

# **INTEGRATED TREATMENT: A CONCEPTUAL FRAMEWORK FOR AN EVIDENCE-BASED APPROACH TO THE TREATMENT OF PERSONALITY DISORDER**

W. John Livesley, MD, PhD

Evidence that various therapies are effective in treating personality disorder and that outcome does not differ substantially across treatments suggests that it is time to replace concerns about the efficacy of specific therapies and which form of therapy to use with an evidence-based approach that combines methods that work from all therapies.

A framework is proposed for selecting and combining eclectic treatment methods and delivering them in a coordinated way. The framework has two components: (1). a system for conceptualizing personality disorder based on empirical knowledge about the structure, etiology, development, and stability of personality pathology to use as a guide to selecting interventions and planning the sequence in which they will be used; and (2). a model of therapeutic change based on the general literature on psychotherapy outcome and specific studies of PD treatments. The framework proposes that integrated treatment be organized around general principles of therapeutic change common to all effective therapies supplemented with more specific treatment methods taken from the different therapies as needed to tailor treatment to individual patients and treat specific problems and psychopathology. The coordinated delivery of such a diverse array of interventions is achieved by using a phases of treatment scheme that proposes that treatment focus on specific symptoms and problems in a systematic and orderly way according to their stability and potential for change.

Over the last few decades, the treatment of personality disorder has changed extensively with the introduction of manualized therapies and the publication of randomized trials demonstrating treatment efficacy. Currently, the field is dominated by a handful of treatments that vie for attention as the most effective approach. The implication is that clinicians treating PD should simply select one of the effective therapies. There are good reasons to question this strategy. The time is ripe for the treatment

---

This article was accepted under the editorship of Paul S. Links.

From Department of Psychiatry, University of British Columbia.

Address correspondence to Dr. John Livesley, Dept. of Psychiatry, University of British Columbia, 2255 Wesbrook Mall, Vancouver, B.C., Canada, V6T 2A1; E-mail: [livesley@interchange.ubc.ca](mailto:livesley@interchange.ubc.ca)

of PD to move beyond a “competing schools or therapies” approach and adopt a more integrated perspective that combines treatment principles and methods that work regardless of their conceptual origins.

This assertion is based on several considerations. Outcome research on PD is at an early stage and studies to date are limited by modest samples, high treatment dropout, and limited follow-up. Outcome seems similar across treatments (Leichsenring & Leibing, 2003) so that it cannot be concluded that any method is better than the rest. Since all evaluated treatments produce significant change, all must include effective interventions. Hence, rather than selecting among treatments with similar outcomes, it is conceivable that enhanced outcomes would be obtained by combining effective components of each. Some of these components are common to all effective therapies whereas others may be specific to a given approach.

Integration is also reasonable because different therapies tend to target different aspects of psychopathology because they hold different assumptions about the primary impairment associated with PD. With borderline PD, for example, postulated impairments include maladaptive object relationships, emotion dysregulation, problems with impulse control, maladaptive cognitions, and impaired mentalizing. However, typical cases of BPD show all of these impairments. Nevertheless, dialectical behavior therapy (DBT; Linehan, 1993) emphasizes emotional dysregulation and increased emotional control through a direct focus on building relevant skills. In contrast, mentalizing-based therapy (MBT; Bateman & Fonagy, 2004) focuses primarily on mentalizing problems with the assumption that improved metacognitive functioning will improve affect regulation. Since patients with BPD have difficulty with both emotion regulation and mentalizing, it seems more appropriate to combine the skill building approach of DBT with MBT techniques to increase mentalizing rather than select between them.

Integrated treatment is also appropriate because current treatments are not comprehensive: none offer the repertoire of methods needed to treat all manifestations of the disorder. The theoretical models underlying current therapies do not fully explain either the range of psychopathology of PD or the multiple biological and psychosocial factors implicated in its development. Under these circumstances, it seems unnecessarily restrictive to rely on a single form of therapy. Instead, it is more important to identify the general principles of change common to all effective treatments and the treatment methods specific to each approach that contribute to their effectiveness.

The challenge facing integrated treatment is how to combine an eclectic array of treatment methods selected from approaches that are conceptually very different in a way that avoids treatment becoming chaotic and confusing. This paper proposes an evidence-based conceptual framework for integrated treatment based on current knowledge about PD and the principles of therapeutic change. It advocates using principles and inter-

ventions common to all effective therapies without adopting their theoretical assumptions and suggests that treatment methods based on these principles be supplemented with effective interventions that are more specific to a given approach to treat specific problems. For example, specific interventions used by DBT and Systems Training for Emotional Predictability and Problem Solving (STEPPS) (Blum et al., 2008) are effective in reducing emotional dysregulation and deliberate self-harm. Thus an integrated approach would use these methods. However, it would also use cognitive restructuring methods from schema-focused therapy (SFT; Young, Klosko, & Weishaar, 2003) and cognitive therapy to change maladaptive cognitions and cognitive structure and psychodynamic interventions when these are indicated to treat avoidance behavior and some aspects of interpersonal pathology.

### **GENERAL TREATMENT PRINCIPLES**

Evidence from outcome studies shows that general mechanisms common to all forms of therapy account for a substantial proportion of outcome variance (Beutler, 1991; Luborsky, Singer, & Luborsky, 1975). Although much of this work was not on PD, a similar conclusion seems warranted (Livesley, 2003; Paris, 2005). Analyses of the empirical literature by the joint Task Force of the Society for Clinical Psychology (Division 12 of the American Psychological Association) and the North American Society for Psychotherapy Research to identify effective principles of therapeutic change, document the importance of generic mechanisms (Castonguay & Beutler, 2006a). These factors include a strong working alliance, an empathic and flexible approach to repairing ruptures to the alliance, a therapist attitude of caring, warmth, empathy, positive regard, congruence, and authenticity, patient-therapist agreement on treatment goals, strong collaboration between patient and therapist in working toward goals, and a relatively high level of therapist activity (Critchfield & Benjamin, 2006).

Although the empirical basis for these conclusions is limited, the Task Force's conclusions are sufficiently robust to propose that evidence-based treatment should be organized around change mechanisms common to all therapies (Castonguay & Beutler, 2006a; Critchfield & Benjamin, 2006; Livesley, 2003; Meyer & Pilkonis, 2006). These general mechanisms will be discussed in terms: (1) therapy factors—principles for organizing an evidence-based integrated treatment; (2) relationship factors especially alliance factors; (3) therapist factors; (4) patient variables associated with outcome; and (5) technique factors.

### **THERAPY FACTORS**

All effective PD treatments have a well-defined, coherent conceptual structure (Critchfield & Benjamin, 2006) that helps to ensure the consistency and coordination needed for effective outcomes. The importance of an un-

derlying conceptual model is illustrated by empirically-supported treatments for BPD. All include a model of the disorder that structures treatment by providing a rationale for selecting interventions. The implication is that integrated treatment cannot be based simply on eclecticism. Rather it needs to incorporate an explicit conceptualization of the psychopathology of PD and the principles of therapeutic change. This is a challenging requirement given the multidimensional nature and etiology of PD because it is not possible to base treatment on a single theoretical position, as is the case with contemporary therapies. Moreover, a comprehensive, evidence-based theory of PD is not available. The proposed solution is to base treatment of two conceptual frameworks; (1) a framework of organizing information on the structure, etiology, development, and stability of PD to use when selecting and planning the sequence for using various treatment methods; and (2) a model of therapeutic change based on the general literature on psychotherapy outcome and specific studies on PD treatments. Before discussing these frameworks, the implications of other general change mechanisms will be considered.

