and its intensity (0–100), interpretation, physical sensations, behavioural expression, and consequences.

Situation	Emotion and its intensity (0-100)	Interpretation of the situation that prompted the emotion	Physical Sensations	Action and Expression of Emotion	Consequences
My friend called me and started to blame me for the failed relationship.	Angry, miserable and guilty	My friend should have understood me. If I would have stood up to my ex-boyfriend maybe I would have been better.	Headache. Sweating Palpitations	Switched off her phone and threw it away. Crying and slapped myself	Misbehaved with parents which led to further arguments. Went angry to bed and forgot to set alarm and it late to work.

Review of these records revealed a recurrent pattern of cognitively distorted interpretations — particularly self-blame and overgeneralisation from the abusive relationship — as drivers of emotional escalation.

By Session 7, the patient reported fewer anger outbursts and reduced intensity of emotional reactions, demonstrating initial mastery of emotion regulation skills.

DBT Emotion Regulation Skills — Applied in Sessions 3–7

Check the Facts — Are my emotional reactions proportionate to the objective situation? Question assumptions; consider all possible outcomes.

Opposite Action — Identify the action urge triggered by the emotion; act opposite if the emotion does not fit the facts (e.g., engage rather than withdraw).

Problem Solving — When the situation itself is problematic, plan and implement direct solutions rather than reacting emotionally.

Thought Defusion — Separate maladaptive trigger thoughts ('I am broken') from adaptive coping thoughts ('I have survived worse').

Thought De-fusion Technique

Trigger Thought	Coping Thought
I'm incompetent.	Mistakes happen; nobody's perfect.
There's something wrong with me.	This situation won't last forever.
I'm broken.	I've already been through many other painful experiences, and I've survived
There's something wrong with me.	This too shall pass
People always hurt me.	I'm strong and I can deal with this.

5.3 Intermediate Phase II — Interpersonal Effectiveness Skills (Sessions 8–11)

Interpersonal dysfunction was a central feature of Miss N.D.'s presentation — characterised by short-lived, intensely attached relationships; difficulty asserting her own needs; and a tendency to abandon her values and preferences to secure others' approval. Three DBT interpersonal skill frameworks were taught across sessions 8–11:

1. **D.E.A.R.M.A.N.** (Describe, Express, Assert, Reinforce, stay Mindful, Appear confident, Negotiate) was introduced first as a structured format for effective communication and need-expression. Role-plays were conducted in session to help the patient articulate her needs clearly without aggression or capitulation — a critical skill gap given her history of passive compliance within abusive dynamics.
2. **G.I.V.E.** (be Gentle, act Interested, Validate, use an Easy manner) was then taught to foster relationship maintenance skills — particularly relevant given the patient's pattern of intense, conflict-ridden attachments.
3. **F.A.S.T.** (be Fair, no Apologies, Stick to values, be Truthful) was introduced to address a specifically important vulnerability: the patient's history of abandoning personal values and self-silencing to gain others' approval — a pattern that had contributed to her prolonged stay in an abusive relationship. The patient initially resisted this skill,

but on reviewing her own history, acknowledged its relevance and committed to practice.

5.4 Intermediate Phase III — Distress Tolerance Skills (Sessions 12–15)

An interpersonal conflict during the middle phase of therapy triggered a return of crying spells and a single instance of self-harming behaviour — providing a clinically valuable opportunity to address distress tolerance directly. Distress tolerance was framed not as problem-solving but as *crisis survival*: the goal is to tolerate acutely painful situations without making them worse. Two categories of skill were taught: Crisis Survival and Reality Acceptance Skills.

Crisis Survival — S.T.O.P. Skill: The patient was taught to **Stop** (resist the impulse to react), **Take a step back**, **Observe** her internal and external environment, and **Proceed** mindfully. The S.T.O.P. skill was practised in imagery rehearsal — the patient visualised the recent conflict with eyes closed and implemented the skill step-by-step in imagination, demonstrating competence before attempting real-world application.

Crisis Survival — A.C.C.E.P.T.S. Distraction: The patient selected Activities (reading, listening to music), Thoughts (mental counting, puzzles), and Sensations (holding ice, taking cold/hot baths) as her preferred distraction strategies — a pragmatic choice informed by her stated preferences and daily routine.

Reality Acceptance — Radical Acceptance: This was conceptually the most challenging yet transformative skill. Radical acceptance was introduced as the complete, non-judgmental acknowledgement of reality as it is — not as approval of what has occurred, but as the recognition that *rejecting reality does not change it, and intensifies suffering*. The patient related powerfully to this concept in the context of her abusive relationship: she had spent five years in self-blame and counterfactual rumination, amplifying her distress. The practice of **Turning the Mind** — repeatedly choosing to return to acceptance when the mind rebels — was introduced as a companion skill.

I.M.P.R.O.V.E. Skill: (Imagery, Meaning, Prayer, Relaxation, one thing in the moment, Vacation, Encouragement) was taught as a structured self-soothing framework. Progressive Muscle Relaxation (PMR) was additionally introduced as a physiological anchor for crisis situations, with home practice assigned.

DBT Distress Tolerance Skills — Applied in Sessions 12–15

S.T.O.P. — Stop, Take a step back, Observe, Proceed mindfully — crisis interruption before impulsive action.

A.C.C.E.P.T.S. — Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, Sensations — distraction from acute distress.

Radical Acceptance — Complete, non-judgmental acceptance of the reality of one's situation; reduces suffering by ending the struggle against what cannot be changed.

I.M.P.R.O.V.E. — Imagery, Meaning, Prayer, Relaxation, One moment, Vacation, Encouragement — self-soothing across multiple domains.

