The Supporter's Guide to Emotion Dysregulation

On the Diagnosis the DSM Calls Borderline Personality Disorder

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This manual does not replace professional treatment.
It supplements it.

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Each week includes: Session Objectives, Supporter Checklist, Session Script, and a Printable Worksheet. Appendices include: Regulation Toolkit, Digital Toolkit Guide, and Guided Imagery Scripts.

Introduction

What the DSM calls Borderline Personality Disorder is, at its root, the story of a highly sensitive nervous system that met an environment unable to hold it.

The environment does not have to be abusive — though it often is. It has to be invalidating: a primary caregiver who is unwilling or unable to mirror and regulate the baby, to reflect back what the child is feeling in a way that says this is real, and you will survive it. When that mirroring fails consistently, the child's nervous system does not learn to self-regulate. It learns to escalate. It learns that only extreme expression gets a response. It learns that closeness is both necessary and dangerous.

That is not a personality disorder. That is an adaptation. The diagnosis came later. The nervous system came first.

About the Label

The term "borderline" was coined by Adolph Stern in 1938 to describe patients he believed sat on the border between neurosis and psychosis. That conceptual framework has since been abandoned by neuroscience. The word stayed. It has been used as a clinical slur for decades — patients blamed for not responding adequately to treatments that were never designed for them. This manual does not endorse the label. It uses it only so you can recognize it on a chart.

The Good News Nobody Told You

The McLean Study of Adult Development — the longest-running longitudinal study of BPD in existence — followed participants for over 30 years. One hundred percent achieved remission. Seventy-seven percent achieved 12-year remission. The suicide rate was 5.9%, not the 10% that had been predicted. Mary Zanarini, who has led this research since 1992, now describes BPD as "the most treatable major mental health condition." Your loved one's prognosis is better than anyone told you.

Who This Is For

- Family members supporting a loved one with a BPD diagnosis
- Partners navigating the relational intensity of emotional dysregulation
- Friends who want to understand what is actually happening — and stay

What Makes This Manual Different

This is not a skill-building manual in the conventional sense. The person you love does not receive techniques as techniques — they receive them as evidence of whether you are staying or leaving. Your regulation is the intervention. Your presence is the treatment. Every module in this program returns to that premise.

You will not be taught to manage your loved one. You will be taught to understand them — and to understand yourself well enough to stay present when everything in you wants to flee or fight.

A Note on Rupture

Rupture will happen. You will say the wrong thing. They will hear abandonment in a neutral sentence. You will feel accused of something you didn't do. This is not a sign that the program is failing. It is the program. How you repair is the entire lesson.

WEEK 1

The Diagnosis Nobody Explained to You

Psychoeducation: what BPD actually is, where the label came from, and why the prognosis is better than anyone told you.

Session Objectives

- Understand BPD as a nervous system condition, not a character flaw
- Learn the history of the 'borderline' label and why it is clinically contested
- Absorb the McLean longitudinal data: 100% remission, 77% at 12 years
- Identify the nine DSM criteria and recognize which ones you have observed
- Establish the frame for this 12-week program

Supporter Checklist

[ ] Check-in: How are you feeling about starting this? What do you already believe about this diagnosis?

[ ] Read the psychoeducation material together or alone first

[ ] Discuss: What did you already know? What surprised you? What do you want to push back on?

[ ] Complete Worksheet A: What I Know Now

[ ] Set the ground rules for your coaching relationship

Session Script

"Before we start, I want to say something directly: the diagnosis your loved one has been given is one of the most misunderstood and most maligned in psychiatry. Clinicians who should know better have used it as shorthand for 'difficult patient.' That ends here. We're going to understand what is actually happening."

"The word 'borderline' comes from 1938. A psychiatrist named Adolph Stern used it to describe patients he thought were on the border between neurosis and psychosis. That framework has been abandoned by neuroscience. The word stayed. It has been used as a clinical slur ever since — for patients who didn't respond to treatments that weren't designed for them."

"Here is what the research actually shows. The McLean Study of Adult Development has been following people with this diagnosis since 1992 — over 30 years. One hundred percent of participants achieved remission. Seventy-seven percent achieved 12-year remission. The lead researcher, Mary Zanarini, now calls this 'the most treatable major mental health condition.' That is not what you were told when you got the diagnosis, was it?"

Key Points to Cover:

- BPD is characterized by nine DSM criteria: fear of abandonment, unstable relationships, identity disturbance, impulsivity, self-harm/suicidality, emotional instability, chronic emptiness, intense anger, and dissociation/paranoia under stress
- A diagnosis requires five of the nine — which means two people with the same diagnosis can look very different
- The emotional storms are not manipulation. They are the nervous system doing exactly what it learned to do
- The prognosis is good. Recovery is real. The McLean data is not an outlier — it has been replicated

"How does all of that land? Anything you want to push back on?"

If they express skepticism about the good prognosis: "I understand. The experience of living with someone in crisis does not feel like good prognosis data. What I'm asking you to hold is both things at once: this is genuinely hard, and it gets better. The research says so."

A Second Lens — Gabor Maté and Compassionate Inquiry:

*"Before we close, I want to introduce one more frame. Gabor Maté — a physician and author of *The Myth of Normal* — argues that many of the behaviors we see in mental health conditions are not symptoms in the conventional sense. They are *adaptations*. The person learned to cope with something overwhelming early in life, and those adaptations are still running, even though the original threat is long gone."*

"Maté is not saying the condition isn't real or biological. He's saying biology is shaped by experience — especially in the first years of life. That matters for us as supporters, because it means we're not dealing with a broken person. We're dealing with a person whose nervous system adapted to something it couldn't handle alone."

"This brings us to our first Compassionate Inquiry exercise. Before our next session, sit with this question for five minutes — just notice what comes up, no need to solve anything:"

> *CI Exercise: The Story I Carry*
>
> *When I see [specific behavior that frightens or frustrates me], the story I tell myself is _____. I first learned this story when _____.*

"Write it down. We'll come back to it. The goal isn't to fix the story — it's to see it. Once you see it, it has less power over you."

> *Go Deeper — Nervous System Sensitivity*

> *The Trauma Essentials site has a dedicated section on Elaine Aron's Highly Sensitive Person research, including a 25-item Sensitivity Questionnaire with auto-scoring. If you want to understand the predisposing biology in more depth — or if your loved one has ever wondered whether they are an HSP — this is the place to start.*
>
> *[Sensitivity Screening --> currantraumaresources.manus.space](https://currantraumaresources.manus.space/window-of-tolerance)*

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 2

The Nervous System That Never Felt Safe

The neurobiology of BPD: why a highly sensitive nervous system plus an invalidating early environment produces the pattern you are living with.

Session Objectives

- Understand Aron's Highly Sensitive Person (HSP) trait as the genetic predisposition
- Understand Linehan's biosocial theory: sensitive nervous system + invalidating environment
- Understand what 'invalidating environment' actually means — and what it does not mean
- Understand the role of failed mirroring in identity development (Fonagy)
- Understand the neurochemical substrate: cholinergic hypersensitivity and affective instability

Supporter Checklist

[ ] Check-in: How was the week? Any reactions to last week's material?
[ ] Review the CI exercise from Week 1 — what came up?
[ ] Psychoeducation: The four-layer neurobiology model
[ ] Normalize: The nervous system is not performing. It is responding.
[ ] Complete Worksheet B: The Nervous System Map

Session Script

"Last week we talked about what the diagnosis is. This week we're going to talk about where it comes from — not to assign blame, but to understand the mechanism. Because once you understand the mechanism, the behavior stops being personal."