## RELATIONSHIP FACTORS

Psychotherapy research consistently shows that outcome is related to the quality of therapeutic relationship and alliance (Smith, Barrett, Benjamin, & Barber, 2006). Although a collaborative relationship is fundamental to treating any disorder, it has particular significance with PD because difficulty with collaboration is a hallmark of the disorder (Cloninger, 2000). This means that particular attention needs to be given to strategies for building a collaborative relationship. At the same time, focus on the alliance offers an effective way to manage maladaptive schemata involving trust, abandonment, rejection, and intimacy that underlie interpersonal dysfunction.

The evidence suggests that the alliance is enhanced when therapist and patient agree on the goals of treatment and how these goals will be attained. Early discussion of goals and the patient's expectations for therapy models the collaboration needed for successful outcome and builds motivation.

## THERAPIST FACTORS

Closely related to relationship factors are therapist factors that contribute to positive outcomes either directly or indirectly through their influence on the alliance. A therapeutic stance based on empathy, support, and validation appears to be most effective in building collaboration and motivation. Nearly half a century ago, Carl Rogers (1957) noted that therapist empathy was a major predictor of outcome. Although this conclusion has not been directly confirmed in studies on PD, the treatment for addictions which tend to be highly comorbid with PD shows that empathy strongly

influences outcome (Miller & Rollnick, 1991, 2002). This does not mean that a purely Rogerian approach is sufficient when treating PD. Indeed, the outcome of such an approach appears poor (Cottraux et al., 2009). However, Rogers' views on empathy are helpful when considering the therapeutic stance in integrated treatment. For Rogers, empathy has an attentiveness component that supports and validates and thereby draws patient into a therapeutic relationship and a reflective component that clarifies and amplifies the patient's material but avoids imposing the therapist's own views onto the patient. This conceptualization is consistent with Fernandez-Alvarez, Clarkin, Saguiro, and Critchfield's (2006) conclusion that outcome is related to therapist open-mindedness, flexibility, and creativity. Although a clear conceptual model is required for effective treatment, the model should not be applied rigidly. Flexibility is especially pertinent during crises (Critchfield & Benjamin, 2006) and when managing threatened disruptions to treatment and obstacles to change. These conclusions suggest that integrated treatment should be based on a conceptual model that is sufficiently coherent and detailed to be applied in a consistent way while also leaving scope for therapists to show the creativity and flexibility needed to manage the complexity of personality pathology.

The trust, openness, and cooperativeness required for a working relationship is a continual challenge for the personality disordered patient and hence the alliance is likely to fluctuate throughout treatment. Consequently, therapists need to monitor the alliance carefully and intervene promptly to repair ruptures to the alliance (Safran, Muran, Samstag, & Stevens, 2002). This often requires active limit-setting to contain therapy disrupting behavior while maintaining a supportive and validating stance.

Other therapist factors associated with good outcomes are comfort with long-term, emotionally intense relationships and the ability to handle intense positive and negative feelings about the patient and treatment. Consequently, patience, tolerance of psychopathology and intense countertransference reactions are associated the positive outcomes. Although most therapist factors linked to outcome are not specific there are two factors specific to treating PD: (1). Outcome is enhanced when the therapist has specialized training and experience in treating specific forms of PD; and (2). A higher level of therapist activity is required when treating PD.

## PATIENT FACTORS

Many of the patient characteristics associated with good outcomes hinder the formation of a positive alliance. Especially important in this regard are poor social skills, impaired object relationships, poor relationships in the nuclear family, pessimism and hopelessness, strong defensive behavior, low psychological mindedness, hostility, and perfectionism. These findings draw attention to factors that therapists need to keep in mind when monitoring the alliance. Other patient factors such as patient motivation have a more direct bearing on the structure of treatment. The evidence

suggests that a commitment to change is critical to successful treatment. Unfortunately, PD characteristically involves low motivation: the psychosocial adversity associated with the development of PD contributes feelings of helplessness, hopelessness, and passivity. The significance of motivation is evidenced by the high level of dropout reported for most treatments. Even under the careful conditions imposed by randomized trials, dropout is substantial. In two recent studies, more than 50% of patients deemed suitable for treatment dropped out either during assessment or before treatment was completed (Cottaux et al., 2009; Giesen-Bloo et al., 2006). This reveals a serious problem with current treatments that requires more attention. Motivation enhancing strategies need to be introduced during assessment and used throughout treatment. The problem of motivation also provides additional justification for a supportive and empathic stance: it is more effective in managing low motivation than confrontational and challenging strategies (Linehan, Davison, Lynch, & Sanderson, 2006; Miller & Rollnick, 2002).

## TECHNIQUE FACTORS

Critchfield and Benjamin (2006) in their integration of effective strategies for treating PD, noted the importance of a goal-orientated approach, priority in dealing with presenting problems, and identification of maladaptive patterns of thinking, feeling, and acting that underlie and maintain problems. The salience of these factors suggests that it is important to focus directly on problems, symptoms, and major concerns early in treatment and to give patients an explanation of how treatment may be helpful. Discussion of immediate concerns also helps patients to recognize the cognitive-emotional factors underlying problem behavior and hence begin the process of linking thoughts, feelings, actions, and experience, the first step in promoting more adaptive ways of thinking and acting that is strategy used in all effective treatments (Critchfield & Benjamin, 2006).

Emphasis on promoting more adaptive functioning is linked to another effective strategy: a consistent focus on change. The need to promote change presents a challenge given the prevalence of low motivation and passivity. The balance between acceptance and support and promotion of change used in DBT (Linehan, 1993) is a useful way to maintain a focus on change while maintaining a supportive and validating stance. Problems arise when therapists focus on only one pole of this dialectic.

## **A FRAMEWORK FOR CONCEPTUALIZING PERSONALITY DISORDER**

The need for a coherent conceptual model when treating PD is addressed by basing treatment on two empirically-informed frameworks that deal with the structure of personality disorder and the structure of treatment, respectively. The framework for understanding PD is intended to facilitate

treatment planning by connecting problems and psychopathology to specific interventions. The framework includes: (1) a distinction between the core or defining features of PD common to all cases and individual differences in problems and personality characteristics that delineate the different forms of disorder; (2) a conceptualization of personality as a loosely organized system based on heritable mechanisms; and (3) a social-cognitive model that represents personality and personality pathology in terms of cognitive-emotional structures derived from adaptive mechanisms.

## TWO-COMPONENT STRUCTURE OF PERSONALITY DISORDER

DSM-IV distinction between general and specific features of PD draws attention to clinical features common to all PDs. The clinical literature consistently describes these features as difficulty establishing a cohesive self or identity (e.g., Kernberg, 1984; Kohut, 1971) and chronic interpersonal dysfunction (e.g., Benjamin, 1993; Rutter, 1987). Both features have significant implications for treatment: they lead to difficulty establishing close collaborative relationships, impaired interpersonal boundaries, and difficulty setting and achieving long-term goals. Since these factors hinder the formation of an effective alliance, an integral component of integrated treatment is the management of core pathology. Hence, a critical issue is the kind of therapeutic stance and relationship that is most likely to be effective in treating core pathology.

The general principles of change discussed earlier (Castonguay & Beutler, 2006a) pointed to the importance the treatment relationship and alliance. An examination of core pathology points to the same conclusion. An emphasis of the relationship provides the support, empathy, and validation needed to build the alliance and manage self and interpersonal pathology. It is also likely to reduce the risk of activating reactive emotions and patterns of relating in ways that hinder treatment. At the same time, these relationship qualities provide a continuous corrective experience that helps to modulate and change maladaptive interpersonal schemata forged by psychosocial adversity that contribute to alliance problems.