Progressive Muscle Relaxation — Systematic muscle tension-release technique to reduce physiological arousal in crisis situations.

5.5 End Phase — Problem-Solving and Consolidation (Sessions 16–17)

In the terminal phase, the patient had enrolled in a new designing course, introducing a fresh set of real-world stressors: assignment deadlines, adapting to peer dynamics, and managing supervisory feedback. Structured problem-solving was taught as a generalised adaptive skill: defining the problem, generating multiple solutions, conducting a cost-benefit analysis for each, implementing the chosen solution, and evaluating outcomes. The patient's self-reported affinity for written reflection was utilised therapeutically — she was encouraged to externalise her problem-solving process through journaling.

The terminal sessions served as a comprehensive skills review and relapse prevention exercise. The biosocial model of EUPD-BT was revisited. All acquired skills — emotion regulation, interpersonal effectiveness, and distress tolerance — were mapped against likely future trigger situations. The patient was encouraged to remain active, engage in pleasurable activities (painting, reading, music — her pre-morbid hobbies), and maintain social connections as ongoing protective factors. Future therapy goals — assertiveness training, self-concept work, and relapse management — were outlined.

6. Therapeutic Outcomes

6.1 Primary Outcomes

Across the 17-session, seven-month course of DBT, Miss N.D. demonstrated clinically meaningful improvements across all primary domains of dysfunction. The patient found a *secure therapeutic base* in the therapeutic relationship — an experience that itself served a corrective interpersonal function for someone whose relational history was defined by instability and abuse. Improvements were observed progressively across all three skill domains.

- **Anger and Emotional Dysregulation:** Frequency and intensity of anger outbursts decreased markedly. By the final session, the patient reported applying Check the Facts and Opposite Action spontaneously in triggering situations. She described a subjective experience of enhanced control over her emotional reactions — a meaningful shift from the complete absence of regulatory capacity at intake.
- **Self-Harming Behaviour:** Self-injurious behaviour (head-banging, starvation, punching walls) was absent throughout the course of therapy following the introduction of distress tolerance skills. The patient demonstrated the capacity to identify triggers and apply crisis survival skills (S.T.O.P., A.C.C.E.P.T.S.) before reaching a threshold of acute dysregulation.

- **Interpersonal Functioning:** Relationships with parents and peers improved significantly. The patient reported less conflict with her mother, greater ease in communicating her needs, and a reduction in the intensity of emotional reactions to interpersonal triggers. She began building relationships within her new designing cohort.
- **Emotional Independence:** The patient reported being less affected by memories of her past abusive relationship — a direct indicator of progress in Radical Acceptance and reality-oriented processing. She engaged with positive emotions through pleasurable activities (painting, reading, listening to music) that she had abandoned during the course of her illness.

6.2 Outcome Summary Table

Table 2: Pre- and Post-Treatment Outcomes Across Clinical Domains

Domain	Pre-Treatment	Post-Treatment
Anger outbursts & emotional dysregulation	Frequent; high-intensity; uncontrolled	Markedly reduced; patient reports sense of control
Self-harming behaviour	Present (head-banging, starvation, punching walls)	Absent during therapy; patient identifies triggers
Crying spells	1–2 times/day; prolonged; disabling	Significantly reduced in frequency and duration
Interpersonal relationships	Conflicted; intense and unstable; isolative	Improved; more stable; better communication
Sleep quality	Fragmented; delayed onset; unrefreshing	Improved; regularised routine
Academic & occupational functioning	Disrupted; interpersonal problems in college	Enrolled in new designing course; managing better
Insight	Grade IV (aware but limited understanding)	Enhanced self-awareness of behavioural patterns

6.3 Future Treatment Plan

Despite substantial gains, several areas require continued therapeutic attention. Planned future goals include: (i) assertiveness training to consolidate the D.E.A.R.M.A.N. and F.A.S.T. skills in real-world interpersonal contexts; (ii) self-concept restructuring to address the persistent, diffuse identity disturbance and tendencies toward self-blame; and (iii) relapse prevention

planning, including the development of a written crisis plan and the identification of early warning signs for emotional dysregulation. Pharmacological review and periodic psychological follow-up remain part of the ongoing management plan.

7. Discussion

The present case demonstrates the effectiveness of DBT in addressing emotional dysregulation and maladaptive interpersonal patterns associated with borderline personality pathology. The patient's symptoms appeared strongly associated with emotional invalidation, fear of abandonment, unstable attachment patterns, and ineffective coping strategies. Consistent with Linehan's biosocial theory (1993), heightened emotional vulnerability combined with invalidating interpersonal experiences contributed to the development and maintenance of borderline features. DBT interventions targeting emotion regulation, interpersonal effectiveness, and distress tolerance were particularly beneficial in reducing impulsive and self-destructive behaviours.

8. Conclusion

This case study presents a clinically detailed account of the assessment and DBT-based psychotherapeutic management of a 27-year-old Indian woman with Emotionally Unstable Personality Disorder, Borderline Type. The case demonstrates that a structured, phased, and formulation-driven individual DBT programme — encompassing emotion regulation, interpersonal effectiveness, and distress tolerance skill modules — can produce clinically meaningful and sustained improvements in this complex clinical population within a hospital-based Indian outpatient context. The therapeutic process underscores the importance of thorough bio-psychosocial formulation, psychoeducation-first engagement, collaborative goal-setting, and the careful sequencing of skill modules in DBT delivery. The case contributes to the emerging but growing body of Indian clinical literature on personality disorders and adds to evidence supporting the feasibility and efficacy of adapted DBT in non-Western cultural settings.

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