"Here's the model. It has four layers."

Layer 1 — The Predisposition (Aron, 2004):

"About 20% of the population is born with a nervous system wired for deeper processing and greater reactivity. Elaine Aron, a psychologist who has studied this trait for decades, calls it Sensory Processing Sensitivity — or the Highly Sensitive Person trait. It's not a disorder. It's a normal genetic variation. These nervous systems process more deeply, feel more intensely, and are more affected by their environment than the other 80%."

"When that nervous system meets a good-enough environment — a caregiver who can hold the intensity, reflect it back, and help the child learn to tolerate it — the result is often a person with unusual depth, empathy, and creativity. When it meets an environment that cannot hold it, the result is what we're talking about today."

Layer 2 — The Environment (Linehan, 1993):

*"Marsha Linehan — the psychologist who developed DBT — proposed what she called the biosocial theory of BPD. The core idea is this: BPD develops from the ongoing transaction between a biologically sensitive nervous system and an *invalidating* environment."*

*"Invalidating does not necessarily mean abusive. It means a primary caregiver who is unwilling or unable to mirror and regulate the baby — to reflect back what the child is feeling in a way that says: *this is real, and you will survive it*. The caregiver may be unable because they are themselves dysregulated, depressed, traumatized, or simply not wired for attunement. The effect on the child is the same: the child's emotional experience is not reflected back accurately. It is dismissed, minimized, punished, or met with inconsistency."*

"What does the child learn? That only extreme expression gets a response. That you have to escalate to be heard. That your internal experience is not trustworthy. Those are not personality defects. Those are lessons."

Layer 3 — The Identity Problem (Fonagy):

*"Peter Fonagy, a developmental psychologist at University College London, adds the mechanism for identity instability. When a caregiver can accurately reflect back what the infant is feeling — what he calls 'marked mirroring' — the child develops a coherent sense of their own inner life. They learn: *I feel this, it is real, and it is survivable.* When that mirroring fails consistently, the child cannot develop that coherent inner life. Identity instability is not a character flaw. It is the developmental consequence of a nervous system that never had its experience accurately reflected back to it."*

Layer 4 — The Neurochemistry (Steinberg et al., 1997):

"In 1997, researchers at Mount Sinai published a study that should have changed how clinicians talk about BPD. They gave patients a drug that temporarily increases acetylcholine — a neurotransmitter involved in mood regulation — and measured the emotional response. BPD patients showed a significantly greater depressive response than both other personality disorder patients and healthy controls. The response correlated specifically with affective instability, not impulsivity. Translation: the emotional flooding that looks like 'drama' or 'manipulation' has a measurable neurochemical basis. The nervous system is not performing. It is responding."

"So here's the full picture: a nervous system wired for depth and sensitivity, raised in an environment that could not hold that sensitivity, that never learned to accurately read or regulate its own internal experience, with a cholinergic system that floods the emotional circuitry faster and harder than most people's. That is what you are dealing with. Not a broken person. A nervous system that adapted to what it had."

"How does that land? What does it change for you — if anything?"

Nervous System Regulation Exercise: Physiological Sigh

"I want to teach you a regulation tool this week — not for your loved one, for you. Because you cannot co-regulate from dysregulation. Your nervous system has to be the steadier one in the room. This is called the Physiological Sigh."

"Take a normal breath in through your nose. At the top of the inhale, take a second, short sniff to fully inflate the lungs. Then exhale slowly and completely through your mouth — longer than the inhale."

"Let's do three together. In... sniff... and out slowly."

> *Why this works: The double inhale re-inflates collapsed alveoli in the lungs, and the extended exhale activates the parasympathetic branch of the autonomic nervous system. Stanford neuroscientist Andrew Huberman's lab has documented this as the fastest known method for reducing physiological arousal in real time. It works in one breath.*

"Practice this before your sessions with your loved one. Practice it when you feel yourself starting to flood. Your regulation is the intervention."

> *Go Deeper — Window of Tolerance*
>
> *The Trauma Essentials site has a full clinical module on the Window of Tolerance — the concept that explains why your loved one's nervous system goes from 0 to 100 so fast, and why certain moments produce shutdown instead of escalation. It includes an interactive diagram of the three arousal zones, the neuroscience behind them, and session language for both hyperarousal and hypoarousal states.*
>
> *[Window of Tolerance --> currantraumaresources.manus.space](https://currantraumaresources.manus.space/window-of-tolerance)*

> *Go Deeper — Polyvagal Theory*
>
> *The Physiological Sigh works because it activates the ventral vagal branch of the autonomic nervous system — the branch Stephen Porges identified as responsible for social engagement, safety, and co-regulation. If you want to understand why your nervous system is the intervention — and how to use that knowledge in real time — the Trauma Essentials Polyvagal Theory module covers the three-circuit model, neuroception, and practical applications for supporters.*
>
> *[Polyvagal Theory --> currantraumaresources.manus.space](https://currantraumaresources.manus.space/polyvagal-theory)*

WEEK 3

The Abandonment Alarm

Understanding the abandonment trigger: what it is, what activates it, and what escalation is actually communicating.

Session Objectives

- Understand the abandonment sensitivity phenotype and its neurobiological basis
- Recognize the difference between actual abandonment and perceived abandonment
- Identify your loved one's specific abandonment triggers
- Understand what escalation is communicating — and what it is not
- Learn the first rule of de-escalation: do not leave

Supporter Checklist

[ ] Check-in: How was the week? Any regulation practice?
[ ] Review Worksheet B — what did the nervous system map reveal?
[ ] Psychoeducation: The abandonment alarm
[ ] Identify your loved one's top three abandonment triggers
[ ] Complete Worksheet C: The Abandonment Trigger Map

Session Script

"This week we're going to talk about the thing that is probably at the center of most of your hardest moments together: the abandonment alarm."

"Gunderson and Lyons-Ruth — two of the most respected BPD researchers — documented that the heritability of the fearful/abandonment component of BPD is 0.48. That means roughly half of the variance in this particular sensitivity is genetic. This is not something your loved one chose. Their nervous system is wired to detect interpersonal threat — specifically, the threat of being left — faster, more intensely, and with less discrimination between real and perceived threat than most people's."

*"Here's the key distinction: the abandonment alarm does not require actual abandonment. It requires *perceived* abandonment. You can trigger it by being five minutes late. By having a neutral tone of voice. By saying 'I need some time to think.' By being distracted when they walk in the room. None of those are abandonment. The nervous system does not care. It has already sounded the alarm."*

"What does the alarm look like? It looks like rage. It looks like clinging. It looks like 'I hate you, don't leave me' in the same breath. It looks like self-harm. It looks like the nuclear option — saying the most devastating thing possible — because if you're going to leave anyway, at least they're in control of when."