## PERSONALITY SYSTEM

Integrated treatment is based on the idea that personality is a loosely organized set of subsystems (Dimaggio, Semerari, Carcione, Procacci, & Nicolò, 2006; Livesley, 2003; Mayer, 2005; Vernon, 1964). The system is assumed to be organized around heritable dispositions that give rise to trait structure. There is robust evidence that the traits delineating PD form four clusters (Widiger & Simonsen, 2005): (1) Anxious-dependent or emotional dysregulation, (2) Dissocial, (3) Social withdrawal, and (4) Compulsivity. As the genetic predispositions contributing to these traits are expressed during development, they begin to influence other parts of the personality system, especially the self and interpersonal systems. These

interrelated structures are essentially knowledge systems that organize information about the self and other people into constructs or schemata that encode information, impose meaning on experience, and predict events. The schemata forming the self-system organize self-referential knowledge into a hierarchical structure. The sense of coherence and personal unity that characterize adaptive self-functioning arise from the network of connections that develop among self-schemata (Toulmin, 1978). The more extensive and complex these connections are, the greater the sense of integration (Horowitz, 1998). The interpersonal system also consists of schemata that include representations of others and beliefs and expectations about the interpersonal world that are used to encode and anticipate interpersonal events and implement response sequences. Emergence of the self and interpersonal systems depends upon an array of cognitive processes that combine and integrate information into schemata and on metacognitive processes underlying self-reflection that are used to understand the mental states of self and others (Dimaggio, Semerari, Carcione, Nicolo, & Procacci, 2007; Fonagy, Gergely, Jurist, & Target, 2002).

The personality system also includes regulatory and impulse control processes that manage emotional expression and coordinate action. The individual's environment is also an important part of the system. Over time, individuals tend to create their own environment: they select and shape personal niches that support their interests and talents and permit expression of salient personality characteristics. Consequently, personal niches make a substantial contribution to maintaining adaptive and maladaptive patterns.

## PERSONALITY SYSTEM AND PSYCHOPATHOLOGY

The idea of personality as a system lays the foundation for understanding the coordination and sequencing of interventions in integrated treatment. The psychopathology of PD is pervasive with each sub-system giving rise to a specific domain of psychopathology. At least seven domains may be recognized: (1) symptoms such as dysphoria and deliberate self-harm; (2) impaired emotion and impulse control; (3) maladaptive expressions of traits such as emotional lability, submissiveness, and callousness; (4) maladaptive interpersonal patterns; (5) self or identity pathology; (6) impaired metacognitive processes; and (7) dysfunctional environmental circumstances.

Decomposition of personality pathology into domains has several treatment implications. First, it suggests that comprehensive treatment should include treatment methods pertinent to each domain. Previously, it was suggested that current treatments are remiss in respect. Second, outcome is domain specific (Piper & Joyce, 2001): treatment methods that work for one domain do not necessarily work for another. For example, cognitive-behavioral methods that increase self-regulation of emotions and impulses are useful in treating such symptoms as affective lability and deliberate

self-harm but they may not be as helpful as psychodynamic methods in managing avoidance behavior associated with trauma. Consequently, different treatment methods are needed as different problem domains come into focus.

Third, domains differ substantially in stability and response to treatment (Tickle, Heatherton, & Wittenberg, 2001). Symptoms typically fluctuate naturally and many change early in treatment. The regulatory mechanisms used to control emotions and impulses are usually more stable than symptoms. However, they also tend to change relatively early in treatment as evidenced by the results of studies of DBT, STEPPS, and other cognitive-behavioral therapies. Maladaptive interpersonal patterns, maladaptive modes of thinking, characteristic expressions of traits (as opposed to the underlying disposition), and some self-attitudes change more slowly. Metacognitive impairments seem to respond similarly as shown for the outcome of transference-focused therapy (TFP; Clarkin, Yeomans, & Kernberg, 1999) and MBT although in some patients these impairments are remarkably intractable. The most stable aspects of personality are core self- and interpersonal schemata: the evidence suggests that these features change relatively slowly.

These findings suggest a hierarchy of stability across domains of psychopathology that may be used to organize the sequence in which problems are typically addressed. During the early stages of longer-term treatment and brief therapy, it may be more effective to focus primarily on the more changeable components of psychopathology and hence give priority to reducing symptoms and increasing emotion and impulse control. This focus is also consistent with evidence that outcome is enhanced when priority is placed on presenting symptoms and concerns (Critchfield & Benjamin, 2006), probably because it increases the probability of early success which usually improves the alliance and builds motivation. Symptomatic improvement and increased self-regulation permit more attention to less tractable domains of psychopathology such as maladaptive interpersonal patterns and improving metacognitive functions. As interpersonal functioning improves, attention may be given the more stable aspects of psychopathology involving core self and interpersonal schemata.

This scheme applies particularly to more reactive patients such as those with high levels of emotional dysregulation and dissocial behaviors. With the more emotionally constricted patients such as those with a high level of social avoidance, less time will be spent initially on containment and improving self-regulation and more on engaging the patient in treatment and increasing metacognitive functioning (see Dimaggio et al., 2007).

## COGNITIVE STRUCTURE OF PERSONALITY

The proposed framework for conceptualizing PD draws extensively on social cognitive models of personality (see especially Cervone, 2005; Mischel, 2004; Mischel & Shoda, 1995). Personality is conceptualized as a system

of information processing-decision making modules that encode and appraise events and initiate response patterns. These modules are assumed to reflect the adaptive architecture of personality (Livesley & Jang, 2008).

Most treatments for PD share the idea that the cognitive-emotional structures used to interpret the world, especially the interpersonal world, are core components of personality and a major treatment goal is reorganization of these structures. These structures are variously referred to as object relationships, working models (Bowlby, 1980), self and object representations (Gold, 1990a, 1990b, 1996; Ryle, 1997; Wachtel, 1985), and cognitive schemata (Beck et al., 2004). Here, they will be referred to as schemata: cognitive structures used to organize information, interpret experience, and guide action (Segal, 1988). However, schemata are not purely cognitive constructs: the cognitive component is often linked to emotional responses to form what Mischel and Shoda (1995) referred to as cognitive-affective units.

Schemata are integral to treating all parts of the personality system because cognitive-emotional structures underlie regulatory mechanisms, traits, and self and interpersonal functioning. For example, the multiple schemata forming the self-system organize self-referential knowledge into a hierarchical structure. Self-schemata range from simple qualities such as *kind* or *impulsive* to elaborate self-images that are organized into increasingly higher-order conceptions that culminate in an overarching self-view or autobiographical self (Angus & McLeod, 2004; Hermans & Dimaggio, 2004; Neimeyer, 2000). PD is defined by severe problems with the structure of the self system. These problems may involve poor differentiation of system leading to relatively few self-schemata and an impoverished understanding of the self, as is often the case with socially avoidant PD. Or integration problems in which the self is fragmented because different schemata are not integrated into a coherent self-structure. As a result, such individuals often feel very differently about themselves on different occasions, as is often the case with BPD. Treatment self-pathology involves promoting greater self-knowledge leading to increasing differentiation of self-schemata and integration of these schemata by continually linking events, thoughts, feelings, and actions.

The interpersonal system is similarly organized. A schema representing another person organizes information about that person's qualities, values, beliefs, and interests. With casual acquaintances, these schemata consist of a few salient qualities such as whether the person is friendly or honest. In contrast, a schema representing someone well-known such as a family member is likely to be more detailed and include an understanding to the different facets of their personality. For example, a person may be thought to be friendly, kind, and cheerful on most occasions but irritable and disagreeable on others. Usually an attempt is made to integrate these apparent discrepancies. For example, by recognizing that a person is normally friendly but irritable when stressed. With PD, the schemata representing another person are often impoverished and poorly integrat-

ed. As with self pathology, treatment goals include greater differentiation of the individual's understanding of others and greater integration of the conceptions of significant others.

