Journal of Personality Disorders, 22(4), 332–352, 2008

AN INTEGRATIVE PERSPECTIVE ON PSYCHOTHERAPEUTIC TREATMENTS FOR BORDERLINE PERSONALITY DISORDER

Erik R. de Groot, MSc, Roel Verheul, PhD,
and R. Wim Trijsburg,† PhD

Although there is an abundance of literature on the psychotherapeutic treatment of borderline pathology, little is known about differences and similarities between treatments of borderline personality disorder (BPD). Potential differences and similarities are especially important in the absence of evidence of the superiority of one treatment over the other (e.g., Livesley, 2004). This article offers an overview of the theory and practice of contemporary psychotherapeutic treatments of BPD, and delineates similarities and differences between the specific treatments. Results show that similarities concerning (1) the formal characteristics, and (2) the importance of therapeutic techniques in treatments for BPD, outnumber the differences. This article concludes by viewing the similarities and differences from an integrative perspective, and recommendations are given for future work in treating patients with and research on the effectiveness of treatments and treatment techniques for BPD.

Borderline Personality Disorder (BPD), though heterogeneous in its form, in general can be characterized by a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity" (DSM-IV-TR; American Psychiatric Association, 2000, p. 706). BPD has been studied intensely over the past decades. In comparison to other patient groups, such as patients with major depressive disorder, borderline patients are more likely to have received psychosocial treatments and medication, and have used mental health resources more extensively (e.g., Bender et al., 2001). They also show higher rates of comorbidity with axis I as well as other axis II disorders than other patient groups (e.g., Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004), and higher rates of success-

From Universiteit van Amsterdam.

The authors would like to thank Dawn Bales, Lorna Smith Benjamin, Dawn Bennett, Wies van den Bosch, Willem Heuves, John Livesley, Anthony Ryle, and Anoek Weertman for their comments on an earlier draft of this article.

Address correspondence to Roel Verheul, Department of Clinical Psychology, Faculty of Societal and Behavioral Sciences, Universiteit van Amsterdam, Roetersstraat 15, 1018 WB Amsterdam, the Netherlands; E-mail: R.Verheul@uva.nl

ful and unsuccessful suicide attempts than the normal population (e.g., Oldham, 2006). Both comorbidities and suicide (attempts) are complicating factors in the treatment of BPD.

Nonetheless, optimism about the possibilities of treatment of BPD has rapidly increased over the past decades. This growing optimism is related to the publication of various treatment models, for example, Dialectical Behavioral Therapy (Linehan, 1993), Schema-Focused Therapy (Young, 1999), and Mentalisation Based Treatment (Bateman & Fonagy, 2004), and randomized clinical trials showing their efficacy.

Although there is an abundance of literature on the psychotherapeutic treatment of borderline pathology, little is known about differences and similarities between treatments of BPD. In fact, though these various treatments may differ from a theoretical point of view, we do not know to what degree they have some (or many) treatment elements in common. Potential differences and similarities are especially important in the absence of evidence of the superiority of one treatment over the other (e.g., Livesley, 2004; Livesley, 2007).

The aims of this article are threefold. First, an overview of the theory and practice of contemporary psychotherapeutic treatments for BPD will be presented. Second, similarities and differences between the specific treatments are delineated. Finally, the similarities and differences will be viewed from an integrative perspective.

OVERVIEW OF PSYCHOTHERAPEUTIC TREATMENTS FOR BORDERLINE PERSONALITY DISORDER

COGNITIVE THERAPY

Cognitive Therapy (CT) of personality disorders derives from standard CT for acute psychiatric disorders. Present-day CT defines personality in terms of patterns of cognitive-affective, motivational, and social processes (Beck, Freeman, Davis, & Associates, 2004), thereby underlining that CT no longer emphasizes cognitions only. However, CT claims that idiosyncratic cognitive schemas determine behavior. According to this theory, schemas that, due to circumstances, may have been adaptive during childhood will be maintained throughout later life even after they have become dysfunctional. Notwithstanding contradictory evidence, dysfunctional schemas tend to persist because of the distortion and discounting of information, which precludes the extinction of maladaptive schemas and the development of more adaptive schemas by negative reinforcement.

The schema concept is the cornerstone of the cognitive treatment of BPD. Borderline patients' beliefs show three dominant themes: (1) "I am inherently unacceptable," (2) "I am vulnerable and powerless," and (3) "The world is dangerous and malevolent" (Beck et al., 2004). The combination of the latter two beliefs is hypothesized to lead to high levels of vigilance and interpersonal distrust. Borderline pathology is further characterized

by a weak sense of identity and dichotomous thinking, i.e., the tendency to evaluate experiences in terms of mutually exclusive categories such as good and bad.