*"None of that is manipulation in the conventional sense. Manipulation implies a strategy. This is a nervous system in a survival state. The strategy is: *make the threat stop.* You are the threat — not because you are dangerous, but because you are necessary."*

"So what do you do? The first rule is: don't leave. Not physically, not emotionally. Stay in the room. Stay regulated. Don't match the intensity. Don't defend yourself. Don't explain. Just stay."

"That sounds simple. It is not simple. We're going to spend the rest of this program learning how to do it."

If they ask 'But what about my needs?': "Your needs matter enormously. We have an entire week on that — Week 11. Right now, we're building the foundation. You cannot address your needs in the middle of an abandonment alarm. You can address them before it starts, or after it passes. Not during."

Nervous System Regulation Exercise: Extended Exhale Breathing

"This week's regulation tool is for when you feel yourself starting to flood during a difficult interaction. It's simple: make your exhale twice as long as your inhale."

"Inhale for 4 counts. Exhale for 8. That's it. You can do this with your eyes open, in the middle of a conversation, without your loved one noticing."

> *Why this works: The ratio of inhale to exhale directly controls the balance between sympathetic and parasympathetic activation. A longer exhale shifts the balance toward parasympathetic — rest and digest — even in a high-stress moment. You don't need to leave the room. You just need to breathe differently.*

"Practice this before our next session. Notice when you need it most."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 4

Your Regulation Is the Intervention

Co-regulation, polyvagal theory, and the single most powerful thing a supporter can offer.

Session Objectives

- Understand co-regulation as a neurobiological process, not a technique
- Learn the basics of polyvagal theory as applied to the supporter role
- Identify your own window of tolerance and what narrows it
- Build a personal regulation toolkit for high-intensity moments
- Understand why your regulation is the intervention — not your words

Supporter Checklist

[ ] Check-in: How was the week? Any abandonment alarm moments?
[ ] Review Worksheet C — what patterns emerged?
[ ] Psychoeducation: Co-regulation and polyvagal theory
[ ] Build your personal regulation toolkit
[ ] Complete Worksheet D: My Window of Tolerance

Session Script

"We've spent three weeks understanding what we're dealing with. Now we start building your toolkit. And I want to start with the most important tool — which is not a technique. It's your nervous system."

"Stephen Porges, a neuroscientist at Indiana University, developed what he calls Polyvagal Theory. The short version: your autonomic nervous system is constantly scanning the environment for safety cues — what Porges calls 'neuroception.' It does this below conscious awareness. And one of the most powerful safety cues available to a human nervous system is another regulated human nervous system in close proximity."

"That's co-regulation. It's not a metaphor. It's a neurobiological process. When you are regulated — when your voice is calm, your face is open, your body is not braced — your loved one's nervous system picks that up. Not always immediately. Not always obviously. But it picks it up."

"The reverse is also true. When you flood — when your voice goes up, your jaw tightens, your eyes narrow — their abandonment alarm reads that as threat. You don't have to say a word. Their nervous system already knows you're activated."

"This is why your regulation is the intervention. Not your words. Not your logic. Not your explanation of why they're overreacting. Your nervous system."

"Now — I am not telling you to be a robot. I'm not telling you to suppress what you feel. I'm telling you to have a plan for what to do with what you feel before it comes out sideways in a moment when your loved one needs you to be the steadier one."

Building Your Regulation Toolkit:

"Let's build your toolkit right now. We've already covered the Physiological Sigh and Extended Exhale Breathing. Here are two more."

Tool 3 — Cold Water:

"Splash cold water on your face, or hold ice cubes. This activates the dive reflex — a hardwired parasympathetic response that immediately slows heart rate. It works in about 30 seconds. It is not subtle, but it is fast."

Tool 4 — Bilateral Stimulation:

"Cross your arms over your chest and alternately tap your upper arms — left, right, left, right — at a slow, steady pace. This is the same bilateral stimulation used in EMDR therapy. It activates both hemispheres of the brain and tends to reduce the intensity of emotional flooding."

"Which of these feels most accessible to you? Which one could you actually use in the middle of a difficult moment?"

Compassionate Inquiry: The Six Questions for Supporters

"This week I want to add a Compassionate Inquiry practice specifically for supporters. These are six questions to sit with — not to answer perfectly, but to notice what comes up."

1. *When my loved one escalates, what do I feel in my body?*
2. *What story do I tell myself about what their behavior means about me?*
3. *What do I need in those moments that I'm not getting?*
4. *What did I learn in my own childhood about expressing need?*
5. *Who in my history does my loved one remind me of when they're dysregulated?*
6. *What would it mean for me if they actually got better?*

"That last question is not a trick. Sometimes supporters have organized their identity around being needed. Sometimes getting better is unconsciously threatening. Just notice."

WEEK 5

Identity — The Precarious Self

Understanding identity disturbance: why consistency is the scaffold, and what mirroring actually looks like in practice.

Session Objectives

- Understand identity disturbance as a developmental consequence, not a choice
- Recognize how identity instability shows up in your relationship
- Learn what accurate mirroring looks like — and what it is not
- Understand why consistency is the most powerful thing you can offer
- Recognize the difference between validating feelings and validating behavior

Supporter Checklist

[ ] Check-in: How was the week? Any regulation practice? Any difficult moments?
[ ] Review Worksheet D — what did the window of tolerance map reveal?
[ ] Psychoeducation: Identity disturbance and the mirroring deficit
[ ] Practice: What does accurate mirroring sound like?
[ ] Complete Worksheet E: The Mirroring Practice Log

Session Script

"Last week we talked about your regulation. This week we're going to talk about identity — specifically, why your loved one's sense of self is so precarious, and what you can do about it."

*"Remember Fonagy's model from Week 2: when a caregiver cannot accurately reflect back what the infant is feeling, the child cannot develop a coherent sense of their own inner life. They grow up without a reliable answer to the question: *Who am I?* Not because they're not trying. Because the developmental scaffolding wasn't there."*

*"What does that look like in an adult? It looks like values that change depending on who they're with. It looks like not knowing what they want, what they like, what they believe. It looks like adopting the identity of whoever they're closest to. It looks like feeling like a different person in different relationships. It looks like the desperate question, asked in different ways: *Am I real? Do I matter? Do you see me?*"*

*"Your consistency is the answer to that question. Not your words — your consistency. Showing up the same way, week after week. Being recognizable. Being predictable. Not in a boring way — in a *safe* way. When you are consistent, you become a mirror they can actually trust."*

What Accurate Mirroring Sounds Like:

"Mirroring is not agreement. It is not telling them they're right when they're not. It is reflecting back what you observe, accurately and without judgment."

Examples:

- "I can see you're really upset right now." (Not: "You're overreacting.")
- "That sounds incredibly painful." (Not: "It's not that bad.")
- "I hear that you feel like I don't care. I want to understand that better." (Not: "That's not true, I do care.")
- "You seem really scared right now." (Not: "There's nothing to be scared of.")

