SFU Forschungsbulletin SFU Research Bulletin 10/1 (2022), S. 50-77 DOI: 10.15135/2022.10.1.50-77

„Borderline-Persönlichkeitsstörung (BPD) und ihre manualisierte Behandlung“

Ein Überblick

“Borderline personality disorder (BPD) and its manualized treatment”

An overview

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Kurzzusammenfassung

Die Borderline-Persönlichkeitsstörung (BPD) ist eine chronische psychiatrische Störung, die das Leben der Betroffenen erheblich belastet und beeinträchtigt. Die BPD betrifft fast 1,0 bis 1,5 % der erwachsenen Bevölkerung. In Anbetracht der Auswirkungen, die die BPD auf das Leben der Patient*innen haben kann, sind das Verständnis der Krankheit und die Entwicklung von Behandlungsansätzen von größter Bedeutung. Diese Behandlungsstrategien sollten daher gründlich untersucht werden, um die besten Optionen für Klient*innen mit BPD zu ermitteln. Im Folgenden geben wir einen Überblick über die manualisierten Behandlungsansätze, die bei BPD am häufigsten eingesetzt werden. Dazu gehören die Dialektisch-Behaviorale Therapie (DBT), die Mentalisierungsbasierte Therapie (MBT), die Schema-fokussierte Therapie (SFT) und die Übertragungsfokussierte Psychotherapie (TFP), die jeweils ausführlich beschrieben werden, um ein tieferes Verständnis der Behandlung zu ermöglichen. Darüber hinaus wurden, soweit möglich, Vergleiche zwischen den Behandlungsstrategien angestellt, um ihre Vorteile gegenüber anderen Ansätzen aufzuzeigen. Es wird davon ausgegangen, dass ein gründliches Verständnis der Behandlungsoptionen Psychotherapeut*innen in die Lage versetzen würde, bessere Entscheidungen zu treffen, um BPD-Patienten zu helfen. Obwohl DBT, MBT und SFT wirksame Ansätze für die Behandlung von BPD sind, geben wir der TFP den Vorzug, die als optionale Behandlungsstrategie für

BPD vorgeschlagen werden könnte. Dennoch müssen in dieser Hinsicht weitere Studien durchgeführt werden, um festzustellen, welcher Ansatz die besten Auswirkungen auf BPD-Patienten haben könnte.

Schlüsselwörter

Borderline-Persönlichkeitsstörung (BPD), Dialectical behavior therapy, Mentalization based treatment, Schema-focused therapy und Transference-focused psychotherapy

Abstract

As a chronic psychiatric disorder, borderline personality disorder (BPD) significantly distresses and impairs the life of an individual. BPD affects almost 1.0 – 1.5% of the adult population. Considering how impactful BPD can be in the lives of patients, understanding the disease and developing treatment approaches are of paramount importance. These treatment strategies should therefore be studied thoroughly to determine the best options available for patients suffering from BPD. Here an overview of the manualized treatment approaches mostly employed for BPD will be presented. These include dialectical-behavior therapy (DBT), mentalization-based treatment (MBT), schema-focused therapy (SFT), and transference-focused psychotherapy (TFP), each of which has been described in detail to provide an in-depth understanding of the treatment. Moreover, where possible, a comparison between the treatment strategies has been made to show their advantages over other approaches. It is believed that a thorough understanding of treatment options would enable psychotherapists to make better decisions aimed at helping BPD patients. Although DBT, MBT, and SFT are potent approaches to the treatment of BPD, a preference for TFP is expressed, which could be suggested as an elective treatment strategy for BPD. Nonetheless, further studies need to be conducted in this respect to determine which approach could exert the best effects on BPD patients.

keywords

Borderline personality disorder (BPD), Dialectical behavior therapy, Mentalization based treatment, Schema-focused therapy, and Transference-focused psychotherapy

1. Introduction

As a chronic psychiatric disorder, borderline personality disorder (BPD) involves suicidal behavior, marked impulsivity, unstable interpersonal relationships, disturbances in self-image, and instability of affects, which significantly distress and impair the life of an individual. BPD patients also suffer significant morbidity, and complicating options for medical care (Kulacaoglu & Kose, 2018). BPD affects almost 1.0 – 1.5% of the adult population and has therefore been the most widely studied personality disorder. BPD patients consume health care services to a high degree, and BPD prognosis is regarded as uncertain primarily due to the consequences of deliberate self-harm and impulsivity (Dahl, 2008).

Feelings of an individual towards him/herself, as well as his/her behaviors and relations to others could be affected by BPD. There exists a wide spectrum of symptoms which challenge the life of the patient in this regard. Therefore, it is really important to study and understand the disease. These challenges may include being intensely scared of abandonment to the extent that the patient takes extreme measures aimed at avoiding real or imagined rejection or separation. On top of that, the patient might show suicidal behavior in response to these fears. Moreover, instability in relationships might be observed. For instance, the patient might idealize the partner for a while, and then suddenly believe that he/she is unpleasant. Accordingly, the patient takes measures which might challenge and impair the relationship. Therefore, these fearful beliefs lead to actions they are indeed avoiding, meaning that they do not know what their behavior would cause. In addition, frequent loss of temper, sarcasm, bitterness, or engagement in physical fights may be observed as results of intense, inappropriate anger. In addition, a wide range of swings in mood which last from a few hours to a few days might be witnessed, including intense anxiety, happiness, shame, or irritability. In this regard, the patient's self-image could rapidly alter, making him, or her shift goals and values. Furthermore, he/she might see him/herself as if he/she doesn't exist at all and might suffer the ongoing feeling of emptiness. Additionally, stress-associated paranoia or loss of contact with reality may be observed, which lasts from a few minutes to a few hours. Last but not least, reckless driving, binge eating, unsafe sex, drug abuse, spending sprees, gambling, or sabotaging success might be witnessed as impulsive behaviors. These are in fact the measures the patients take for self-regulation and are considered as coping styles or defensive mechanisms. These actions are performed by patients since they seek to control and manage themselves, not knowing that they are not helpful to them (American Psychiatric Association, 2017; Barlow, 2014; Clarkin, Levy, Lenzenweger, & Kernberg, 2004).

Together, considering how impactful BPD can be in the lives of patients, understanding the disease and developing treatment approaches are of paramount importance. Throughout the last two decades, various approaches have been formulated and developed for the treatment of BPD. Four major approaches among these include dialectical-behavior therapy (DBT), mentalization-based treatment (MBT), schema-focused therapy (SFT), and transference-focused psychotherapy (TFP) (Choi-Kain, Finch, Masland, Jenkins, & Unruh, 2017). The present paper aims to give a short overview of these approaches. After a brief presentation of the descriptive approaches to BPD, each of the above-mentioned manualized approaches will be described with regard of both the psychopathological and treatment model.

2. Borderline personality disorder: descriptive approaches

The characterization of BPD as a major mental disorder takes into account several main factors. These include unstable self-sense, impulsive behavior, emotional sensitivity, functional impairments, high treatment costs, negative impacts on depressive disorders, high risks of suicide, and interpersonal instability. Severe stigma and high morbidity may constitute other factors in this regard. Together, the definite causes of BPD are not well understood, however adverse life events as well as genetic factors are considered relevant. A lifetime prevalence of 5.9% is reported for BPD, though its prevalence in treatment settings is considerably higher. There is no evidence to suggest that the frequency of BPD is higher in women.

BPD symptoms reveal four main phenotypes, which include interpersonal instability, behavioral dysregulation, cognitive and/or self-disturbance, and affective and/or emotional dysregulation. In another setting, BPD symptoms are divided into two types, which include acute symptoms and temperamental symptoms. The frequent association of other psychiatric disorders with BPD has also been reported, including trauma-related disorders, major depressive disorders, and anxiety. Certain psychotherapy treatments could be advantageous in the treatment of some of the complications experienced by BPD patients, though there exists no specific cure for all these difficulties (Bender et al., 2001; Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Oldham, 2006; Skodol et al., 2002; Zanarini et al., 2007).