Hypervigilance, dichotomous thinking, and a weak sense of self are considered to have a reinforcing and self-perpetuating effect, especially on interpersonal relationships, and consequently are major targets for therapy (Beck et al., 2004). CT for personality disorders strongly focuses on the therapeutic relationship, characterized by collaboration and guided discovery, and allows for the processing of transference reactions (i.e., emotional reactions within the therapy process), vital to fully understanding the patient's system of thoughts and beliefs.

A randomized controlled trial of mere CT for BPD is currently underway (Davidson et al., 2006). It is assumed that treatment of one year or longer is effective in reducing most problematic behaviors, but many BPD patients need longer treatment for more extensive remediation (Beck et al., 2004).

SCHEMA-FOCUSED THERAPY

Schema-Focused Therapy (SFT) evolved as an extension, rather than a replacement, of Beck's original model, and aims specifically at treating patients with persisting personality problems (Young, 1999). Instead of concentrating on automatic thoughts and underlying assumptions, SFT focuses primarily on the deepest level of cognition, schemas. The SFT model defines schemas as "stable and enduring themes that develop during childhood and are elaborated throughout an individual's lifetime, and are dysfunctional to a significant degree" (p. 9). In contrast with underlying assumptions, schemas, and especially early maladaptive schemas (EMSs), are self-perpetuating and therefore more resistant to change.

As the threat of schema change is too disruptive to be tolerated, personality disordered patients tend to develop a variety of cognitive and behavioral maneuvers that reinforce and ultimately maintain the schema (Young, 2002). These maneuvers are defined as "schema processes." These were categorized as: (1) schema maintenance: cognitive distortions and maladaptive behavior that directly reinforce and perpetuate a schema; (2) schema avoidance: cognitive, behavioral, and emotional strategies helping the individual to avoid schemas which would generate a highly intensive affect; and (3) schema compensation: overcompensating behaviors or cognitions, with a high potential of reinforcing schemas due to their extreme nature.

Young identified 18 EMSs, subdivided in five broad domains: (1) disconnection and rejection, (2) impaired autonomy and performance, (3) impaired limits, (4) other-directedness, and (5) hypervigilance and inhibition (Young, 1999). A "natural" grouping of schemas and schema processes is called a "schema mode." These differ from personality traits in that modes are coping mechanisms triggered by events. This concept resembles the

so-called "ego states" in classic psychoanalysis (Young, 2002). Young hypothesized that four schema modes are essential of BPD: the abandoned child mode (or "abused and abandoned child"), the angry/impulsive child mode, the punitive parent mode, and the detached protector mode. A fifth mode, the healthy parent mode, would denote the healthy side of the patient.

Interventions in SFT focus in particular on three core manifestations of maladaptive schemas: (1) problems in interpersonal relationships, (2) self-functioning (diffusion of identity), and (3) affect regulation. Treatment is explorative and insight-oriented and accentuates the therapeutic alliance as an important tool for modification and restructuring of schemas. Turning the healthy parent mode to good account is crucial for developing and continuing a working relationship with the BPD patient (Young, 2002). Making contact with the abused and abandoned child, which helps correcting dysfunctional schemas and enables the person to learn new schemas, is conditio sine qua non for treatment. Apart from the cognitive and behavioral techniques used in standard cognitive therapy, SFT employs some specific techniques such as "limited reparenting" and "empathic confrontation" (Young, 1999).

SFT was shown to be effective in treatments for a variety of patients with DSM Axis I disorders as mood and anxiety disorders, drug abuse and eating disorders (Young, 2002). Recently, a large-scale randomized study in the Netherlands showed that three years of SFT for BPD was effective in reducing psychopathology and in improving quality of life (Giesen-Bloo et al., 2006).

DIALECTICAL BEHAVIORAL THERAPY

Dialectical Behavior Therapy (DBT) is based on a biosocial theory of personality suggesting that BPD is primarily a dysfunction of the emotion regulation system, stemming from biological abnormalities in conjunction with an invalidating environment (Linehan, 1993). Divergence between inner experience and the invalidating environment will also result in doubts about the soundness of inner experiences and the accuracy of one's interpretation of events.

DBT applies directive, problem-oriented techniques, based mainly on behavior therapy, and balances these with supportive techniques (e.g., empathy, acceptance) and techniques drawn from Zen Buddhism (Linehan, 1993). Additionally, so-called dialectical strategies are applied, alternating problem-solving with validation, balancing acceptance with change, and using paradox and metaphors.

The primary focus of DBT is stabilization by helping patients to achieve control over their behavior (Linehan, 1993). Especially in this first stage of treatment, creating a positive therapeutic alliance is crucial for therapeutic success. Reduction of suicidal and other self-mutilating or life-threatening behavior takes priority over reduction of treatment- and life-interfer-

ing behaviors, and the acquisition of behavioral skills in the areas of mindfulness (being aware without being judgmental), interpersonal effectiveness, emotion regulation, distress tolerance, and self-management.