*"Notice what mirroring is NOT: it is not agreeing that you abandoned them when you didn't. It is not validating the interpretation — it is validating the *feeling*. 'I hear that you felt abandoned when I was late' is different from 'You're right that I abandoned you.' The first is mirroring. The second is a lie."*

*"The goal is for your loved one to hear: *My experience is real. Someone sees it. I am not crazy.* That is what identity is built from. One accurate reflection at a time."*

If they say 'But I've been doing this for years and nothing changes':

"I hear that. And I want to be honest with you: this is slow work. The nervous system that was shaped over years of early experience does not rewire in weeks. What you are doing is building a new data set — evidence, over time, that the world can be different. That takes time. The question is not whether it's working fast enough. The question is whether you can stay."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 6

The Splitting Problem

Understanding idealization and devaluation: how to stay present through the cycle, and what it means when you become the villain.

Session Objectives

- Understand splitting (idealization/devaluation) as a developmental defense, not an attack
- Recognize the idealization-devaluation cycle in your relationship
- Learn how to stay present during devaluation without defending or collapsing
- Understand what you represent when you become 'all bad'
- Develop a plan for the next devaluation episode

Supporter Checklist

[ ] Check-in: How was the week? Any mirroring practice?
[ ] Review Worksheet E — what did the mirroring log reveal?
[ ] Psychoeducation: Splitting and the idealization/devaluation cycle
[ ] Role-play: What do you say when you're the villain?
[ ] Complete Worksheet F: The Devaluation Survival Plan

Session Script

"This week we're going to talk about something that is probably one of the most disorienting experiences in this relationship: the moment when you go from being the most important person in the world to being the source of all their pain. In the clinical literature, this is called splitting."

"Splitting is not a choice. It is a developmental defense that forms when the nervous system cannot hold ambivalence — cannot hold the idea that the same person can be both good and frustrating, both loving and disappointing. For the developing child whose caregiver was inconsistent, holding ambivalence was too dangerous. If the person who feeds you is also the person who frightens you, your nervous system has to make a choice: safe or dangerous. It cannot hold both."

"So the nervous system learns to split. When you are good, you are all good — idealized, perfect, the only person who has ever understood them. When you do something that triggers the abandonment alarm, you become all bad — the source of all their pain, someone who never cared, someone who is just like everyone else who has hurt them."

"Here is the critical thing to understand: when you are all bad, you are not actually you. You are a placeholder for every person who has ever left, dismissed, or failed to see them. You have become the stand-in for the original wound. That is not a compliment. But it is also not personal."

What To Do When You're the Villain:

"You cannot argue your way out of splitting. Logic does not work on a nervous system in a survival state. What works — slowly, over time — is staying."

Scripts for devaluation moments:

- "I hear that you're in a lot of pain right now. I'm not going anywhere."
- "I know it doesn't feel like it right now, but I'm still here."
- "You can be angry at me. I can handle it. I'm staying."
- "I'm not going to defend myself right now. I just want you to know I'm here."

"Notice what you are NOT doing: you are not agreeing that you're terrible. You are not apologizing for things you didn't do. You are not explaining or justifying. You are staying present and regulated, and you are saying so out loud."

"The idealization will come back. It always does. And when it does, you don't have to pretend the devaluation didn't happen — but you also don't have to relitigate it. Just stay present in the good moment too."

If they say 'I can't keep doing this':

"That is a completely legitimate thing to feel. And we're going to spend Week 11 entirely on you — on what you need, on what is sustainable, on what your limits actually are. Right now, I just want you to have the tools to get through the next devaluation episode without either collapsing or retaliating. That's the goal for this week."

Nervous System Regulation Exercise: The Physiological Sigh

"When you are in the middle of a devaluation episode — when you are the villain and everything in you wants to defend, explain, or leave — your nervous system is flooded. Logic is offline. The fastest way to bring it back online is the physiological sigh."

"Here is how it works: take a normal inhale through the nose, then at the top of that inhale, take a second short sniff to fully inflate the lungs. Then release it all in one long, slow exhale through the mouth. That's it. One breath."

> *Why this works: The physiological sigh is the fastest known way to reduce physiological arousal. The double inhale re-inflates collapsed alveoli in the lungs, and the long exhale activates the parasympathetic nervous system. Stanford neuroscientist Andrew Huberman's research shows this is the only breathing pattern that works in real time — not after five minutes of meditation, but in the moment, in the room, with your eyes open.*

"You can do this while they are talking. You can do it while you are standing there being called every name in the book. It takes three seconds. And it will keep you present long enough to say: 'I hear that you're in a lot of pain right now. I'm not going anywhere.'"

"Practice it this week. Not during a crisis — before one. Get the muscle memory in your body so it's available when you need it."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 7

Rupture and Repair

Why repair is the actual treatment — and what repair looks like when one of you is still dysregulated.

Session Objectives

- Understand rupture as inevitable and repair as the therapeutic mechanism
- Learn the difference between repair and apology
- Understand the timing of repair — when to attempt it and when to wait
- Practice the repair conversation
- Understand what repair does for identity development over time

Supporter Checklist

[ ] Check-in: How was the week? Any devaluation episodes? How did you handle them?
[ ] Review Worksheet F — what does the devaluation plan look like in practice?
[ ] Psychoeducation: Rupture and repair as the mechanism of change
[ ] Practice: The repair conversation
[ ] Complete Worksheet G: The Repair Log

Session Script

"I want to start this week with something that might be counterintuitive: rupture is not the problem. Rupture is inevitable in any close relationship, and it is especially inevitable in this one. The problem is not rupture. The problem is when repair doesn't follow."

*"Ed Tronick's research on the 'still face' experiment showed that even very young infants can tolerate brief moments of misattunement — as long as repair follows. What damages development is not the rupture itself, but the absence of repair. The nervous system learns: *when things go wrong between us, they can be fixed.* That is the lesson your loved one never fully learned. And it is the lesson you are now in a position to teach — one repair at a time."*

"Repair is not the same as apology. An apology says 'I was wrong.' Repair says 'I see that something happened between us, I care about it, and I want to come back into connection with you.' You can repair without having done anything wrong. You can repair after a devaluation episode where you held your ground perfectly. Repair is about returning to connection — not about assigning fault."

The Timing of Repair:

"You cannot repair in the middle of a flooding episode. The nervous system that is in survival mode cannot receive repair — it can only receive threat or safety. Wait until the storm has passed. Wait until you can see in their face that they're back in their window of tolerance. Then repair."

The Repair Conversation:

"Here is a simple structure for repair. You don't have to use these exact words — but this is the shape of it."

1. *Name what happened: "I want to talk about what happened between us [yesterday/this morning/last week]."*
2. *Acknowledge the impact: "I can see that hurt you / scared you / felt like I was leaving."*
3. *Take your part: "I could have [stayed calmer / said it differently / not walked away]." (Only what is actually true for you.)*
4. *Reaffirm the relationship: "I'm not going anywhere. We're okay."*
5. *Leave space: "Is there anything you want to say?"*

"Notice step 3: you are only taking your actual part. If you did nothing wrong, you don't manufacture an apology. You can still repair without a false apology: 'I can see that what I said landed differently than I intended. I want to understand what you heard.'"

"And notice step 5: leave space. Don't rush to close it. They may need to say something that is hard to hear. Your job is to stay regulated while they say it."

What Repair Does Over Time:

"Every successful repair deposits something into the nervous system's account: evidence that rupture is survivable, that connection can be restored, that you are not going to disappear when things get hard. Over time, that evidence accumulates. The abandonment alarm gets quieter — not because the sensitivity is gone, but because the data set has changed. This is the mechanism of change. This is why repair is the actual treatment."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 8

Impulsivity and Self-Harm

Understanding the function of self-harm, how to respond, and what absolutely not to do.