2.1 Diagnostic and statistical manual of mental disorders

The earliest version of the diagnostic and statistical manual of mental disorders (DSM) was published in 1952. Its later versions were released in 1968 (DSM-II), 1980 (DSM-III), 1987 (DSM-III R), 1994 (DSM-IV), 2000 (DSM-IV TR), and 2013 (DSM-V), as manuals for both classifying and evaluating mental disorders (Vahia, 2013). The diagnosis of BPD in DSM-5 (American Psychiatric Association, 2017) is based on several factors. These include a predominant pattern of instability in self-image, affects, and interpersonal relationships, and exceptional impulsivity which starts in adulthood and exists in several contexts, with at least five of the following: 1) reckless efforts aimed at avoiding real or imaginary abandonment, with the exclusion of suicidal behaviors; 2) interpersonal relationships that are unstable and extreme, and swing between extremes of idealization and devaluation; 3) constantly or exceptionally unstable self-image; 4) impulsivity in at least two potentially self-harming behaviors including careless driving, spending, substance abuse, sex, or binge eating; 5) continuous suicidal gestures, threats, or behavior, or even self-mutilating behaviors; 6) affective instability due to conspicuous reactivity of mood; e.g. intense episodic dysphoria, irritability, or short-term anxiety; 7) persistent feeling of emptiness; 8) difficulty controlling anger; 9) stress-related, temporary paranoid ideation or extreme dissociative symptoms (American Psychiatric Association, 2017).

2.2 International classification of diseases

According to the international classification of diseases (ICD-11), the definition of a personality disorder involves difficulties in aspects of functioning of an individual’s self and/or interactive

dysfunction with a long-term persistence (2 years or more). These disturbances are evident in maladaptive behaviors, cognition, emotions, and several interactive or personal circumstances. BPD is identified by ICD as a condition in which instable emotions are present due to significant mood reactivity. Additionally, there exist vague inner preferences and identity disturbance. Other factors include feelings of emptiness, persistent emotional crises, self-harm behavior, extreme anger, and efforts to avoid any sort of abandonment. Psychotic-like traits or temporary dissociative indications are also observed when one is extremely aroused in terms of affects (World Health Organization, 2018).

3. *Theoretical approaches*

Various approaches have been developed for conceptualizing and treating BPD. Among these, the most prominent are DBT, MBT, SFT, and TFP (O'Connell & Dowling, 2014). These represent manualized approaches centered in the provision of focused and active interventions emphasizing patients' contemporary relationships and functioning. They also provide manuals for supporting and guiding the therapist, encouragements for being active, emphasis on processing affects, and improved cognitive coherence (Kulacaoglu&Kose, 2018).

3.1 Dialectical-behavior therapy

DBT (M. M. Linehan, 1987) was first developed by Linehan to treat chronically parasuicidal women and, successively, was fully adapted for the conceptualization and treatment of BPD.

Conceptualization of BPD

Dialectics is explained in two different ways; (1) as a guide for clinicians for developing theoretical hypotheses according to the complications and treatment of the patient, and (2) as treatment strategies aimed at effecting change. Several therapeutic dialectical strategies are central to DBT (Barlow, 2014). Theoretical inspirations of DBT involve dialectical philosophy, biosocial theory of personality functioning, behavioral science, and Eastern contemplative practice. Linehan (Linehan et al., 1999) first announced DBT as a structured cognitive-behavioral therapy (CBT) for suicidal, BPD-suffering women. The aim of the therapy is to alter behavior and manage affect through the harmonization and synthesis of acceptance and change, which are essential to DBT. "Dialectical" in fact indicates that no absolute certainties exist, and that opposing concepts could both be true. Patients in DBT are taught to avoid thinking, with the aim of decreasing thinking processes and polarizing behaviors. The focus in DBT is to learn new skills and practice them. The basis of DBT, in fact, is the biosocial theory of emotional dysregulation. In this regard, it is stated that the transactions between biological emotional vulnerabilities and an invalidating environment eventually result in a pervasive emotional dysregulation (Barlow, 2014; Bendit, 2014; Klein & Miller, 2011; Lynch, Trost, Salsman, & Linehan, 2007a; O'Connell & Dowling, 2014; Prada, Perroud, Rufenacht, & Nicastro, 2018; Swenson, Sanderson, Dulit, & Linehan, 2001). High sensitivity and emotional reactivity are described as emotional vulnerability while an invalidating environment is defined as conditions in which one's experiences are inappropriate. In BPD, patients are provided with support to acquire skills for

controlling intense emotional experiences, diminishing vulnerability, and moderating maladaptive, mood-dependent behaviors. Moreover, validation of emotions, thoughts, and behaviors are increased (Barlow, 2014; Bendit, 2014; Klein & Miller, 2011; Lynch et al., 2007a; O'Connell & Dowling, 2014; Prada et al., 2018; Swenson et al., 2001).

The theoretical orientation behind DBT consists of three notional positions, including Zen practice, dialectical philosophy, and behavioral science. To counter the behavioral science aspect, the patient is accepted (techniques of Zen and Western contemplative practice), and the dialectical framework is used to balance these positions. DBT was specifically based on consistent behaviorist theoretical positions. Nonetheless, the actual approaches markedly overlap those of various different alternative therapy orientations, including cognitive, strategic, patient-centered, and psychodynamic therapies. The final goal, however, is to assist patient with building a worthwhile life and surviving it (Barlow, 2014; Lynch et al., 2007a).

Treatment of BPD

BPD was defined by Linehan as a dysfunction of the emotional regulation system, and DBT is a new treatment approach for BPD which fits with Linehan's biosocial theory. DBT originally evolved from CBT, and is among the first treatments in randomized controlled trials (RCTs). DBT involves weekly one-to-one sessions and group skill training for up to a year. There are four modes of intervention in DBT, namely individual psychotherapy, group therapy, phone calls, and consultation team meetings. DBT aims to reduce behaviors that limit the patient's quality of life, and therapy-interfering, suicidal, and self-mutilating behaviors. DBT also focuses on acquiring, applying, and generalizing adaptive emotion regulation skills (Barlow, 2014; Bornovalova & Daughters, 2007; Lynch et al., 2007a; O'Connell & Dowling, 2014). The core elements comprising DBT include (1) BPD biosocial theory, (2) a conceptual framework for stages of the treatment, (3) a defined target arrangement throughout each treatment stage, (4) a delineation of functions of treatment, (5) different treatment modes to realize those functions, and (6) numerous arrangements of strategies of acceptance, change, and dialectical treatment (Robins & Chapman, 2004).

One of the challenges of treating BPD patients is the recognition of domains where issues lie. In DBT, such issues are addressed by conceptualizing the treatment in a series of stages that can be defined by the dysfunction level. The treatment stages of DBT involve the provision of control over destructive behavior for patients (stage 1) and increasing proper experience of emotions (stage 2). The next stages include the provision of better self-confidence, improved relationships, and regular joy and sorrow for the patient (stage 3), and the promotion of an enhanced sense of liberty, happiness, or connectedness (Robins & Chapman, 2004). The focus of the DBT therapist should be on (1) reducing life-threatening behaviors, (2) decreasing treatment-interfering behaviors, (3) enhancing therapeutic alliance, (4) reducing behaviors that seriously interfere with quality of life, (5) improving distress tolerance skills, and (6) improving awareness and performance of skilled behaviors (Bornovalova & Daughters, 2007; Robins & Chapman, 2004). Four functions need to be addressed to treat a BPD patient using DBT, including assisting the patient with developing new skills, addressing motivational obstacles interfering with the utility of skills, generalizing learned skills to daily life, and keeping the therapist skilled and motivated. This is done by adopting different treatment modes, including group training of skills,

individual psychotherapy, telephone coaching between sessions when required, and a team meeting for consultation with the therapist (Robins & Chapman, 2004).