There is also a substantial cognitive component to traits. The genetic factors underlying each trait give rise to neuropsychological structures that are shaped by environmental events into beliefs and expectancies that influence the way traits are expressed (Livesley & Jang, 2008). For example, anxiousness is probably based on an adaptive mechanism for managing threat (Gray, 1987; Livesley, 2008). Experiences of threatening events give rise to cognitions that influence the evaluation of threatening events and the person's appraisal of his or her ability to handle events. Gradually, these cognitions affect the threshold for perceiving threat and hence experience of anxiety and the intensity of fearful responses. Similar processes occur with other traits. This suggests that effective management of maladaptive traits includes restructuring associated schemata as will be discussed later.

The conception of personality as an information processing system and knowledge structure implies that a generic treatment task is to restructure maladaptive beliefs (schemata) and associated emotions and promote the acquisition of more adaptive alternatives. As Critchfield and Benjamin (2006) noted, effective treatments increase knowledge about the way symptoms and problem behaviors are linked to maladaptive schemata and associated emotions.

### **A FRAMEWORK FOR CONCEPTUALIZING THERAPEUTIC CHANGE**

The second component of a conceptual model for integrated treatment is a framework for understanding therapeutic change that translates the general principles underlying effective treatments into a set of treatment methods that are consistent with the framework for understanding PD. In formulating this framework, particular attention needs to be given to developing strategies to ensure the coherent and coordinated delivery of an eclectic array of specific interventions selected from different therapeutic approaches. The proposed framework is based on three ideas. First, a distinction is drawn between general treatment methods based on generic change mechanisms and specific interventions selected from different therapeutic models to treat given problems and domains of psychopathology. Second, the treatment process is conceptualized as a series of phases with each phase primarily addressing a specific set of problem domains. The sequence with which problems are addressed is based on the hierarchy of stability and changeability of personality domains noted earlier. Third, a stages of change model is used to describe how specific features of personality pathology change based on Prochaska and DiClemente's naturalistic description of changes in addictive behavior (DiClemente, 1994; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 1994). The phases of change scheme describes the overall

course of therapy whereas the stages of change model describes change in specific problems and behaviors embedded within the different phases.

## GENERAL AND SPECIFIC CHANGE MECHANISMS

Although general mechanisms common to all treatments account for substantial outcome change, this is not the full story. Each treatment approach also includes strategies and methods specific to that approach that are used to treat specific domains of psychopathology. For example, DBT incorporates specific interventions to treat unstable emotions and deliberate self-harm, and SFT therapy uses specific cognitive interventions to modulate maladaptive interpersonal schemata. Outcome appears to show some degree of domain specificity (Piper & Joyce, 2001) with some interventions being more effective for some domains than others. Unlike general treatment methods, the specific interventions used vary during treatment as different problem domains become the focus of change.

The distinction between general and specific treatment methods implies a hierarchy of interventions. Priority is given to interventions taken to ensure safety of the individual and others (Linehan, 1993; Clarkin et al., 1999). Once safety is assured, general treatment methods are used to build an effective alliance and patient motivation. Once these conditions are met, specific interventions are used to treat the problem at hand.

The general principles of therapeutic change discussed earlier may be translated into five major strategies that form the core components of integrated treatment:

1. Delineate the frame of therapy by defining the therapeutic stance and establishing an explicit treatment contract
2. Establish and maintain a collaborative treatment alliance
3. Maintain a consistent treatment process
4. Build motivation for change
5. Promote self-observation and self-reflection

Interventions based on these principles form the basic structure of treatment. Specific interventions are added to this structure as needed to deal with specific problems. In effect, general interventions form the basic structure to which specific interventions are added when needed.

## THE THERAPEUTIC FRAME AND TREATMENT CONTRACT

All effective treatments are highly structured and attach importance to establishing a clearly defined frame for therapy consisting of the therapeutic stance and treatment contract. The frame provides a structure for therapeutic activity, defines treatment boundaries, helps to ensure a consistent process, and creates conditions for change. The stance sets the tone of treatment and shapes intervention strategies by defining the re-

sponsibilities and activities that structure patient-therapist interaction. Given the importance of relationship factors for successful outcome, the most appropriate stance involves support, empathy, and validation, and fostering the patient's participation in a collaborative descriptive exploration of problems and the acquisition of more adaptive responses.

Most approaches agree that a structured agreement helps to contain emotional reactivity and create a safe and consistent therapeutic environment. The joint Task Force mentioned earlier, concluded that outcome is related to a goal-oriented approach in which "a treatment frame (is) established in collaboration with the patient and structured to achieve clear and explicit goals" (Critchfield & Benjamin, 2006, p. 262). A discussion of goals forges the idea that treatment is a collaborative process for which patient and therapist share responsibility. This discussion includes agreement on the practical arrangements of therapy such as frequency of sessions and duration of treatment, a clear explanation of the treatment process and how treatment will address patient problems and concerns, and a frank discussion of the therapist's contributions and limits (Critchfield & Benjamin, 2006).

## TREATMENT ALLIANCE

The alliance is given priority because it provides support and predicts outcome. Unfortunately, a collaborative relationship is not easily achieved—it is the result of treatment rather than a prerequisite for treatment. For this reason, careful attention needs to be given to building the alliance and promptly repairing any ruptures that occur. Two ideas are useful for this purpose: Luborsky's (1984) two-component description of the alliance and Safran, Muran, and Samstag (1994) and Safran and colleagues's (2002) work on repairing ruptures to the alliance.

Luborsky (1984) suggested that the alliance has a perceptual component in which the patient sees the therapist as helpful and themselves as accepting help and a relationship component where patient and therapist work cooperatively for the patient's benefit. The first component involving perceived credibility of therapy and therapist is achieved through interventions that communicate hope, convey understanding and acceptance of the patient's problems, support treatment goals, acknowledge areas of competence, and recognize progress toward attaining treatment goals. The relationship component is built by promoting the patient's participation in a joint search for understanding, helping the patient learn new skills, encouraging the patient-therapist bond, and emphasizing the collaborative nature of treatment.

This implies a validating treatment process that builds the alliance through affirmation of the legitimacy of the patient's experiences. Validation serves multiple functions. It is inherently empathic and supportive. It also helps to counter earlier invalidating experiences (Linehan, 1993) and hence promotes self-validation, a prerequisite for constructing a more

adaptive self-structure. The task is to validate experience without validating causes and consequences of experiences and responses that are invalid. This involves helping the patient to distinguish the experience, the reasons given for the experience, and the conclusions drawn from it.

Deterioration of the alliance needs to be addressed promptly but supportively. Safran and colleagues (1994, 2002) suggested a five-stage process to repair alliance problems: (1) changes in the alliance such as decreased involvement are noted; (2) the patient's attention is drawn to the event; the reasons for the rupture and the way that it was experienced are explored and the patient is encouraged to express any negative feelings about the event; (3) the therapist validates the patient's account of the experience; (4) if these steps are not effective, attention focuses on how the patient avoids recognizing and exploring the rupture; and (5) the therapist acknowledges his or her contribution to the relationship problem and promotes joint reflection on the reasons why things went awry and how to reestablish a collaborative bond. The value of this approach is that it uses a potentially negative event to change maladaptive schemata.

## CONSISTENCY

A consistent treatment process is also associated with effective outcome (Critchfield & Benjamin, 2006). Interestingly, patients who benefit from treatment mention therapist consistency as a major factor in their improvement (Livesley, 2007). Consistency in this context is defined as adherence to the frame of therapy. This is the reason why the treatment contract is so important. Consistency provides the structure needed to contain unstable emotions and impulses. It also contributes to the formation of more adaptive representations of self and others by providing a stable experience of the self within the treatment relationship. Maintenance of consistency is, however, a challenge because unstable self-states, labile emotions, distrust, and difficulty with cooperation often lead to recurrent attempts to alter the frame and challenge the therapist's resolve to be consistent. Success requires skill in setting limits in a supportive way that does not damage the empathic stance. This is best achieved by confronting attempts to change the frame by recognizing and thereby validating the reasons for violating the frame while pointing out how the violation could adversely affect therapy.