Session Objectives

- Understand self-harm as a regulation strategy, not an attention-seeking behavior
- Learn the function of self-harm in the context of emotional flooding
- Develop a clear, non-reactive response protocol
- Understand the difference between self-harm and suicidality
- Know when to escalate to emergency services

Supporter Checklist

[ ] Check-in: How was the week? Any repair attempts?
[ ] Review Worksheet G — what did the repair log reveal?
[ ] Psychoeducation: The function of self-harm
[ ] Develop your response protocol
[ ] Complete Worksheet H: My Self-Harm Response Plan

Session Script

"This week we're going to talk about the topic that probably frightens you most: self-harm. And I want to start by saying something directly: your fear is understandable, and it is also one of the things that makes self-harm harder to address. We're going to work on that today."

"Self-harm — cutting, burning, hitting, scratching — is a regulation strategy. That is not a euphemism. It is a neurobiological fact. When the emotional flooding becomes intolerable, self-harm works. It releases endorphins. It shifts the nervous system's focus from emotional pain to physical pain, which the brain processes differently. It creates a sense of control in a moment of total overwhelm. For someone whose nervous system never learned to self-regulate through relationship, self-harm may be the most reliable regulation tool they have."

"That does not mean it is okay. It means it makes sense. And understanding why it happens is the first step to helping your loved one find other ways to get the same result."

What Self-Harm Is NOT:

- It is not manipulation (usually — there are exceptions, and we'll address them)
- It is not attention-seeking in the dismissive sense of that phrase
- It is not a suicide attempt — though it can escalate to one, and we'll talk about how to tell the difference

The Critical Distinction — Self-Harm vs. Suicidality:

"Non-suicidal self-harm is about managing unbearable feeling. The person wants to feel better, not to die. Suicidality is about wanting the pain to stop permanently. The distinction matters because the response is different."

"Signs that self-harm may be shifting toward suicidality: statements of hopelessness ('nothing will ever change'), giving away possessions, saying goodbye, a sudden calm after a period of extreme distress — that calm can mean a decision has been made. If you see those signs, treat it as a crisis. Call 988 (Suicide & Crisis Lifeline) or go to the nearest emergency room."

Your Response Protocol:

"When you discover self-harm, here is the protocol. Not a suggestion — a protocol, because in that moment your nervous system will flood and you need a plan."

> *1. Stay regulated. Take a breath. Do not gasp, cry, or express horror — even if you feel it. Your reaction is data for their nervous system.*
>
> *2. Address the physical first. "Let me see that. Do you need first aid?" Practical, calm, present.*
>
> *3. Don't interrogate. Not: "Why did you do this?" Not: "How could you?" Not: "Do you know how this makes me feel?"*
>
> *4. Mirror. "You were in a lot of pain." That's it. You don't have to fix it.*
>
> *5. Stay. Don't leave the room in distress. Don't punish. Don't withdraw.*
>
> *6. Later — not now — problem-solve. "I want to help you find something that works as well as this but doesn't hurt you. Can we think about that together?"*

What NOT to Do:

- Do not make them promise to stop (they can't keep that promise, and breaking it will feel like another failure)
- Do not search their room or remove all sharp objects (this is a control strategy that damages trust and doesn't work)
- Do not threaten to leave if they do it again
- Do not tell other family members without their permission unless there is immediate safety risk

WEEK 9

The Treatment Landscape

DBT, GPM, MBT, and TFP — what each approach targets, and how to use their principles in your daily interactions.

Session Objectives

- Understand what DBT, GPM, MBT, and TFP each address and how they differ
- Practice the MBT 'Mentalizing Pause' — the core curiosity stance
- Practice the TFP 'Role Clarification' — naming the dynamic without escalating it
- Know how to support your loved one's treatment without undermining it

Supporter Checklist

[ ] Check-in: How was the week?
[ ] Psychoeducation: The four evidence-based treatments for BPD
[ ] Exercise: The Mentalizing Pause (MBT)
[ ] Exercise: Role Clarification (TFP)
[ ] Discuss: What treatment is your loved one currently receiving?
[ ] Complete Worksheet I: Treatment Support Plan

Session Script

"This week I want to talk about treatment — specifically, the treatment your loved one may be receiving or has received, and what your role is in relation to it. There are four evidence-based approaches for BPD. Each one targets something different. Understanding them will make you a better support person, regardless of which one your loved one is in."

The Four Approaches

*"**DBT — Dialectical Behavior Therapy** (Marsha Linehan, 1980s): The most well-known. Teaches four skill sets — mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. It was designed to reduce the behaviors that were getting people hospitalized: self-harm, suicidality, impulsivity. It works. For many people, it works very well. What it was not primarily designed to do is address the relational wound at the center of this condition."*

*"**GPM — Good Psychiatric Management** (John Gunderson, McLean Hospital): Explicitly relational. Focuses on helping the person understand their own interpersonal hypersensitivity — to see the pattern, to connect the dots between their reactions and the underlying fear of abandonment. Gunderson's research showed GPM was as effective as DBT in randomized controlled trials. The relationship is the treatment."*

*"**MBT — Mentalization-Based Therapy** (Anthony Bateman & Peter Fonagy, 1999): Built on the observation that people with BPD lose the capacity to 'mentalize' — to hold their own mind and another person's mind in view simultaneously — when they are emotionally activated. MBT doesn't teach skills. It restores a capacity. The goal is to help the person slow down enough to ask: *What is actually happening in this interaction? What am I feeling? What might they be feeling? Are those the same thing?*"*

*"**TFP — Transference-Focused Psychotherapy** (Otto Kernberg, Weill Cornell): Works directly with the relationship between patient and therapist as a live laboratory for the relational patterns that cause suffering. TFP focuses on the moment-to-moment dynamics — who is playing what role, when the roles shift, what the person's internal object world looks like when it is activated. It is intensive and requires a trained therapist. But its core insight — that the roles we play with each other are driven by internalized relational templates — is something you can work with right now."*

Exercise 1: The Mentalizing Pause (MBT)

"This exercise comes directly from MBT. Bateman and Fonagy found that the single most destabilizing moment in a relationship with someone who has BPD is when both people stop mentalizing at the same time — when you both lose the capacity to hold the other person's inner world in view. What follows is not a conversation. It is two nervous systems in collision."

"The Mentalizing Pause is a way to interrupt that collision before it happens. Here's how it works:"

> *The Mentalizing Pause — Practice Script*
>
> *When you notice the conversation starting to escalate — your voice getting tighter, their voice getting louder, the topic narrowing to a single accusation — stop. You do not have to announce it. You can simply say:*
>
> *"I want to make sure I understand what you're saying. Can I check something with you?"*
>
> *Then ask one of these questions — genuinely, not rhetorically:*
>
> *- "What did you think I meant when I said that?"*
> *- "What were you feeling right before this started?"*
> *- "What do you need from me right now that you're not getting?"*
>
> *You are not trying to fix anything. You are trying to restore the capacity to see each other. That is the entire intervention.*

"The reason this works is neurological. When the question is genuine — when you are actually curious, not performing curiosity — it activates the prefrontal cortex in both of you. It slows the amygdala response. You are not just using a technique. You are changing the neurochemistry of the interaction."