Problem solving (change) and validation (acceptance) compose core strategies of DBT. Extreme positions which possess a tendency to elicit their antithesis are highlighted by dialectical strategies. A reciprocal style (acceptance), as well as an irreverent one (change) compose communication style strategies. On the other hand, case management strategies involve an intervention based on the environment for the patient (acceptance), consulting the patient (change), and giving the patient the benefit of a consultation team (balancing acceptance and change). Specific strategies may be employed more than others with a given patient and within a session. Finally, not all strategies are essential or appropriate (Barlow, 2014; Robins & Chapman, 2004). Overall, DBT has been used as one of the most widely investigated approaches in the treatment of BPD. Enhancing skills attributed to adaptive behavior is the focus of this therapy, the aim of which is to develop the ability to cope with affects, distress and interrelationship complications. Data from RCTs support the effectiveness of DBT. The therapy has also been demonstrated to be beneficial in relieving rage, general mental health, suicidal and self-harm behavior, and lowering the total number of hospitalizations. Moderate global and specific symptoms have been reported to be affected by DBT (Cohen's d≈0.50) (Barlow, 2014; Harned, Banawan, & Lynch, 2006; Kliem, Kröger, & Kosfelder, 2010; Lieb et al., 2004; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan et al., 1999; Linehan., 2014; Lynch, Trost, Salsman, & Linehan, 2007b; Norcross & Goldfried, 2019; Sempértegui, Karreman, Arntz, & Bekker, 2013; Stoffers et al., 2012; Zanarini, 2009).

A meta-analysis and systematic review assessed the efficacy of DBT for BPD both qualitatively and quantitatively. Through this systematic search, five RCTs were identified, within which the impacts of DBT on the reduction of depression symptoms, parasuicidal behavior, suicide attempts, or attrition during treatment were assessed in BPD adults. A net benefit in favor of DBT (pooled Hedges' g −0.622) was revealed through the combination of effect measures (five studies in total) for parasuicidal behavior and suicide. In five RCTs (pooled risk difference −0.168), DBT was slightly superior to treatment as usual (TAU) in the reduction of attrition during treatment. In three RCTs (pooled Hedges' g −0.896), no significant difference was observed between DBT and TAU in the reduction of the symptoms of depression. Efficacy in the stabilization and control of self-destructive behavior, and improvement in patient compliance are demonstrated by DBT (Panos, Jackson, Hasan, & Panos, 2013). The efficacy of DBT for the treatment of BPD was also supported by Koons et al. (Koons et al., 2001) in an article which evaluated the effectiveness of DBT in women veterans with BPD. In general, significant improvements were demonstrated following DBT therapy, in comparison to TAU.

Westen (Westen, 2000) stated that DBT is useful in exerting an initial improvement on several variables related to BPD outcomes, particularly parasuicidal behavior. Nonetheless, its genuine efficiency in exerting alterations which last after treatment discontinuation is not known. The absence of any follow-up data at intervals suitable for the assessment of the efficiency of a treatment for a disorder which is chronic by definition, is a huge gap in the literature. Nevertheless, the gap between widespread beliefs about the efficacy of DBT and the data is not specific to DBT. It could be suggested, in accordance to a recent meta-analysis, that analogous disparities are typical in several studies on empirically supported therapies, including brief treatments for depression. Since 1991, a list of RCTs

that reviewed research on DBT has been compiled by the Linehan Institute (available here). This list indicates that DBT has been more efficient than community-based TAU in multiple areas, such as the reduction of parasuicidal behaviors, improvement of treatment adherence, and reduction of the number of hospitalizations. Moreover, DBT has been efficient in comorbid binge eating disorder, bulimia nervosa, substance use disorders, and depression.

3.2 Mentalization-based treatment

MBT was founded by Bateman and Fonagy and is focused on the improvement of mentalization in BPD patients. Mentalization involves making sense of self attitudes and that of others, based on intentional mental states, including beliefs, feelings, and desires.

Conceptualization of BPD

Development and operationalization of the term “mentalization” was performed by researchers of the Ecole Psychosomatique de Paris, though its first usage is attributed to Fonagy in 1989. The term has since been developed to better understand several mental disorders (Bateman & Fonagy, 2010). Mentalization refers to the ability to make implicit and explicit sense of ourselves and each other, with respect to mental progressions and subjective states. As we attend, both physically and psychologically, to the mental states of people who surround us, mentalization could be defined as an overarching social construct. In fact, the self-experience of mind is misinterpreted in many mental disorders, hence the mentalization disorder (Bateman & Fonagy, 2010). Maturation of mentalization takes place in a framework in which there exists an attachment relationship between an infant and a caregiver, where the latter provides meaning for the internal states of the former. The infant would possibly suffer a diminished ability for representing affect and controlling attention if there were no contingency between his/her emotional experiences and the caregiver’s mirroring. Furthermore, in the context of interpersonal relationships, a state of hyperactivation of the attachment system might be observed as a result of additional stress in approaching the attachment figure. There exists an inverse relationship between attachment system activation and mentalization (Fonagy, Luyten, & Strathearn, 2011; Rossouw, 2013).

Light can be shed on MBT by three linked concepts, including mentalization itself, pretend mode, and psychic equivalence. Through the compromise of mentalization, both the interpersonal world and subjective internal experiences stop making sense. Fundamental pathology, according to the theory of MBT for BPD, involves the vulnerability to recurrent mentalizing loss and slower recovery pace for mentalization in interpersonal relationships. These make the patient vulnerable to rapidly-altering emotional states and impulsivity. An inhibited neural system, a prementalistic functioning mode, and intense attachment result from a hyperactivated attachment system (Fonagy et al., 2011; Rossouw, 2013). It is stated in psychic equivalence mode that the patient considers his/her thoughts accurate reflections of reality, and simultaneously lacks the capability of considering other reasons for behavior. For one thing, they consider purposeful rejection on the part of their partner when they are abandoned. Decoupling of the mental world and the external reality takes place in the pretend mode, resulting in no persistent development of internal reflection with any change with regards to external information. Moreover, there would be no bridge between internal and external reality through their

dissociation. Finally, incorporation of a teleological understanding of the world takes place in non-mentalizing modes, where meaning is determined by physical outcomes. Thus, the judgment made by the patient is founded on actual events in the physical world (Bateman & Fonagy, 2004b; Daubney & Bateman, 2015).

Treatment of BPD

MBT was developed as an effective treatment for BPD patients, with its implementation requiring a low training level - primary nurses and mental health professionals could perform it - and the fact that it encourages further development of mentalizing. The application of mentalizing theory is observed in various patient groups, disorders, and contexts, though its main application is in BPD, which is supported by empirical evidence from RTCs (Bateman & Fonagy, 2010). Stabilizing the self-sense is the focus of MBT, and its effective implementation requires more activity, honesty, and partnership from the therapist, in comparison to the classical analytic stance. When treating BPD patients psycho-dynamically, the therapist is expected to turn into what the patient desires. In fact, the therapist should simultaneously perform as required, and keep in mind the best image of the state of mind for both patient and himself. This is defined as the mentalizing stance of therapist. Three important aspects of treatment by MBT are the intervention aims, the therapeutic stance, and the mentalizing of transference (Bateman & Fonagy, 2004b; Bateman & Fonagy, 2010).