## MOTIVATION

Although motivation to change is essential for patients to seek help and work productively on their problems, low motivation is inherent to PD. Thus motivation cannot be a prerequisite for treatment and therapists need to make extensive use of motivation interviewing techniques (Miller & Rollnick, 2002; Rosengren, 2009) to elicit and affirm a commitment to change. This commitment is built on expectations that treatment will be

successful and any discontentment that patients may feel about the way things are and the way they would like them to be. Discontent, like hope, is a powerful motivator (Baumeister, 1994).

When motivation is poor, the evidence suggests that the best course is to maintain a supportive stance while attempting to explore the consequences of maladaptive behavior. Although therapists are often tempted to be more confrontational at these times, it rarely works and usually adversely affects the alliance. As, Linehan, Davison, Lynch, and Sanderson (2006) noted, motivation is enhanced when the therapist deals with low motivation and therapeutic impasses in a supportive and flexible way and acknowledges that change is difficult.

### SELF-REFLECTION AND METACOGNITIVE FUNCTIONING

The generic component of therapy does not only consist of the relationship factors discussed above. It also includes an instrumental component that involves creating new experiences and new learning, and opportunities to try out new ways of acting and thinking in the context of a supportive relationship. These methods stimulate an increase in self-understanding and self-knowledge and the capacity for self-reflection. These are especially important in treating personality disorder because self-reflection and related metacognitive processes are impaired in most forms of disorder and improved functioning is fundamental to improving interpersonal functioning and building an adaptive self structure. Metacognitive impairments associated with PD include general difficulties in understanding the mental state of self and others (Bateman & Fonagy, 2004; Choi-Kain & Gunderson, 2008; Semerari et al., 2007) and more specific problems such as recognizing and communicating about emotions (Domes, Schulze, & Herbertz, 2009; Nicolò et al., 2011) and awareness of a sense of agency (Dimaggio, Vanheule, Lysaker, Carcione, & Nicolò, 2009). Therapist awareness of these impairments helps them to ensure that interventions to increase metacognitive functioning are consistently incorporated into the treatment process.

### SPECIFIC TREATMENT METHODS AND PHASES OF CHANGE

Specific interventions are used only when the alliance and patient motivation are satisfactory. The concern when using an intervention drawn from therapies with different and even incompatible theoretical assumptions is how to avoid therapy becoming disorganized and unfocused. This could occur when a combination of potentially conflicting interventions are used in rapid succession as different problems are raised. This eventuality is avoided in several ways. First, it is important to differentiate between an intervention and the theoretical assumptions on which it is based. Thus, for example, some DBT or SFT methods may be used without adopting their underlying theory. Second, ideas about differences in stability and

changeability of personality pathology across domains discussed earlier form the basis for dividing treatment into five phases: (1) Ensuring the *safety* of the patient and others; (2) *Containment* of symptoms, emotions, and impulses; (3) *Regulation and control* of emotions and impulses that contribute to symptoms including deliberate self-harm by increasing self-regulation skills and strategies; (4) *Exploration and change* of the more stable cognitive-emotional structures underlying maladaptive behavior and interpersonal patterns and modulation of associated traits; and (5) *Integration and synthesis* of a more adaptive self structure. Although general treatment strategies are used in each phase, specific interventions often differ substantially across phases. Consequently, the phases of change scheme offers a way to coordinate an eclectic combination of interventions and the general progression is from more structured to less structured treatment methods.

### PHASES OF CHANGE AND SPECIFIC INTERVENTIONS

*Safety.* Treatment of severe PD, especially the more reactive emotionally dysregulated and dissocial forms, typically begins with a crisis characterized by emotional and behavioral instability and symptomatic distress but it may involve regressive and dissociated behavior, and cognitive dysregulation with impaired thinking and quasi-psychotic symptoms. In these situations, the primary goal is to ensure the *safety* of the patient and others. This largely achieved through structure and support that is usually delivered through outpatient treatment or crisis intervention services or occasionally brief in-patient treatment.

*Containment.* The brief safety phase merges with containment. Here the goal is to contain and settle unstable emotions and impulses and restore behavioral control. The safety and containment phases are essentially crisis management with the goals of returning the patient quickly to the pre-crisis level of functioning and laying the foundation for further treatment. Change is achieved through general mechanisms of support, empathy, and structure supplemented with medication as needed. Containment interventions are based on understanding that in a crisis state the patient's primary concern is relief from distress. This comes from feeling understood (Joseph, 1983; Steiner, 1994). Hence, the task for the therapist is to acknowledge and align with the patient's distress.

Containment is used throughout treatment whenever a crisis occurs or cognitive functioning is impaired due to intense emotional arousal or dissociative reactions. The only specific intervention used during the containment phase is medication to treat specific symptoms of impulsivity, affective lability, or cognitive dysregulation (Soloff, 2000).

*Control and Regulation.* Crisis resolution and the establishment of greater stability is usually accompanied by increased rapport and alliance that permits the use of more specific interventions designed to reduce symptoms by increasing emotion and impulse control and promoting self-

reflection. This requires an array of cognitive-behavioral interventions augmented with medication. Emphasis is placed on cognitive behavioral methods for two reasons. First, there is accumulating evidence of their value in treating deliberate self-harm, suicidality, and emotional dysregulation based on RCTs of treatments such as DBT (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) and STEPPS (Blum et al., 2008) and evaluations of manualized treatments for emotional dysregulation and self-harm (Evans et al., 1999; Schmidt & Davidson, 2004). These treatments offer an array of empirically supported interventions that can be tailored to the needs of individual patients. Second, evidence especially from forensic studies suggests that specific behavioral problems are best addressed directly using cognitive-behavioral methods (Lipsey, 1995).

During this phase, treatment is guided by the assumption that self-harm arises from a chain of events that begins with a triggering event that is usually interpersonal that arouses maladaptive schemata especially those involving abandonment and rejection. Schema arousal leads to escalating dysphoria that often culminates in deliberate self-harm. The model is consistent with the assumptions of both DBT (Linehan, 1993) and TFP (Clarkin et al., 1999; see Swenson, 1989). Treatment begins by explicating this sequence because most patients are not fully aware of links between components in the chain and by eliciting a commitment to change. Explication of the sequence increases awareness of the links between problem behaviors, situational factors, emotional reactions, and associated cognitions that Critchfield and Benjamin (2006) found to be critical for effective change. Subsequently, components in the chain are systematically targeted with specific interventions: treatment focuses on reducing self-harm and other crisis behavior, increasing affect regulation, restructuring emotional experience, and restructuring perceptions of triggering situations by helping patients to recognize that many of these situations may be understood differently. Underlying maladaptive schemata especially those linked to adversity are discussed but systematic attempts to explore and modify them are deferred if possible until emotion control improves because intense emotion arousal is potentially destabilizing for individuals with PD.

As the sequence of events leading to crises is explored, the idea of delaying self-harming behaviors is introduced with the initial goal of reducing the frequency of these behaviors rather than eliminating them—the latter is unrealistic early in treatment. The establishment of modest goals increases the probability of early success which may be used to enhance the alliance and feelings of self-efficacy. Simple behavior interventions such as distraction, self-soothing, and response prevention may be used for this purpose. At the same time, a psychoeducational component is introduced to explain the sequence of events leading to crises and the reasons for self-harming acts. Self-harming behavior is explained as a self-regulation strategy to reduce distress which usually increases the alliance and

reduces self-blame. This explanation also encourages contemplation of alternative ways to handle distress. This sets the stage for introducing cognitive-behavioral interventions to increase emotional control.