*"Practice this week: Use the Mentalizing Pause once — in any conversation, not necessarily a difficult one. Just practice the stance: *I wonder what they are experiencing right now that I can't see.*"*

Exercise 2: Role Clarification (TFP)

"This exercise comes from TFP. Kernberg observed that in relationships with people who have BPD, the roles shift rapidly and often without warning. One moment you are the rescuer. The next you are the persecutor. The moment after that, you are the abandoner. These are not descriptions of you. They are descriptions of the internal object world — the cast of characters the nervous system learned to expect in relationships."

"Role Clarification is not about confronting your loved one with this. It is about you knowing what role you are currently occupying, so you do not get lost in it."

> *Role Clarification — Practice Script*
>
> *After a difficult interaction, sit down and answer these three questions in writing:*
>
> *1. What role was I playing in that interaction?*
> *(Rescuer / Persecutor / Abandoner / Witness — or your own words)*
>
> *2. What role was I being assigned?*
> *(What did their behavior seem to expect from me? What was the implicit script?)*
>
> *3. Did I accept the assignment? If so, what would it look like to step out of it next time?*
> *(Not by refusing to engage — by staying present without taking the role)*
>
> *Example: "I was playing Rescuer. The assignment was: fix this or you don't love me. I accepted it by immediately apologizing for something I didn't do. Next time I could say: 'I can hear that you're in pain. I'm not going to apologize for something I didn't do, and I'm not going anywhere.'"*

"The goal is not to diagnose the interaction. The goal is to stay yourself inside it. TFP calls this 'maintaining technical neutrality' — not coldness, not distance, but the capacity to remain a distinct person while staying in contact. That is what your loved one's nervous system needs most: proof that you exist as a separate person who will not be destroyed by their pain and will not disappear because of it."

Supporting Treatment Without Undermining It

"A few practical points, regardless of which treatment your loved one is in:"

- Don't ask your loved one to report on their therapy sessions. That's their space.
- Don't contact their therapist without their knowledge and consent (except in a safety emergency).
- If they tell you their therapist said something that contradicts what you're learning here, don't argue. Bring it to your own support system.
- If they're not in treatment, don't make treatment a condition of your support. Encourage it, yes. Ultimatums, no — ultimatums activate the abandonment alarm.
- If you want to understand MBT or TFP more deeply, Bateman & Fonagy's Mentalization-Based Treatment for Borderline Personality Disorder (2006) and Clarkin, Yeomans & Kernberg's Psychotherapy for Borderline Personality (1999) are the primary texts.

> *Go Deeper — Body-Based Regulation*
>
> *The affective flooding in BPD is a full-body event — not a cognitive one. Two of the most effective approaches for working with the body directly are Somatic Experiencing (Peter Levine) and Deep Brain Reorienting (Frank Corrigan). The Trauma Essentials site has full clinical modules on both, including core concepts, session language, and the neuroscience behind bottom-up regulation.*
>
> *[Somatic Experiencing --> currantraumaresources.manus.space](https://currantraumaresources.manus.space/somatic-experiencing)   [DBR --> currantraumaresources.manus.space](https://currantraumaresources.manus.space/dbr)*

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 10

Limits Without Abandonment

How to hold limits in a way that doesn't activate the abandonment alarm — and why this is harder than it sounds.

Session Objectives

- Understand the difference between limits and ultimatums
- Understand why conventional boundary-setting often backfires with BPD
- Learn to set limits in a way that is relational, not punitive
- Develop language for limits that communicates 'I'm staying' rather than 'I'm leaving'
- Identify your non-negotiable limits and how to hold them

Supporter Checklist

[ ] Check-in: How was the week?
[ ] Psychoeducation: Limits vs. ultimatums — why the distinction matters
[ ] Identify your non-negotiable limits
[ ] Practice: Limit language that doesn't sound like abandonment
[ ] Complete Worksheet J: My Limits Map

Session Script

"This week we're going to talk about something that every supporter needs and almost nobody teaches well: how to hold limits with someone whose nervous system reads limits as abandonment."

"First, a distinction. A limit is about what you will and won't do. An ultimatum is about what they must do or else. Limits are relational — they describe your behavior. Ultimatums are coercive — they try to control their behavior. With someone whose abandonment alarm is hair-trigger, ultimatums almost always backfire. They activate the alarm, which escalates the behavior, which makes you more likely to follow through on the ultimatum, which confirms the abandonment fear. That is a cycle you do not want to be in."

"A limit sounds like: 'I can't stay in this conversation when there's yelling. I'm going to take a 20-minute break and come back.' An ultimatum sounds like: 'If you keep yelling, I'm leaving.' The first describes your behavior. The second threatens theirs."

*"Notice the critical addition in the limit: 'I'm coming back.' That is not weakness. That is the difference between a limit and an abandonment. The abandonment alarm cannot hear 'I need a break.' It hears 'I'm leaving.' So you have to say both things: *I'm stepping back, and I'm coming back.*"*

Non-Negotiable Limits:

"There are some limits that are non-negotiable — not because you're punishing them, but because you cannot function without them. Physical safety is one. Verbal abuse in front of children is another. You know your list."

"For non-negotiable limits, the language is direct but relational: 'I love you and I'm not going anywhere. And I cannot [specific behavior]. When [specific behavior] happens, I will [specific response]. Not to punish you — because I need to stay regulated enough to keep showing up for you.'"

*"Notice the frame: you are holding the limit *in service of the relationship*, not as a threat to it. That is not manipulation. That is the truth. If you burn out, you cannot stay. The limit is what makes staying possible."*

The Hardest Limit:

"The hardest limit to hold is the one around your own wellbeing. 'I need to sleep.' 'I need to not be called at 3am every night.' 'I need one day a week that is mine.' These feel selfish. They are not selfish. They are the conditions under which you can continue to show up. We'll go deeper on this next week."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 11

Taking Care of the Supporter

Compassion fatigue, secondary traumatization, and the grief of loving someone in chronic pain.

Session Objectives

- Understand compassion fatigue and secondary traumatization
- Assess your own current state honestly
- Identify what you have lost or given up in this relationship
- Build a sustainable self-care structure — not a spa day, a survival plan
- Understand when to consider your own therapy

Supporter Checklist

[ ] Check-in: How are you — really?
[ ] Psychoeducation: Compassion fatigue and secondary traumatization
[ ] Honest assessment: Where are you right now?
[ ] Build your sustainability plan
[ ] Complete Worksheet K: The Supporter's Inventory

Session Script

"This week is about you. Not your loved one — you. And I want to start by acknowledging something that doesn't get said enough: what you are doing is hard. Not in the 'this is challenging' sense. In the 'this can break people' sense. And you deserve support for that."

"Compassion fatigue is what happens when you give more than your nervous system can sustain. It's not weakness. It's a physiological response to chronic exposure to another person's suffering. The symptoms look like burnout — exhaustion, numbness, irritability, cynicism — but they also include hypervigilance, intrusive thoughts, and a gradual erosion of your own sense of self. Sound familiar?"