The first task in MBT is to stabilize the affects, as superficial consideration of inner representations would result from lack of control on emotional expression. This could also affect the continuousness of therapy and threaten the patient's life. Therefore, identifying and expressing affects are the first targets. Intervention purpose and results are more important than the nature of intervention in MBT (Bateman & Fonagy, 2010). Mentalizing the therapist's therapeutic stance should include the following; (1) humbleness rooted in a "not-knowing" sense, (2) determination in taking time to recognize the changes in outlooks, (3) legitimizing and acknowledging disparate outlooks, (4) dynamically investigating patients with regard to experiences they have by asking for the comprehensive illustration of the experience ("what" questions) instead of explanations ("why" questions), and (5) cautiously avoiding the desire to comprehend what makes no sense (Bateman & Fonagy, 2010). To assist patients in distinguishing their self-perception from how they are understood by others is another important issue. There exist six steps to this, which include (1) validating the transference feeling or establishing the perspective of the patient, (2) exploring and identifying the causes which generate the transference feeling, (3) enactment of the therapist, (4) collaborating to reach an interpretation, (5) presenting an alternative perspective by the therapist, and (6) monitoring patient's reactions thoroughly. As MBT is derived from the theories of attachment and cognition, its main theory is that primary complications of attachment result in impairments and decrease the mentalizing ability of BPD patient. Therefore, improving mentalization capacity is the focus of MBT, the aim of which is to obtain stable affect and impulses. Data from trials suggest that MBT is significantly effective in reducing suicidal and parasuicidal behavior, interpersonal complications, and depression (Bateman & Fonagy, 1999, 2009; Sempértegui et al., 2013; Stoffers et al., 2010).

The most recent evaluation of the efficacy of MBT was reported in a study by Griffiths (Griffiths et al., 2019), which was conducted for patients with self-harming behaviors. It was shown that self-injuring

behaviors, social anxiety, control of emotion, and borderline characteristics were considerably reduced as the time passed by. Moreover, mentalization was capable of meaningfully predicting change over time in hospital presentation for self-harm and self-reported self-harm. Also, a statistically meaningful reduction on all measures was demonstrated on patients in the partial hospital program in another study, as opposed to the control group, who had trivial change or deterioration over the same period. Enhanced social and interpersonal function, improved depressive symptoms, decreased inpatient days, and reduced suicide and self-harming acts initiated after 6 months and continued to the termination of treatment at 18 months (Bateman & Fonagy, 1999). Evaluation of the 44 patients in the original study was performed at 3 month intervals following the completion of the trial utilizing equal outcome measures. It was shown that patients with partial hospital treatment both maintained their substantial gains, and showed a statistically meaningful continued enhancement on most measures. This was opposed to the control group who showed only slight change during the same period. Stimulation of longer-term rehabilitative alterations was demonstrated due to continued enhancement in social and interpersonal function (Bateman & Fonagy, 2001). In both conditions across all outcome variables, considerable enhancements were detected. A steeper reduction of both self-reported and clinically considerable issues, such as suicide attempts and hospitalization, was shown in patients randomized to RCT of MBT in an outpatient setting (Bateman & Fonagy, 2009).

Volkert et al. provided the latest data from 2015 to 2018 on the efficiency of MBT for personality disorders (PD) (Volkert, Hauschild, & Taubner, 2019). They stated that 14 novel MBT trials had been published since 2015. Mainly, adult populations (n = 11) and patients with a BPD diagnosis (n = 8) were investigated, and MBT was compared with another psychotherapeutic treatment (n = 6). Most of the research put forward that MBT is capable of improving the clinical outcomes for adolescents and adults with BPD and comorbid diagnoses. Moreover there exist signs of alterations in mentalizing being a particular mechanism of change stimulated by MBT. In spite of promising findings, methodologically sound and sufficiently powered experiments to study both the effectiveness and efficiency of MBT, especially beyond BPD, are urgently in demand.

3.3 Schema-focused therapy

SFT (Young, 1999) was founded by Young and is based on conceptualizing personality disorders cognitively and integratively with the use of more eclectic strategies, as compared to usual cognitive therapy methods. The target of ST involves establishing a working relationship by laying emphasis on the emotions and bonding issues of the patient.

Conceptualization of BPD

The Foundation of SFT involves conceptualizing personality disorders cognitively and integratively by adapting heterogeneous and comprehensive methodologies. SFT is focused on the establishment of functional relationships through laying emphasis on bonding complications and the emotions of the patient. By integrating practical techniques and particular interventions, the patient will obtain the ability to contain and endure abandonment and hopelessness. By laying emphasis on the change of the schema mode throughout the model of the therapy, the patient will learn to deal with several modes (e.g. irritation, abandonment, punitive parents). Such treatment takes 1-4 years, which involves

working with maladaptive coping styles and an adjustment of schema modes (Arntz, 1994; Tarrier, Wells, & Haddock, 2009; Young, 1999; Young, Klosko, & Weishaar, 2007). Despite huge interest in the therapy, SFT still shows room for improvement and further empirical data are needed to validate the theory for BPD. Schema modes and early maladaptive schemas (EMS), as the main concepts in SFT, are not directly linked to any specific personality pathology. Instead, they define the core foundations of personality disorders. The role of schema modes and EMS, as well as their association with several personality disorders have been validated by different studies (Arntz, Klokman, & Sieswerda, 2005; Jovev & Jackson, 2004; Kaslow, 1996; Lobbestael, Arntz, & Sieswerda, 2005; Nordahl, Holthe, & Haugum, 2005; Nordahl & Nysaeter, 2005a; Petrocelli, Glaser, Calhoun, & Campbell, 2001; Rijkeboer, van den Bergh, & van den Bout, 2005).

The concept of schema refers to organizing principles that comprise rudimentary arrangements and comprehensive themes of awareness, with regards to both society and self. However, Young discovered that the establishment of inflexible, dysfunctional belief system takes place early in the life of personality disorder patients as patterns for understanding the surrounding environment and themselves. Accordingly, EMS was developed by Young for identifying schemas that were more self-perpetuating, firm, profoundly rooted, and confined, and that started in childhood. EMS, indeed, are seen as dysfunctional, permanent, and steady themes that are developed in childhood and expanded throughout one's lifetime. Young proposed that schemas could be considered as prototypes to stimulate and process interactive behaviors, feelings, and beliefs, as they principally illustrate early interactive experiences (Beck, 1969; Kellogg & Young, 2006; Nysæter & Nordahl, 2008; Tarrier et al., 2009; Young, 1999). With respect to BPD, several schema modes have been suggested by Young and colleagues. These include the abandoned child mode, the irritated and impulsive child, the punitive parent mode, the mode of detached protector, and the healthy adult mode. An intensely underdeveloped healthy adult mode is experienced by BPD patients, and thus they suffer more intense and abrupt shifts in alternating between other modes, as compared to healthy adults. Shifting dynamics between diverse schema modes, which could be a reaction towards changes in inner or outer contexts, are major foundations in comprehending a BPD patient's behaviors. Last but not the least, emotional need and pain are associated with BPD, regardless of the mode (Lobbestael, van Vreeswijk, & Arntz, 2007; Nysæter & Nordahl, 2008; Young et al., 2007).