Steps to increase emotional control begin by helping the patient to identify emotions and recognize the nuances of their emotional experience—many patients experience relatively undifferentiated feelings. Attention is also given to improving distress tolerance because many patients are remarkably phobic about negative emotions. Although many therapies promote emotion recognition and tolerance using set exercises, it is often more effective to incorporate these interventions into the process of therapy so that the therapeutic relationship can be used to modulate emotional arousal.

In tandem with these interventions, patients are encouraged to use self-soothing and distraction at the first signs of distress. Simple relaxation methods may be introduced as ways to self-manage emotions and attention-control is increased by teaching the patient how to divert attention from distressing thoughts rather than ruminating about them. Specific cognitive interventions are also used to help the patient to change maladaptive ways of thinking that escalate distress such as rumination, catastrophizing, and self-invalidation.

Two other interventions are also useful during this phase. First, patients often benefit from learning more effective ways to seek help when a crisis looms. Most patients only seek help after harming themselves and many present in an angry and demanding manner that can alienate those they turn to for help. Second, many crises can be averted if patients learn to examine interpersonal situations more carefully and avoid personalizing situations so readily. For example, a patient may assume that a friend's reluctance to meet is an indication that the friend does not really like them rather than recognizing that people have their own lives and may have prior commitments. Encouraging patients to question their interpretation of events often helps to restructure experiences and decrease maladaptive perceptions that trigger crises.

The duration of this phase of treatment varies considerably across different forms of disorder and cases. With less emotionally volatile disorders, this phase may be relatively short, although even more inhibited and socially withdrawn individuals often need help managing anxiety, dysphoria, and distress. With more reactive forms of disorder involving labile emotions and/or strong tendencies to act impulsively, this phase is likely to be prolonged.

*Exploration and Change.* The goal of this phase is to explore and change the cognitive-emotional structures underlying symptoms and problems. The issues addressed during this phase include maladaptive schemata associated with self-harm and violence, dysfunctional interpersonal patterns, maladaptive expression of traits such as submissiveness and social avoidance, cognitive styles such as catastrophic thinking and self-invalidation, and the consequences of trauma. Work of these problems invari-

ably involves dealing with emotionally charged material associated with psychosocial adversity. This is why work on these issues is postponed until the patient is able to handle distress more effectively.

The common elements to the varied problems addressed during this phase of treatment are maladaptive cognitive-emotional structures. Consequently, treatment is largely directed toward restructuring maladaptive schemata through continued use of cognitive interventions such as the SFT methods that are effective in treating BPD (Giesen-Bloo et al., 2006). However, psychodynamic strategies and methods are also useful in managing tendencies to avoid painful issues and to explore and change maladaptive interpersonal patterns. The focus on the relationship the patient establishes with the therapist emphasized by psychodynamic treatments is useful in identifying broad patterns of thinking and relating. This can then be followed with a detailed evaluation of these patterns using the behavioral analyses favored by cognitive-behavioral therapy to clarify specific ways these patterns are expressed and the environmental contingencies that evoke and maintain them.

Psychodynamic interventions also take on greater importance because the treatment relationship becomes a major vehicle for changing core interpersonal schemata involving distrust, rejection, abandonment, self-derogation, and shame. The relationship with the therapist is a useful way to explore the situational factors that activate maladaptive schemata, the feelings associated with schema activation, and the impact of these cognitive-emotional structures on interpersonal behavior. These interpersonal methods are usually the most effective way to change core schemata (Young et al., 2003) because patients with severe PD often have difficulty using standard cognitive interventions (Layden, Newman, Freeman, & Morse, 1993). This contention is supported by the results of a randomized comparison of Rogerian supportive therapy with cognitive therapy: outcome was poor for both treatments (Cotteaux et al., 2009). This suggests that standard cognitive therapy may be too structured and Rogerian therapy too unstructured for treating PD. The consistent use of interpersonal methods to explore and change core maladaptive schemata offers a way to combine important ingredients of both therapies.

Cognitive restructuring is also useful in modulating maladaptive expressions of traits such as impulsivity, submissiveness, and sensation-seeking. Although these traits are highly heritable, change is possible. However, it may be more effective to focus on reducing the frequency and intensity of trait expression by modifying the expectations associated with trait arousal and expression than attempting more radical changes in trait structure. For example, beliefs about personal invulnerability associated with recklessness and sensation seeking can be challenged. With emotional traits such as anxiousness, it is often possible to combine restructuring beliefs about how threatening the world is and personal inability to cope with threats, with the anxiety-control skills learned earlier. With other traits, it may be more effective to help the patient to learn more adap-

tive ways to express them. For example, many BPD patients are highly sensation seeking. This trait often contributes to crises and interpersonal conflicts because these events satisfy the need for stimulation even though they are distressing. Patients can often be helped to find more adaptive ways to meet the need for stimulation.

*Integration and Synthesis.* The final phase of treatment—the creation of sense of identity—is not reached with many patients. The goal of this phase is to help the individual to achieve greater integration of the personality system. The changes required do not rely primarily on analysis and resolution of maladaptive and conflicted ways of being but rather on the synthesis of new processes and structures, especially a more coherent sense of self, more integrated representations of others, and the capacity for self-directedness. Clinical evidence suggests that such changes are more difficult to achieve and usually require long-term treatment. Although there is little empirical research on this aspect of treatment, the nature of self-pathology suggests that the systematic use of general therapeutic strategies provides an important environment that challenges core schemata and promotes self-understanding by providing consistent and veridical feedback. The methods of self psychology, constructionist approaches, and cognitive analytic therapy (Ryle, 1975) may be of value in constructing a more adaptive self narrative.

## STAGES OF CHANGE

The final component of a framework for conceptualizing treatment and coordinating interventions is based on the stage of change model developed by Prochaska and DiClemente for describing naturalistic change in addictive behavior (DiClemente, 1994; Prochaska et al., 1992, 1994). They proposed six stages to the change process: precontemplation, contemplation, preparation, action, maintenance, and termination. This model offers a systematic way to approach therapeutic change to both specific behaviors such as deliberate self-harm and more general features such as submissiveness or categorical thinking. The model suggests that change is orderly and that the requirements of each stage need to be met before proceeding to the next stage in the change process. Using this approach, changes in personality pathology may be considered to fall into four stages: problem recognition, problem exploration, identification of alternative behaviors, and consolidation and generalization. Since a typical treatment deals with multiple problems and these problems that change at differing rates, each treatment involves multiple stages of change processes that are embedded within the phases of change discussed previously.

The *problem recognition* stage has two components: (1) helping patients to recognize problem behaviors and personality characteristics, and (2) eliciting a commitment to change. The duration of this stage varies considerably. Patients often present with specific behaviors that they want to change, in which case the stage is brief—all that is required is to identify

the problem and elicit a commitment to change. With some problems, however, considerable preparatory work may be needed before patients can recognize the problem or understand how their characteristic ways of thinking and acting that contribute to their difficulties. In these circumstances, problem recognition is often hindered by the ego-syntonic nature of some behaviors and the tendency to attribute problems to those around them so that the patient's focus is on changing these people rather than themselves. Establishing a commitment to change is an important part of problem recognition that builds the alliance and forms the basis for *exploration of the problem* and underlying cognitive, emotional, and motivational processes.

With most problems, exploration involves clarification of the problem behavior, detailed exploration of the events that trigger the behavior and discussion of the short-term and long-term consequences of the behavior as discussed when describing the control and regulation phase. This process establishes links among problems, events, thoughts, and feelings that contributes to more integrated functioning as well as providing the foundation for specific changes. When the behavior in question involves more complex patterns such as traits, interpersonal patterns, and cognitive styles, exploration often involves identification and explore the global pattern such as submissiveness or catastrophic thinking followed by detailed exploration of the specific behaviors through which the pattern is expressed. Important consequences of exploration are increased self-knowledge and improved self-monitoring and self-reflection.