"Secondary traumatization is a step further. It happens when you have been exposed to your loved one's trauma and crisis often enough that your own nervous system has been shaped by it. You may have developed your own startle response. Your own hypervigilance. Your own difficulty sleeping. Your own sense that the world is not safe. That is not weakness. That is what happens to nervous systems that are in chronic proximity to dysregulation."

The Grief Nobody Talks About:

"There is also grief. The grief of the relationship you thought you were going to have. The grief of the person you remember before the crises became the center of everything. The grief of your own needs going unmet for so long that you've stopped noticing them. That grief is real. It deserves to be named."

What Sustainable Support Looks Like:

"I am not going to tell you to take bubble baths. I'm going to tell you to build a structure that makes it possible for you to keep showing up. That structure has three components:"

> *1. Regular contact with your own support system. Not to vent about your loved one — to be seen as a person who has their own life, their own needs, their own story.*
>
> *2. Your own therapy. Not couples therapy, not family therapy — your own individual therapy with someone who understands trauma and complex relationships. This is not optional if you are in secondary traumatization.*
>
> *3. Time that is yours. Not earned, not negotiated — structurally yours. One morning a week. One evening. Something that is not available for crisis management.*

"I want to be honest with you: if you are in secondary traumatization, this program alone is not enough. You need your own support. That is not a failure. That is the reality of this work."

The Question Worth Sitting With:

"Before we close, I want to offer a Compassionate Inquiry question that is specifically for supporters:"

> *What would it mean for me if my loved one actually got better?*

"That is not a trick question. Sometimes supporters have organized their identity around being needed. Sometimes the role of caretaker has become the primary relationship with themselves. Just notice what comes up. No judgment."

The Compassionate Inquiry Pause (Adapted from Gabor Maté's CI framework — 10 minutes)

"I want to walk you through a structured pause. This is not meditation. It is a brief, directed inquiry into what is actually happening in your body and your story right now. You do not need to share anything. Just follow the prompts."

Step 1 — Arrive

"Close your eyes if that feels comfortable, or soften your gaze downward. Take one slow breath. Not a deep breath — just a complete one. In through the nose, out through the mouth. Notice that you are here, in this moment, not in the last crisis or the next one."

Step 2 — Notice the body

"Scan your body from the top of your head to the soles of your feet. Don't try to change anything. Just notice. Where are you holding tension? Where do you feel heaviness? Where do you feel nothing at all? That numbness is information too."

Step 3 — Name the feeling

"Without judgment, name what you are feeling right now. Not what you think you should feel. Not what would be reasonable to feel. What is actually present. It might be exhaustion. It might be resentment. It might be grief. It might be love. It might be all of those at once. Just name it."

Step 4 — Ask the question

*"Now ask yourself this: *When did I first learn that my needs were less important than someone else's?* Don't force an answer. Just let the question sit. Notice what comes up — a memory, an image, a sensation, a name. You don't have to do anything with it right now."*

Step 5 — Return

"Take another breath. Open your eyes when you're ready. Whatever came up belongs to you. It doesn't need to be explained or justified. It just needs to be acknowledged."

"Gabor Maté's central insight is this: we do not choose our patterns of self-abandonment. We learned them early, from people who were doing the best they could. The compassionate part of Compassionate Inquiry is not directed at your loved one. It is directed at you — at the child who learned to manage someone else's emotional world before they had the tools to manage their own."

"That is the work of this week. Not fixing anything. Just seeing it."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

WEEK 12

The Long Game

What recovery actually looks like, the McLean data revisited, and how to sustain what you've built.

Session Objectives

- Revisit the McLean longitudinal data with new eyes
- Understand what recovery looks like — and what it doesn't look like
- Assess what has changed over the 12 weeks
- Build a maintenance plan
- Name what you are taking forward

Supporter Checklist

[ ] Check-in: How are you both feeling about reaching the end of the program?
[ ] Revisit the McLean data: what does it mean now that you've done this work?
[ ] Assessment: What has changed? What hasn't?
[ ] Build your maintenance plan
[ ] Complete Worksheet L: The Long Game

Session Script

"We made it to Week 12. I want to start by acknowledging that — not as a formality, but because staying in this program for 12 weeks while living what you're living is not a small thing. You showed up. That matters."

"Let's go back to where we started: the McLean data. One hundred percent remission. Seventy-seven percent at 12 years. When I told you that in Week 1, you may have heard it as a statistic. Now you've spent 12 weeks understanding the mechanism — the nervous system, the invalidating environment, the mirroring deficit, the abandonment alarm, the splitting, the repair. Does that data land differently now?"

What Recovery Actually Looks Like:

"Recovery from BPD does not look like the absence of sensitivity. The nervous system that was wired for depth does not become a different nervous system. Recovery looks like: the abandonment alarm gets quieter. The splits become less total. The ruptures become less catastrophic because repair has become a known quantity. The identity becomes more stable because there is more evidence that the self is real and continuous. The impulsivity decreases because the emotional flooding is less overwhelming."

"Recovery looks like a person who still feels things deeply — but who has more tools, more history of surviving their own feelings, and more evidence that the people they love are not going to disappear. You are part of that evidence. Every time you stayed, you were part of that evidence."

What Hasn't Changed:

"I also want to be honest about what 12 weeks cannot do. It cannot undo years of early experience. It cannot eliminate the sensitivity. It cannot guarantee that there won't be crises. What it can do — what I hope it has done — is give you a framework for understanding what is happening, tools for staying regulated, and a different relationship with the moments that used to feel like they were destroying you."

The Maintenance Plan:

"Recovery is not a destination. It is a practice. Here is what I want you to commit to going forward:"

> *1. Keep the weekly check-in. Even if it's shorter. Even if it's just 20 minutes. The structure matters.*
>
> *2. Keep the repair practice. Every rupture is an opportunity. Don't let them accumulate.*
>
> *3. Keep your own support. Your sustainability is not optional.*
>
> *4. Come back to this manual. When things get hard, come back to the week that addresses what you're facing. This is a reference, not a one-time read.*

"What are you taking forward from this? What is the one thing that has changed most in how you understand what you're dealing with?"

Closing:

"I want to end with something Gunderson wrote near the end of his career, after decades of studying this condition: he described BPD as 'one of the few psychiatric illnesses that is not lifelong.' He spent his life fighting the stigma, fighting the nihilism, fighting the clinicians who gave up on these patients. He was right. The prognosis is good. Your loved one can get better. And you — by staying, by learning, by showing up week after week — are part of how that happens."

Printable worksheet available in the online manual at curranscoachingmanuals.manus.space

Appendix: Regulation Toolkit

21 evidence-based exercises for calming, grounding, activating, and self-soothing.

Calming Sympathetic Arousal

For fight/flight, activated, anxious states

- **Physiological Sigh** (1–3 breaths)
  Double-inhale through nose, long exhale through mouth. Fastest voluntary method for calming.
- **4-7-8 Breathing** (2–5 min)
  Inhale 4 counts, hold 7, exhale 8. Extended exhale stimulates vagus nerve.
- **Left Nostril Breathing** (5–10 min)
  Close right nostril with thumb, breathe only through left. Activates parasympathetic branch.
- **Humming / Vocal Toning**(3–5 min)
  Hum or produce a low 'voo' sound on exhale. Vibration stimulates vagus nerve through larynx.
- **Progressive Muscle Relaxation** (10–20 min)
  Tense each muscle group 5–7 sec, release. Feet to head. Interrupts tension-anxiety loop.
- **Hand on Heart** (1–5 min)
  Place hands over heart with gentle pressure. Releases oxytocin, reduces cortisol.