Treatment of BPD

As a treatment opportunity for BPD, SFT has evolved impressively recently, and has attracted the interest of therapists due to its superior positive effects compared to TFP. The general description of the theoretical principles of SFT for BPD have been examined extensively (Giesen-Bloo et al., 2006; Kellogg & Young, 2006; Nysæter & Nordahl, 2008; Sempértegui et al., 2013; Young & Klosko, 2019; Young et al., 2007). SFT is an extension of Beck's cognitive therapy, enabling the treatment of more prevalent and permanent psychological disorders. Young's observations in this regard included (1) vague complaints from patients, (2) tendency to keep a distance in the therapeutic relation or (3) to grow dependent on the therapist, (4) inflexible belief systems, and (5) affective and cognitive avoidance, which obviously could not be overruled by the techniques of cognitive therapy. Young realized that treating BPD successfully requires the enrichment of cognitive therapy with strategies from object relations as well as attachment theories and Gestalt and emotion-focused therapies, which

required a 1–4 year-long therapeutic contact (Kellogg & Young, 2006; Salkovskis, 2004; Sempértegui et al., 2013; Young, 1999; Young et al., 2007).

There are five mechanisms of healing and change in the treatment of BPD patients through SFT, which include limited reparenting, emotion-focused work, particular imagery and dialogues, cognitive restructuring and training, and behavioral pattern breaking. Moreover, three fundamental experiential techniques in SFT include imagery work, dialogues, and letter writing. Cognitive techniques in SFT, also, play significant roles, and enjoy two principal purposes, which include education and cognitive restructuring. Through the educational aspect, the patient is taught ordinary needs and emotions. However, cognitive restructuring states that things did not work out in a nourishing manner because the parents themselves had suffered complications. Additionally, to combat the toxicity remaining after the punitive parent, the patient's positive characteristics are highlighted (Kellogg & Young, 2006). Employing SFT for BPD treatment involves three phases of treatment, including bonding and emotional modulation, changing the schema mode, and developing autonomy. During the first phase, a relationship that opposes the patient's relationship with his/her punitive parent is established by the therapist with the patient. In the second phase, the relationship with the abandoned child is maintained, and reorganization of the patient's inner constellation mode occurs. In the last phase, developing independence outside the therapy relationship is emphasized (Kellogg & Young, 2006).

Some studies have assessed the efficiency of SFT for BPD treatment. Among these, two of them are single case studies (Morrison, 2000; Nordahl & Nysaeter, 2005b). The first study was performed by Morrison and included a standard cognitive therapy of a 29 year old female together with SFT. Regrettably, not using any formal diagnostic instrument resulted in the inexistence of data on the baseline severity of BPD symptoms. Description of the patient was performed at baseline as exhibiting severe panic attacks, anxiety, depression, low self-esteem, and high scores on 12 of the EMSs, with the exception of the Entitlement schema. In the end of the 73 treatment sessions for 42 months (including six-4-month follow-up sessions), the depression and anxiety scores of the patient were very low (Morrison, 2000). The second study was performed by Nordahl & Nysaeter and included 6 patients diagnosed with primary DSM-IV BPD. The strategy of the treatment involved the core SFT elements highlighting schema mode work and confined re-parenting. Also, implementation of An A-B direct replication series with follow-up evaluations at twelve months was performed. As shown by great effect sizes, improvement was high from baseline to follow-up, with a clinically meaningful enhancement for 5 of the 6 patients involved. Moreover, 3 of the 6 patients no longer fulfilled the criteria for BPD by the termination of the treatment (Nordahl & Nysaeter, 2005b). Another study making use of a randomized design (Farrell, Shaw, & Webber, 2009) investigated the effect of further including eight-month SFT to group psychotherapy as usual. SFT was compared with TAU by Farrell through the addition of an 8-month group SFT treatment (30 weekly 90 min sessions) to ongoing weekly individual eclectic psychotherapy (TAU), as well as comparing such combination to TAU alone. Adaptation of the SFT to group format was performed aimed at making this therapy more cost-effective and allowing for the benefit of other group therapy pros, including peer support, practicing opportunities, and mediated learning. In another controlled trial SFT was compared to TFP, the aim of which was to contribute to overall changes in personality (Giesen-Bloo et al., 2006). This trial offered to date the most solid evidence of the efficiency of SFT for BPD. The sample included 86 BPD

outpatients at 4 health centers, among whom 90% were women. Random assignation of the patients to SFT or TFP groups was performed. With the exception of a history of self-harming behavior, the groups were socio-demographically and clinically analogous, for instance with regards to the psychopathology severity and number of comorbid disorders. BPD severity was assessed before randomization and afterwards every three months, along with quality of life, severity of general psychopathology, in addition to general aspects of personality, such as self-esteem. Following 3 years of SFT and TFP, patients exhibited considerable enhancement in quality of life, and reduced symptoms of BPD, general psychopathology, and therapy specific results. DBT and SFT were examined for the treatment of BPD by Montgomery-Graham et al. (Montgomery-Graham, 2016). They stated that DBT was efficient at treating BPD in over ten RCTs (Carter, Willcox, Lewin, Conrad, & Bendit, 2010), (Clarkin, Levy, Lenzenweger, & Kernberg, 2007b; Harned et al., 2008), (Koons et al., 2001), (Linehan et al., 1991; Linehan et al., 2006; Linehan et al., 2002), (McMain et al., 2009), (Stanley, Brodsky, Nelson, & Dulit, 2007), (van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005), (Verheul et al., 2003)). Several RCTs have compared the standard twelve months of DBT to TAU and revealed a larger decrease in the rate of self-harming deeds, hospitalization, and treatment drop-out within the DBT group (Linehan et al., 1991; Verheul et al., 2003). Furthermore, such RCTs showed that DBT evidenced a decrease in depression, self-injury behavior, anger, alcohol abuse, and suicidal ideation in BPD patients (Montgomery-Graham, 2016). In addition, a recent meta-analysis of DBT for BPD evaluated 16 studies employing 8 RCTs and 8 non-RCTs to assess overall global effects, and self-harming and suicidal behaviors with several treatments compared to DBT (Kliem et al., 2010). Through evaluating merely RCTs, the meta-analysis showed a moderate overall effect size of $d = 0.51$, $t(6) = 8.05$, $p < .001$ for DBT in treating BPD patients in comparison to TAU and non-BPD-specific treatments. Nonetheless, by comparing DBT to BPD-specific treatments, the effect size was revealed to be decreased to $d = .39$, $t(7) = 2.59$, $p = .036$, which is insignificant effect size.

According to (Montgomery-Graham, 2016), the most solid data so far on the efficiency of SFT for BPD was provided by Giesen-Bloo et al. (Giesen-Bloo et al., 2006), in a study that included 86 patients with BPD who were assigned to SFT or TFP and matched on socio-demographic characteristics. Considerable enhancement in decreasing BPD symptoms and general psychopathology was observed in all patients after 3 years of SFT or TFP. A greater treatment effect on the whole consequences of therapy was shown in the SFT group. A comparison between an 8-month group SFT treatment plus TAU which was ongoing with weekly individual eclectic psychotherapy ($n = 16$) and TAU alone ($n = 16$, later $n = 12$) was made by Farrell et al. (Farrell et al., 2009). Rates of attrition were 0 % for the SFT group and 25 % for the TAU group. Meaningful difference between the groups was observed in post-treatment and follow up with the combination group exhibiting a great pooled enhancement in all outcome variables: global functioning, BPD diagnostic criteria, severity and rate of symptoms of BPD, and severity of overall psychopathology. At the end of the process, 15 SFT patients were no longer diagnosed with BPD, as opposed to 75 % of the controls. Moreover, enhancement in all aspects of the disorder was shown in SFT patients (affect, cognition, impulses, and interpersonal interaction). For several SFT patients, such results were long-lasting and even enhanced, while controls deteriorated. According to Sempértegui et al. (Sempértegui et al., 2013), few studies exist on the effectiveness of SFT, even though reviewed findings advocate that SFT is a capable treatment approach. The therapy could be performed on-demand as a cost-effective approach with positive economic outcomes in societies of Western Europe.