Detailed exploration of problem behaviors, the situational factors that evoke them, and their impact on well-being, inevitably evoke ideas about acting differently. Thus, exploration merges with the *acquisition of alternatives*. Here the focus is on learning to analyze problems and find new solutions. This is a frustrating stage for many patients: they are more aware of their problems and how they contribute to their difficulties but are unable to change their ways often because they are concerned or even afraid of the consequences of change, especially when change is likely to have an impact on significant others and hence evokes fears of anger and rejection. As Linehan and colleagues (2006) noted, in these circumstances, change is most likely to occur when therapists are supportive and acknowledge just how difficult it is to make changes.

The final stage in changing specific behaviors is *consolidation and generalization*. Changes made in therapy need to be generalized to everyday life. This is most likely when the patient is actively encouraged to apply the things learned in therapy to real-life situations. Difficulties encountered can then be discussed in detail and any successes can be used to consolidate change and challenge any fears about the consequences of change. Even when change begins, behaviors fluctuate and old ways return especially in stressful situations. Exploration of these situations provides an opportunity to review and consolidate progress in problem solving, self-understanding, self-reflection, self-monitoring, and self-validation.

Change also seems to be more enduring when the patient attributes it to his or her own efforts and to internal factors such as personal efficacy, self-control, and the effects of learning as opposed to changes in external circumstances (Heatherton & Weinberger, 1994). This stage in changing a specific problem behavior or pattern provides an opportunity to review how the therapist and patient have been able to work together to achieve the patient's treatment goals.

### **CONCLUDING COMMENTS**

This paper argues that it is time for the treatment of PD to move away from a concern about the comparative efficacy of current therapies and to adopt an evidence-based approach that integrates effective methods from all therapies. There is little further to be learned from a partisan approach to compare or debate the relative merits of treatments that do not yield substantially different outcomes and have substantial practical and conceptual limitations. Practical limitations arise from the failure to address directly all aspects of the multidimensional psychopathology and etiology of PD whereas conceptual limitations arise from fact that current treatments are not grounded in an evidence-based theory of PD that adequately accounts for the multiple biological and psychosocial factors that contribute to the disorder.

The framework offered for thinking about and organizing integrated treatment is intended to be sufficiently structured to provide the cohesive and consistent approach needed for effective outcomes while being sufficiently flexible for therapists to tailor treatment to their specific style, patient needs, treatment setting, and therapeutic modality. Consequently, the principles of integrated treatment are relevant to short-term crisis intervention lasting at most a few months, medium-term treatment lasting perhaps a year or so that is primarily concerned with increasing emotion and impulse regulation and decreasing self-harming behavior, and long-term treatment lasting several years that is intended to change interpersonal patterns and promote more integrated personality functioning. The framework proposed is also intended to be flexible in the sense that it can be really modified to accommodate empirical and conceptual advances. In this sense, the framework proposed is simply an interim position until a truly integrative model can be constructed based on a comprehensive, evidence-based theory of PD.

### **REFERENCES**

- Angus, L., & McLeod, J. (Eds.) (2004). *The Handbook of Narrative and Psychotherapy: Practice, theory and research*. Thousand Oaks, CA: Sage.
- Bateman, A., & Fonagy, P. (2004). Psychotherapy for borderline personality disorder. Oxford: Oxford University Press.
- Baumeister, R. F. (1994). The crystallization of discontent in the process of major life change. In T. F. Heatherton, J. L.

- Weinberger, et al. (Eds.), *Can personality change?* (pp. 281–297). Washington, DC: American Psychological Association.
- Beck, A. T., Freeman, A., Davis, D. D., & Associates. (2004). *Cognitive therapy of personality disorders*. New York: Guilford.
- Benjamin, L. S. (1993). *Interpersonal diagnosis and treatment of personality disorders*. New York: Guilford Press.
- Beutler, L. E. (1991). Have all won and must all have prizes? Revisiting Luborsky et al.'s verdict. *Journal of Consulting and Clinical Psychology, 59*, 226–232.
- Blum, N., St. John, D., Pfohl, B., Stuart, S., McCormick, B., Allen, J., Arndt, S., & Balck, D. W. (2008). Systems training for emotional predicability and problem solving (STEPPS) for outpatients with borderline personality disorder: A randomized controlled trial and 1-year follow-up. *American Journal of Psychiatry, 165*, 468–478.
- Bowlby, J. (1980). *Loss*. London: Hogarth Press.
- Castonguay, L. G., & Beutler, L. E. (Eds.), (2006a). *Principles of therapeutic change that work*. New York: Oxford University Press.
- Castonguay, L. G., & Beutler, L. E. (2006b). Common and unique principles of therapeutic change: What do we know and what do we need to know? In L. G. Castonguay & L. E. Beutler (eds.), *Principles of therapeutic change that work* (pp.353–369). New York: Oxford University Press.
- Cervone, D. (2005). The architecture of personality. *Psychological Review, 111*, 183–204.
- Choi-Kain, L. W., & Gunderson, J. G. (2008). Mentalization: Ontogeny, assessment and application in the treatment of borderline personality disorder. *American Journal of Psychiatry, 165*, 1127–1135.
- Clarkin, J. F., Yeomans, F. E., & Kernberg, O. (1999). *Psychotherapy for borderline personality disorder*. New York: Wiley.
- Cloninger, C. R. (2000). A practical way to diagnose personality disorder: A proposal. *Journal of Personality Disorders, 14*, 99–108.
- Cottraux, J., Note, I. D., Boutitie, F., Millierey, M., Genouihlac, V., Yao, S. N., et al., (2009). Cognitive versus Rogerian supportive therapy in borderline personality disorder. *Psychotherapy and Psychosomatics, 78*, 307–316.
- Critchfield, K. L., & Benjamin, L. S. (2006). Integration of therapeutic factors in treating personality disorders. In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work* (pp. 253–271). New York: Oxford University Press.
- DiClemente, C. C. (1994). If behaviors change, can personality be far behind? In T. F. Heatherton, & J. L. Weinberger (Eds.), *Can personality change?* (pp. 175–198). Washington, DC: American Psychological Association.
- Dimaggio, G., & Lysaker, P. H. (Eds.) (2010). *Metacognition and severe adult mental disorders: From basic research to treatment*. London: Routledge.
- Dimaggio, G., Semerari, A., Carcione, A., Nicolo, G., & Procacci, M. (2007). *Psychotherapy of personality disorders: Metacognition, states of mind, and interpersonal cycles*. London: Routledge.
- Dimaggio, G., Semerari, A., Carcione, A., Procacci, M., & Nicolò, G. (2006). Toward a model of self-pathology underlying personality disorders: Narratives, metarepresentation, interpersonal cycles and decision-making processes. *Journal of Personality Disorders, 20*, 597–617.
- Dimaggio, G., Vanheule, S., Lysaker, P. H., Carcione, A., & Nicolò, G. (2009). Impaired self-reflection in psychiatric disorders among adults: A proposal for the existence of a network of semi independent functions. *Consciousness and Cognition, 18*, 653–664.
- Domes, G., Schulze, L., & Herberth, S. C. (2009). Emotion recognition in borderline personality disorder: A review of the literature. *Journal of Personality Disorders, 23*, 6–19.
- Evans, K., Tyrer, P., Catalan, J., Schmidt, U., Davidson, K., Tata, P., Thornton, S., Barber, J., & Thompson, S. (1999). Manual assisted cognitive-behavioral therapy (MACT): A randomized controlled trial of a brief intervention with bibliotherapy in the treatment of recurrent deliberate self-harm. *Psychological Medicine, 29*, 19–25.
- Fernandez-Alvarez, H., Clarkin, J. F., Salguero, M., & Critchfield, K. L. (2006).