Activating from Shutdown

For numb, dissociated, foggy, dorsal vagal states

- **Cold Water / Temperature** (15–60 sec)
  Cold water on face triggers dive reflex — involuntary parasympathetic override.
- **Orienting** (2–5 min)
  Slowly look around the room with curiosity. Sends updated safety signals to brainstem.
- **Bilateral Movement** (2–3 min)
  March in place, right hand to left knee, left hand to right knee. Integrates hemispheres.
- **Gentle Shaking** (2–5 min)
  Stand, gently bounce from legs upward. Discharges stored survival energy (Levine).

Grounding Practices

For both activation and shutdown

- **5-4-3-2-1 Sensory** (3–5 min)
  Name 5 see, 4 touch, 3 hear, 2 smell, 1 taste. Anchors in present moment.
- **Weighted Contact** (10–20 min)
  Weighted blanket or firm pressure. Deep proprioceptive input signals safety.
- **Feet on Floor** (2–5 min)
  Press feet flat, imagine roots growing down. Gravity is constant and reliable.

Self-Soothing / Co-Regulation

Activate the social engagement system

- **Self-Havening** (2–5 min)

  Three touch areas: (1) Arm Havening — cross arms, stroke shoulder to elbow. (2) Face Havening — fingertips at center of forehead, sweep outward to temples; then fingertips beside nose, sweep outward across cheeks. (3) Palm Havening — rub palms together slowly. Activates C-tactile nerves, produces delta waves.
- **Butterfly Hug** (30 sec–2 min)

  Cross arms, alternate tapping shoulders. SHORT sets (10–30 sec) for calming.

Emergency / Crisis Tools

- Cold water on face — triggers dive reflex
- Physiological sigh — fastest voluntary calming
- Ice cube in hand — overrides dissociation
- Strong taste/smell — forces present-moment awareness
- Stamp feet hard — proprioceptive grounding
- Count backwards from 100 by 7s — engages prefrontal cortex

Match State to Practice

Panic / Acute Anxiety

Try: Cold water, Physiological sigh, 5-4-3-2-1

General Anxiety

Try: 4-7-8 Breathing, Hand on Heart, PMR

Dissociation / Numb

Try: Cold water, Orienting, Shaking, Strong smell

Shutdown / Collapsed

Try: Shaking, Bilateral Movement, Cold water

Hypervigilance

Try: Orienting, Humming, Left Nostril Breathing

Flashback

Try: 5-4-3-2-1, Feet on Floor, Orienting, Cold water

Anger / Discharge

Try: Shaking, Stamp feet, Bilateral Movement

Sleep Difficulty

Try: 4-7-8 Breathing, Self-Havening, PMR

Self-Compassion

Try: Hand on Heart, Self-Havening, Butterfly Hug

Based on polyvagal theory (Porges), Somatic Experiencing (Levine), and current neuroscience research.

Appendix: Your Digital Toolkit

This manual comes with a full set of online tools at curranscoachingmanuals.manus.space. Here is what is available to you.

- **12-Week Session Scripts**
  Complete scripts for every session. Read them out loud -- designed to sound like a real conversation, not a textbook.
- **Interactive Worksheets**
  Fillable in the app or printable. Completed worksheets save automatically so you can track patterns over time.
- **Regulation Toolkit (21 Exercises)**
  Organized by what your loved one is experiencing right now. Calming, grounding, activating, self-soothing, and emergency tools.
- **Binaural Beats Audio Environment**
  Bilateral stimulation tones through stereo headphones. Four presets, adjustable volume, ambient sounds. A relaxation aid, not therapy.
- **Guided Imagery Studio**
  Record guided imagery scripts in your own voice with BLS tones underneath. Teleprompter walks you through each section. Export as MP3.
- **Compassionate Inquiry Framework**
  Based on Gabor Mate's model. Reflective exercises woven into every weekly session to look underneath symptoms.
- **Coaching Journal**
  Private, searchable journal for tracking observations, patterns, and your own growth as a coach.
- **Progress Tracking**
  Visual indicators for module completion, worksheet status, and checklist items. Exportable for treatment team coordination.
- **Crisis Safety Plan**
  Structured plan with emergency contacts, warning signs, coping strategies. Fill it out before Week 1. Print two copies.
- **Self-Care Assessment**
  Honest assessment of your own well-being -- physical, emotional, social, spiritual. If you burn out, the program stalls.
- **Coach's Toolkit**
  Quick-reference tools, communication scripts, de-escalation strategies for in-the-moment use.
- **FAQ**
  The questions supporters actually ask: What if they refuse? What if I say the wrong thing? When do I call 911?
- **Downloadable PDF**
  This document. Print the whole thing or just the pages you need for a given session.

Access all tools at curranscoachingmanuals.manus.space

Appendix: Guided Imagery Scripts

From 101 Trauma-Informed Interventions by Linda Curran. Each script is available as an individual downloadable PDF and in the online Guided Imagery Studio with teleprompter and BLS audio.

The Container (Appendix 4)

Containment Imagery -- ~12 minutes

An imaginal resource for compartmentalizing distressing material in order to be present. Not repression -- a technique to attend to what needs attending to until the necessary resources are available.

Comfortable Place (Appendix 5)

Safe/Neutral Place Imagery -- ~15 minutes

Establishes a mental refuge -- a place of safety and calm the client can return to at any time. Uses all five senses to anchor the experience.

Repairenting (Appendix 6)

Imagery for Disrupted Attachment -- ~18 minutes

Addresses early attachment disruption by inviting the client to re-experience being cared for by a nurturing figure. Clinician-guided -- requires safety screening before use.

CLINICIAN-GUIDED: Requires safety consent before recording.

Care and Nurture (Appendix 7)

Imagery for Care and Nurture -- ~10 minutes

Develops the capacity to give and receive care. The client imagines nurturing a young being, then receiving that same quality of care.

The Secure Base (Appendix 9)

Post-Crisis Regulation for Supporters -- ~15 minutes

A guided imagery script for supporters after a BPD crisis. Grounded in Fonagy's secure base concept -- the internalized experience of a reliable, non-abandoning presence. This script helps the supporter's nervous system return to a regulated state and builds an internal resource that can be accessed between crises. Use in the quiet after a crisis has passed, not during.

BPD manual only. For the supporter, not the person with BPD.

Download individual script PDFs from the Guided Imagery Studio at curranscoachingmanuals.manus.space

Important Disclaimer

This manual is an educational resource designed to support family members and friends. It does not replace professional treatment, including medication management, psychotherapy, or formal clinical intervention.

The Compassionate Inquiry exercises included in this manual are adapted from Gabor Mate's framework for use by lay supporters. They are not therapy. If any exercise brings up strong emotions or memories, please seek support from a qualified mental health professional.

If you or your loved one is in crisis, contact the 988 Suicide & Crisis Lifeline (call or text 988) or go to your nearest emergency room.

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