The main elements of SFT in regard to its effectiveness are bonding with the patient by limited re-parenting, formulation of schema, improving modes of schema and interpersonal coping skills, and problem solving. As stated by the patients, conceptualization of modes of schema, experiential techniques, and the good therapeutic relationship are the most useful elements (Nordahl & Nysaeter, 2005a).

3.4 Transference-focused psychotherapy

Conceptualization of BPD

TFP, as a manualized and evidence-based therapy, is a treatment opportunity for BPD and other severe personality pathologies. The basis of TFP involves psychoanalytic concepts and techniques, which are arranged and adjusted to address personality disorders. TFP postulates that certain BPD signs are rooted in the inability to integrate identity, which is in correspondence to the absence of coherence in comprehending self or others. “Identity diffusion” is the term used for such a non-integrated psychological state and is related to being dependent on defensive strategies involving the dissociation of conflicting conscious experience aspects (“splitting-based defenses”). Also, it has an association with vulnerability to the experiences that involve cognitive distortions in the setting of activation of emotions (Clarkin, Lenzenweger, Yeomans, Levy, & Kernberg, 2007; Clarkin, Yeomans, & Kernberg, 2009; Higa & Gedo, 2012; Kernberg, 1995; Levy, Clarkin, et al., 2006; Levy, Meehan, et al., 2006; New & Siever, 2002; Yeomans, Levy, & Caligor, 2013). Based on Kernberg’s object relations theory, TFP speculates that psychological structures are rooted in primary relations with caregivers, and their internalization occurs later throughout development (Kernberg, Yeomans, Clarkin, & Levy, 2008). A personality organization is therefore established through the degree to which such self and other representations integrate and differentiate. BPD patients preserve splitting as archaic defenses, with the desperate hope that positive representations of self-or-other might be sustained. An adaptive cost is observed in such defense, since in the event that BPD patients split, opposing and chaotic descriptions of self or others will be created in them, producing further pain (Clarkin, Lenzenweger, et al., 2007; Clarkin et al., 2009; Higa & Gedo, 2012; Kernberg, 1995; Levy, Clarkin, et al., 2006; Levy, Meehan, et al., 2006; New & Siever, 2002; Yeomans et al., 2013).

Non-coherent and unintegrated sense of others, and self, is linked to the denial of psychological aspects of life and to particularly aggressive and negative experiences that are comprehended as external. Light is therefore shed on the model of treatment by such confusion with regards to the foundation of particular aspects of emotional experience (Clarkin, Lenzenweger, et al., 2007). It is postulated that both identity diffusion and biological factors make a contribution to the complications with affect modulation, and to the pattern of insecure interpersonal relationships, which describe BPD (New & Siever, 2002). Also caused by an unintegrated self are feeling of emptiness and internal grief, which result in the hopeless attempts the patient makes to relieve distress (Yeomans et al., 2013). Weakened ability to recognize the actions of others, impetuous and dictatorial aggression, and emotional dysregulation result in the inability of BPD patients to resolve contradictions and their disturbed object relation (Clarkin et al., 2009). The overall aim of the therapy is to assist patients with integrating the helpless/victim or hostile/punitive part objects into a cohesive self through utilizing transference interpretations, conflicts, and explanations. These provide the opportunity for the patient

to integrate cognitions and emotions. Successful transference interpretations depend on the patient's ability to consider the therapist's representations with respect to his/her own mental states, as well as the knowledge of mind that the patient has (Higa & Gedo, 2012; Kernberg, 1995; Levy, Clarkin, et al., 2006; Levy, Meehan, et al., 2006).

Treatment of BPD

As a long-term, theory driven psychodynamic treatment, TFP is suited to severe personality disorders, the aim of which involves improving self and interpersonal functioning in addition to relieving symptoms and resolving maladaptive behaviors. The efficiency of TFP for BPD treatment has been emphasized by empirical evidence. The focus of TFP is on pathologies in self and other functioning, i.e. pathologies that are fundamental to a whole spectrum of personality disorders. The treatment model of TFP is initiated by the cautious diagnostic assessment and formulation of the case. Prior to beginning the treatment, a frame for treatment is presented as a verbal treatment agreement. The Basic TFP strategy involves the identification of object relations that organize the patient's contemporary experiences. Following the identification of the dominant object relations, guided intervention takes place to understand the interpretive process of TFP. Prior to TFP treatment, cautious diagnosis is performed, and a thorough assessment is made of general work functioning, social and close relations, and individual interests and habits. Evaluation of conventional symptoms and personality functioning is performed by assessing personality organization level, following which the diagnostic impression is shared and discussed with the patient to determine the treatment procedure (E. Caligor, Clarkin, & Yeomans, 2019; Kealy & Ogrodniczuk, 2019). Generally, the aim of TFP is to address extreme, severe, inflexible, and split off BPD inner representations of an individual, and others, through laying focus of the approach on investigating and reframing the patient-induced transference. The superiority of TFP to TAU is supported by evidence from RCTs. Nonetheless, neither general psychopathology and global functioning, nor impulsivity features can be totally improved by TFP (Clarkin, Levy, et al., 2007b; Doering et al., 2010b; Sempértegui et al., 2013; Stoffers et al., 2012; Yeomans & Delaney, 2008).

Three elements summarize TFP treatment, namely TFP strategies, tactics, and techniques. Strategies involve long-term purposes of treatment. Tactics are the limitations and main concerns within the therapy process. Techniques include interventions which are practiced throughout therapy session (Stern & Yeomans, 2018). The first task is to name actors and interactions, or share the way patients experience themselves, and the therapist, when shifts in affect occur throughout the therapy session. It is possible to make clarifications aimed at better understanding active affects and self-states. Together, the baseline work in TFP is to assist patients with tracking affective states, sense of self, and sense of the therapist during sessions (Caligor, Levy, & Yeomans, 2015; Kernberg, 2014; Kernberg et al., 2008; Stern, Diamond, & Yeomans, 2017; Stern & Yeomans, 2018). TFP tactics involve the establishment of psychodynamic treatment conditions that enable the therapist to conduct TFP effectively and safely, through efficiently exploring and containing clinical complications and the patient's urgent priorities. The treatment contract establishes the treatment's logistical frame and the patient's specific conditions to protect both patient and therapist. Other TFP tactics include adherence by the patient to the treatment priorities, such as limiting any behaviors that pose complications in the patient's life. The ultimate within-session tactics of TFP involve such tactics, in addition to the principal guideline for the therapist's listening stance as well as his/her tracking or interference with the

dominant affect (Kernberg et al., 2008; Stern & Yeomans, 2018). The TFP therapist strives to intervene with the patient from a technical neutral stance, which does not mean ignorance or lack of affective engagement, and interventions that focus on elucidation and interpretation. The focus in TFP is on assisting the patient to perceive how complicated they are and how to maintain, and live with, that complication. The therapist might occasionally be required to shift from the neutrality stance to a more authoritative stance in certain cases, including when faced with self-mutilating acts. The principal thinking activity TFP therapists engage in involves identifying active dyads in their relationship with the patient, the dominant affect that is connected to both self-representation and projection (countertransference) by patients. Paying attention to countertransference is linked to the persistent attention to, and exploration of, transference. BPD patients are prominent for posing significant challenges of countertransference, since they suffer intense affects and predominant projection-based defense mechanisms (Stern & Yeomans, 2018).