- Participant factors in treating personality disorders. In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work* (pp. 203–218). New York: Oxford University Press.
- Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.
- Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilberg, W., Dirksen, C., van Asselt, T. et al. (2006). Outpatient psychotherapy for borderline personality disorder: Randomized trial of schema-focused therapy vs transference-focused therapy. *Archives of General Psychiatry*, *63*, 649–658.
- Gold, J. R. (1990a). Culture, history, and psychotherapy integration. *Journal of Integrative and Eclectic Psychotherapy*, *9*, 41–48.
- Gold, J. R. (1990b). The integration of psychoanalytic, interpersonal, and cognitive approaches in the psychotherapy of borderline and narcissistic disorders. *Journal of Integrative and Eclectic Psychotherapy*, *9*, 49–68.
- Gold, J. R. (1996). *Key concepts in psychotherapy integration*. New York: Plenum Press.
- Gray, J. A. (1987). *The psychology of fear and stress*. Cambridge: Cambridge University Press.
- Heatherton, T. F., & Weinberger, J. L. (Eds.). (1994). *Can personality change?* Washington, DC: American Psychological Association.
- Hermans, H.J.M., & Dimaggio, G. (Eds.) (2004). *The dialogical self in psychotherapy*. London: Brunner/Routledge.
- Horowitz, M. J. (1998). *Cognitive psychodynamics: From conflict to character*. New York: John Wiley.
- Kernberg, O. F. (1984). *Severe personality disorders*. New Haven, CT: Yale University Press.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Joseph, B. (1983). On understanding and not understanding: Some technical issues. *International Journal of Psychoanalysis*, *64*, 291–298.
- Layden, M. A., Newman, C. F., Freeman, A., & Morse, S. B. (1993). *Cognitive therapy of borderline personality disorder*. Needham Heights, MA: Allyn & Bacon.
- Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry*, *160*, 1223–1232.
- Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive-behavioural treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, *48*, 1060–1064.
- Linehan, M. M., Davison, G. C., Lynch, T. R., & Sanderson, C. (2006). Techniques factors in treating personality disorders. In L. G. Castonguay & L. E. Beutler (eds.), *Principles of therapeutic change that work* (pp. 239–252). New York: Oxford University Press.
- Lipsey, M. W. (1995). What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents? In J. McGuire (Ed.), *What works: Reducing reoffending: Guidelines from research and practice* (pp. 63–78). Oxford, UK: John Wiley.
- Livesley, W. J. (2003). *Practical management of personality disorder*. New York: Guilford Press.
- Livesley, W. J. (2007). Integrated therapy for complex cases of personality disorder. *Journal of Clinical Psychology: In Session*, *64*, 207–221.
- Livesley, W. J. (2008). Toward a genetically-informed model of borderline personality disorder. *Journal of Personality Disorders*, *22*, 42–71.
- Livesley, W. J., & Jang, K. L., (2008). The behavioral genetic of personality disorders. *Annual Review of Clinical Psychology*, *4*, 247–274.
- Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy*. New York: Basic Books.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies. *Archives of General Psychiatry*, *32*, 995–1008.
- Mayer, J. D. (2005). A tale of two visions: Can a new view of personality help to integrate psychology? *American Psychologist*, *60*, 294–307.
- Meyer, B., & Pilkonis, P. (2006). Developing treatments that bridge personality and

- psychopathology. In R. F. Krueger & J. L. Trickett (Eds.), *Personality and psychopathology* (pp. 262–291). New York: Guilford Press.
- Miller, W. R., & Rollnick, S. (1991) *Motivational interviewing*. New York: Guilford Press.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing for change*. New York: Guilford Press.
- Mischel, W. (2004). Toward an integrative science of the person. *Annual Review of Psychology*, 55, 1–22.
- Mischel, W., & Shoda, Y. (1995). A cognitive-affective system theory of personality: Reconceptualizing situations, dispositions, dynamics, and invariance in personality structure. *Psychological Review*, 102, 246–268.
- Neimeyer, R. A. (2000). Narrative disruptions in the construction of the self. In R. A. Neimeyer & J. D. Raskin (Eds.), *Constructions of disorder* (pp. 207–241). Washington, DC: American Psychiatric Association Press.
- Nicolò, G., Semerari, A., Lysaker, P. H., Dimaggio, G., Conti, L., d'Angerio, S., et al. (2011). Alexithymia in personality disorders: Correlations with symptoms and interpersonal functioning. *Psychiatry Research*, 190, 37–42.
- Paris, J. (2005). Treatment of borderline personality disorder. *Canadian Journal of Psychiatry*, 50, 435–441.
- Piper, W. E., & Joyce, A. S. (2001). Psychosocial treatment outcome. In W. J. Livesley (Ed.), *Handbook of personality disorders*. New York: Guilford Press.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change. *American Psychologist*, 47, 1102–1114.
- Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1994). *Changing for good: The revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits*. New York: William Morrow.
- Rogers, C. R., (1957). The necessary and sufficient conditions for therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.
- Rosengren, D. B., (2009). *Building motivational interviewing skills: A practitioner workbook*. New York: Guilford Press.
- Rutter, M. (1987). Temperament, personality, and personality disorder. *British Journal of Psychiatry*, 150, 443–458.
- Ryle, A. (1997). *Cognitive analytic therapy and borderline personality disorder*. Chichester, UK: John Wiley.
- Safran, J. D., Muran, J. C., & Samstag, L. W. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A. O. Horvath, & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 225–255). New York: John Wiley.
- Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2002). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 235–254). New York: Oxford University Press.
- Schmidt, U., & Davidson, K. (2004). *Life after self-harm*. Hove, UK: Brunner-Routledge.
- Segal, Z. (1988). Appraisal of the self schema construct in models of depression. *Psychological Bulletin*, 103, 147–162.
- Semerari, A., Carcione, A., Dimaggio, G., Nicolò, G., & Procacci, M. (2007) Understanding minds, different functions and different disorders? The contribution of psychotherapeutic research. *Psychotherapy Research*, 17, 106–119.
- Smith, T. L., Barrett, M. S., Benjamin, L. S., & Barber, J. P. (2006). Relationship factors in treating personality disorders. In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work* (pp. 219–238). New York: Oxford University Press.
- Soloff, P. H. (2000). Psychopharmacology of borderline personality disorder. *Psychiatric Clinics of North America*, 23, 169–190.
- Steiner, J. (1994). Patient-centered and analyst-centered interpretations: Some implications of containment and countertransference. *Psychoanalytic Quarterly*, 14, 406–422.
- Swenson, C. (1989). Kernberg and Linehan: Two approaches to the borderline patient. *Journal of Personality Disorders*, 3, 26–35.
- Tickle, J. J., Heatherton, T. F., & Wittenberg, L. G. (2001). Can personality change? In W. J. Livesley (Ed.), *Handbook of personality disorder* (pp. 242–258), New York: Guilford Press.
- Toulmin. S. (1978). Self-knowledge and

- knowledge of the "self." In T. Mischel (Ed.). *The self: Psychological and philosophical issues* (pp. 291–317). Oxford: Oxford University Press.
- Vernon, P. E. (1964). *Personality assessment: A critical survey*. London: Methuen.
- Wachtel, P. L. (1991). From eclecticism to synthesis: Toward a more seamless psychotherapeutic integration. *Journal of Psychotherapy Integration*, 1, 43–54.
- Widiger, T., & Simonsen, E. (2005). Alternative dimensional models of personality disorder: Finding a common ground. *Journal of Personality Disorders*, 19, 110–130.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy*. New York: Guilford Press.