Primary technique of TFP involves an interpretive process, or close tracking of TFP strategies. Similarly, it involves the recognition and designation of dyads from the time they emerge, their oscillation in the treatment process, and their defensive actions contrary to dyads of other layers. Clarifications involve efforts made with the aim of recognizing the dominant dyad, the patient's expressions and their underlying reasons, and the patient's feeling about his/her expressions. These clarifications assist in the identification of the dyad (Caligor, Diamond, Yeomans, & Kernberg, 2009; Clarkin, Yeomans, & Kernberg, 2006; Kernberg et al., 2008; Otto, John, & Frank, 2015; Rockland, 1992; Stern & Yeomans, 2018). Several purposes are pursued within the first year of treatment by TFP, including the limitation of self-mutilating behaviors, maintenance of attendance to therapy sessions, and identification and exploration of the dominant object relation patterns. The main tasks therapists have to perform also involve maintenance of the framework of treatment, containing affective responses and using them, and engagement in the interpretive process steps. These include seeking clarification, opposing contradictions, imploring reflection, and interpreting motivation (Yeomans et al., 2013). The effectiveness of TFP was demonstrated in an article by Clarkin et.al. (Clarkin, Levy, Lenzenweger, & Kernberg, 2007a) which evaluated three treatments (TFP, DBT, and dynamic supportive treatment) for BPD. Throughout 1 year of treatment, analysis of the individual growth curve showed that patients in all groups enjoyed meaningful positive change in social adjustment, global functioning, anxiety, and depression. DBT and TFP were both considerably related to enhancement in suicidality. Only supportive treatment and TFP were related to improving anger. TFP and supportive treatment were each related to enhancement in impulsivity. Merely TFP could meaningfully predict change in irritability and direct and verbal assault. Moreover, TFP has been demonstrated as an efficient treatment for BPD in one uncontrolled study (Clarkin et al., 2001). They examined pre-post amendments witnessed in the one-year outpatient treatment of BPD patients with TFP. Therein, it was shown that TFP could be a promising psychotherapeutic approach warranting further research. In both groups, which included the intent-to-treat and treatment completion, patients who received TFP exhibited meaningful development in a number of significant areas. The patients were used as their own controls, and it was soundly suggested that extending TFP could be well-tolerated and could lead to significant enhancement in functioning in a wide spectrum of areas. Moreover, Doering (Doering et al., 2010a) compared TFP with treatment by experienced community psychotherapists in a randomized controlled trial (NCT00714311) involving 104 female out-patients under treatment for a year with

either of the therapies. Their results indicated that considerably less patients dropped out of the TFP group (38.5% v. 67.3%). Likewise, considerably fewer patients attempted to commit suicide (d = 0.8, P = 0.009). Meaningful superiority of TFP in the domains of borderline symptomatology (d = 1.6, P = 0.001), psychiatric in-patient admissions (d = 0.5, P = 0.001), personality organization (d = 1.0, P = 0.001), and psychosocial functioning (d = 1.0, P = 0.002), was demonstrated. Considerable improvement was indicated in both groups in the domains of depression and anxiety and the TFP group in general psychopathology, all without meaningful between-group differences (d = 0.3-0.5). No group showed changes in self-mutilating behavior. They concluded that TFP could be regarded as more efficient than the treatment approach employed by experienced community psychotherapists in the domains of borderline symptomatology, personality organization, and psychosocial functioning. Furthermore, there is primary data supporting the superiority in reducing suicidality and requirement for psychiatric in-patient treatment.

4. Discussion and conclusion

The present study was aimed at providing a comprehensive overview of manualized treatment approaches for BPD, as well as some other treatment strategies mostly employed for BPD. BPD is a major mental disorder, which can be characterized by several factors, such as unstable self-sense, impulsive behavior, emotional sensitivity, functional impairments, high treatment costs, negative impacts on depressive disorders, high risks of suicide, and interpersonal instability. DSM was published as a manual for both classifying and evaluating mental disorders (Vahia, 2013). According to the ICD-11, the definition of a personality disorder involves difficulties in aspects of the functioning of an individual's self and/or interactive dysfunction with a long-term persistence (2 years or more). BPD is identified by ICD as a condition in which instable emotions are present due to significant mood reactivity (World Health Organization, 2018). Several approaches have been developed for conceptualizing and treating BPD. These include DBT, MBT, SFT, and TFP (O'Connell & Dowling, 2014). Some interventions in DBT are common to all behavior therapies, including irreverence, exposure and response prevention, therapist reciprocal vulnerability, skills training, cognitive restructuring, and reinforcement. However, interventions peculiar to DBT include telephone consultation, validation as an explicit therapist skill set, commitment strategies, microanalytic chain analysis, high degree of therapist self-disclosure, distress tolerance skills, emotion regulation and opposite action skills, dialectical focus, mindfulness as a set of skills, and primary and secondary targeting (Lynch., Chapman, Rosenthal, Kuo, & Linehan, 2006).

Common structural features are shared by the strategies employed to treat BPD (Bateman & Fonagy, 2000), however their particular effectiveness depends on their ability to improve the capacity of a patient to mentalize. In such psychotherapeutic strategies, a significant common factor involves the shared potential for recreating an interactional attachment matrix where mentalization could be developed and flourished. Mentalization of the patient by the therapist is performed in such way that patient's mentalizing is fostered, and this is considered as a main facet of the therapeutic relationship (Bateman & Fonagy, 2004a).

However, the fact that mentalization could be a main facet of efficient psychotherapeutic process is under debate. Firstly, implicit mentalization must be the basis of any therapeutic work. There could be no psychological therapy without the existence of social engagement, and there could be no social engagement without the existence of mentalization. General opinion, secondly, has accepted since the work of John Bowlby (Bowlby, 1988) that the attachment system could be activated invariably by psychotherapy, which also produces secure base experience as a component. Thirdly, an image of the mind of patient is repeatedly constructed and reconstructed in the mind of the therapist. Next, in psychological therapies, mentalizing is prototypically a process of shared, join attention within which the interests of the therapist and patient are converged in the mental state of the patient. Then, regardless of orientation, the obvious content of the intervention of the therapist would be mentalistic, whether the therapist is primarily preoccupied with linear thinking, reciprocal roles, dialectics, automatic negative thoughts, or transference reactions. Lastly, therapy's dyadic nature fundamentally fosters the capacity of patient for generating numerous perspectives (Bateman & Fonagy, 2004a).

Principles particularly addressed by SFT for the treatment of BPD include; (1) assessing symptoms and patterns of personality (formulation of case), (2) educating about and assessing schema and schema modes, (3) establishing treatment goals, (4) negotiating limits with regards to the availability of the therapist based on symptoms' severity, (5) dealing with schemas or schema modes, (6) discovering novel interpersonal skills and communication, (7) adjunction of supportive treatments (couples or family therapy), and (8) terminating the therapy and preventing relapse (Nysæter & Nordahl, 2008). One could realize dissimilarities between psychoanalytic treatment and TFP by listening to their individual sessions. However, a different treatment atmosphere could be revealed over time through the differences in employing the techniques (Kernberg et al., 2008). Significant association between ego psychological psychoanalysis and TFP include proceeding from surface to depth, the constant focus on the immediate behavior of the patient in the hours, and initiating from a typical foundation of observations mutual between the therapist and patient. The latter indeed reflects novel progresses in ego psychology associated with defense analysis (Busch, 1992, 2000; Gray, 1996). In the comparison between traditional ego psychologically based psychoanalytic psychotherapy and TFP, it could be revealed that the latter focuses more on the interpretation of transference, and is capable of eluding supportive techniques with the aim of facilitating the development of transference thoroughly. Likewise, due the fact that TFP is founded on empirical research and thus gradually developed, it is more precise and specific regarding the application of techniques and parameters, which leads to clearer delimitations from other strategies (Kernberg et al., 2008).

The difference between TFP and MBT is in the assumption of MBT that interpretation in the early phases could be perilous and potentially damaging as a formulation is imposed on the patient unparalleled to his experienced mental state. TFP disagrees with such postulation and declares that it is founded on confusing interpretation's nature with healthier patients. In this case, repression is the center of defensive operations and the point of interpretation is unconscious meanings. These did not exist in the conscious mind of the patient, however via free association, could turn into conscious as a response to correct interpretations. Nonetheless, to the extent that the starting phases of TFP and MBT's description are basically equal, with the more emphasis on the contract of treatment and TFP

parameters being exceptions, it could be suggested that initial phase of TFP is closely corresponded to MBT. Moreover, this could be supportive for patients, which reinforces the common sense that contemporary psychoanalytic psychotherapy which recognizes the nature of psychic structure and the associated development of transference of personality disorder patients, is a significant and caring treatment modality (Kernberg et al., 2008).

By comparing TFP to other empirically advocated treatments for BPD, including MBT (Bateman & Fonagy, 1999), SFT (Giesen-Bloo et al., 2006; Young, Klosko, & Weishaar, 2003), DBT (Linehan, 1993; Linehan et al., 2006), and supportive psychotherapy (SP) (Clarkin, Levy, et al., 2007b), few questions rise. These include how treatments dissimilar in their comprehension of the pathology and the route through which they treat the patients are associated with symptom enhancement (Kernberg et al., 2008). A common dissimilarity between TFP and other approaches (MBT, SFT, and DBT) is in the fact that the latter ones recognize BPD as a disease based on deficit instead of on internal conflict. In the comparison between psychodynamic SP and TFP, it could be stated that the focus of SP is on strengthening the adaptive functioning of the patient directly through cognitive support, affective support, directly intervening in the life of the patient outside the sessions, and non-interpretation of the transference in consonance with a non-technically neutral attitude. Efforts aimed at fostering and protecting a positive transference, in SP, are the methods that are preferred for facilitating the recognition of the emotional and cognitive attitudes of the therapist as well as the views of the associated emotional conflicts. On the contrary, TFP is founded on a reliable attitude of technical neutrality, in-application of caring techniques, and analysis of systematic transference in the “here and now” (Clarkin, Levy, et al., 2007b; Kernberg et al., 2008).

With regards to cognitive–behavioral-based integrative strategies, the difference between TFP and DBT and SFT is in the fact that the former is aimed at resolving intrapsychic struggles between inconsistent internalized object relations and the accompanied distortions of perception. These emphasize the integration of projected internalized object relations. On the contrary, BPD is considered as founded basically on emotional dysregulation of an individual by DBT. This, also through combining validation of affective states with teaching skills, allows for tolerating distress, reducing or eliminating painful emotions, and stopping problem behaviors. Such techniques are in correspondence to the reduction of symptoms. However, there exist analogies between DBT and TFP with regards to the requirement for a vibrant and articulated structure of treatment, a logic for the primacy of addressable issues, ongoing stress on and perseverance of treatment frame, and the requirement for supervision groups in progress (Kernberg et al., 2008; Linehan et al., 2006). It is explicit that SFP is supportive, suggesting that the therapist is capable of nurturing, praising, providing extra time and transitional objects, as well as physically holding the patient “when appropriate”. Similar to DBT and somehow MBT, SFP discards the requirement for integrating aggressive affects and considers whole aggressive affects as being rooted in admissible wrath. Conclusively, TFP is a valuable extension of psychoanalytic treatment for a wide range of patients, which is validated empirically to the degree that warrants future research on its role in treating a challenging population of patients (Giesen-Bloo et al., 2006; Kernberg et al., 2008; Young et al., 2003).

BPD is a condition in which there exists a lack of an integrated ego, as reviewed similarly by all the treatment approaches and the DSM-V. Each of these treatment approaches finally come to the

conclusion that the very first interaction between the mother and the infant has been performed incompletely, and the combination which results in the formation of ego, has not occurred entirely. Therefore, the ego is fragmented and incoherent, and the entire signs and symptoms observed in BPD are due to the impaired function of the ego. For instance, impulsivity, unstable self-image, suicidal attempts, self-harming behaviors, feeling of emptiness, difficulties in controlling anger, paranoid ideas, and dissociative symptoms when facing challenges and stress, all lead us to a common point where it could be stated that the main issue has been the lack of formation of a proper attachment to the corresponding caregiver. In this regard, it would be useful to reform and repair the caregiver-infant relationship by providing situations in which the patient could re-experience circumstances similar to that of his/hers early in life. Indeed, the common axis in all of the treatment approaches is to repair the mother-infant interaction through the therapist-patient interaction in a way that the ego could be properly developed. In this respect, some of the treatment approaches, such as self-psychology and modern psychoanalysis, focus on this issue.

Under the circumstances in which each of the treatment approaches better form the appropriate therapist-patient interaction, the process of therapy could be strengthened. All of these treatment options have a common axis and are in fact doing the same task, however from different angles. Therefore, it could be stated that the most important point to be considered in the treatment of BPD is the provision of the circumstances in which the patient could once again develop his/her ego. When this is done, all ego functions would be developed with optimal performance. The entire quality of the life of a patient indeed depends on the quality of the function of the ego. Therefore, when the ego is mature enough, developed, and functional, the life of the patient could go back to normal. However, this takes a very long time, especially when performed through psychoanalysis (self-psychology, modern psycho-analysis, or relational or interpersonal psychotherapies). This is because it takes a long time for the patient to establish a relationship with the therapist based on a therapeutic alliance, wherein he/she could re-experience fill in the gaps in his/her personality.

There exist several techniques in modern psychoanalysis by which we could reform the ego. Spotnitz (Spotnitz, 2004) and Margolis (Margolis, 1994) have stated that the contact function is a tool by which ego could be repaired. It is performed by listening to the patient and following him/her whenever he/she contacts the therapist since it is believed that the patient is the best person who knows the appropriate time to hand-in his/her ego to the therapist who can repair where it is impaired. This is in fact a structural regeneration, which enjoys techniques such as joining, contact function, object-oriented questions, etc.

Modern psychoanalysis indeed develops a solid infrastructure on which ego functions could be established through any of the treatment approaches and techniques. In fact, when a patient is endowed with the opportunity to develop a proper interaction and appropriate relationship with the therapist who is attuned with the patient, based on mutual trust which is observed in the relationship between the infant and the mother, he/she could develop his/her ego better. However, this is performed at his/her own pace. Another important point to be considered in modern psychoanalysis is that the therapist provides the patient with the opportunity to guide and tell the therapist implicitly when to perform particular tasks. This is exactly similar to the conditions where an infant gives us signs of what he/she needs at particular times.

All in all, it is suggested to firstly find the exact developmental phase in which the ego is impaired, and secondly, on this basis employ the proper approach in every phase to develop the ego. For instance, modern psychoanalysis and self-psychology are suggested to be employed in the very primitive phases in which the patient suffers from narcissistic conditions.

Together, this paper provided a comprehensive overview of manualized treatment approaches for BPD. These included DBT, MBT, SFT, and TFP. As a complicated mental disorder, BPD requires treatment by mental health professionals, who could employ a particular strategy to improve the condition. Among these strategies, each enjoys its own pros and cons, all of which have been mentioned in the sections above. Considering these, the psychotherapist is expected to employ the approach which best fits the conditions of the patient. Therefore, he/she is required to have a comprehensive understanding of the latest updates of every treatment approach, which have been provided in this article. Although DBT, MBT, and SFT are potent approaches to the treatment of BPD, TFP can be regarded as stronger since it is a more dynamic and relatively new approach, which is being improved daily by the scientists of the field. Accordingly, it could be suggested as a superior treatment strategy for BPD. Taken together, none of these approaches are flawless, and future research should be conducted towards enhancing their efficacy so that patient conditions might be even further improved.

5. *Conflicts of interest*

The Author declares no conflicts of interest.

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