The DBT program consists of different modules. Group skills training, following a highly structured psycho-educational format alternates with individual outpatient sessions focusing on the analysis of motivational obstacles to change (Linehan, 1993). Telephone calls between sessions are used to provide (1) coaching and promotion of the generalization of skills, (2) crisis intervention, and (3) opportunities for repairing the therapeutic alliance. Finally, therapist consultation meetings are held for maintenance of motivation and skills of therapists.

In four randomized controlled trials, DBT proved superior to treatment-as-usual (TAU) in decreasing parasuicidal acts, medical risk of parasuicide, number of hospital days, drop-out from treatment, and anger (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994; Koons et al., 2001; Linehan et al., 2006). Most of these gains were maintained through a one-year follow-up (Shearin & Linehan, 1994; Linehan et al., 2006). A three-month inpatient treatment with DBT prior to long-term outpatient therapy showed significant improvement in depression, dissociation, anxiety, and global distress (Bohus et al., 2000). Also, a highly significant decrease in number of parasuicidal acts was shown. These results were replicated in a controlled study (Bohus et al., 2004).

A 12-month randomized clinical trial of DBT with female borderline patients in the Netherlands resulted in better retention rates in self-mutilating and self-damaging behavior as compared to TAU (Verheul et al., 2003). Six months after the discontinuation of DBT, the therapeutic gains regarding parasuicidal and impulsive behaviors, and alcohol use, were maintained (Van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005).

Outpatient DBT was not effective in decreasing depression, hopelessness, and in improving survival coping beliefs and overall life satisfaction. Overall, DBT is considered an efficacious treatment of high-risk behaviors among patients with BPD, but may not be effective in changing the personality disorder itself (e.g., Scheel, 2000).

COGNITIVE ANALYTIC THERAPY

Cognitive Analytic Therapy (CAT) integrates ideas of cognitive psychology and therapy, object-relations theory and a model of the social formation and dialogic structure of self processes derived from Vygotsky (Ryle & Kerr, 2002). The core concept of CAT is the reciprocal role procedure (RRP), in which *roles* are defined as "combining memory, affect and action, organized in relation to the search or the experience of reciprocation" (Ryle, 1997, p. 27). RRPs develop on the basis of early parent/caretaker-child interactions. Ongoing interactions induce complementary roles (self and

other), and lead the developing child to create an idiosyncratic repertoire of RRPs.

Over time this repertoire of RRPs develops into an integrated complex of procedures that can be activated in specific contexts. CAT suggests that when children are confronted with inconsistencies or overwhelming traumatic experiences, the integration of procedures can be disrupted (Ryle, 1997), leading to a structural dissociation of self processes which, among other effects, disrupts self reflection (Ryle & Marlow, 1995).

According to CAT, borderline pathology is maintained by three factors: (1) self-states (defined in terms of mood, access to and control of emotion, and the accompanying reciprocal role) are dissociated and unstable, and characterized by a small range of role procedures. When in the role characterizing a given state, the borderline patient will seek others who reciprocate, or can be induced to reciprocate, or who are seen to reciprocate, and hence reinforce the role procedure, (2) when this fails, the borderline patient will move to another self-state instead of revising the first procedure, and (3) discontinuity of experiences and a flawed recall of a state when being in another state, results from, and, in its turn will reinforce, the absence of a central self-observing and self-managing capacity in which the individual is capable of identifying and taking responsibility of his or her actions (Ryle, 1997).

The first aim of CAT is to aid integration and to mobilize the patient's capacity for self-reflection and self-control (Ryle, 1997). To accomplish this, CAT rests heavily on the core technique of "descriptive reformulation": i.e., the joint creation of verbally and diagrammatically precise descriptions of problematic role procedures and self-states. A "reformulation letter" is written tracing the origins and manifestations of problematic procedures, in the patients' personal histories, life experiences and current relationships, including the developing therapeutic relationship, and diagrams tracing states and state shifts are constructed (Ryle & Kerr, 2002). A wide range of other therapeutic techniques is included in this process, provided that their relation to the overall understanding of the reformulation is clear. The focus is on self-states and coping procedures and how these can be adapted and improved. The skillful management of the therapeutic relationship is central to this as problematic RRPs are normally expressed in the therapeutic relationship where they must be recognized and challenged. In addition to being an individual therapy, CAT is offered as a framework of understanding to assist services/care teams to better help BPD patients (Ryle, personal communication).

Comparison of CAT reformulations with formulations of the same session materials derived from research based methodologies supports the validity of the process of reformulation in CAT (Bennett & Parry, 1998). Results from a pilot study (Ryle & Beard, 1993) suggested that more than half of BPD patients accepted and were able to use CAT, in some cases requiring no further treatment. A naturalistic study of 24 sessions of CAT

showed improvement in borderline pathology, with over 50% of patients no longer meeting BPD criteria after treatment, with additional progress at 18 months follow-up (Ryle & Golynkina, 2000). Specific effectiveness of CAT is currently being studied in a randomized controlled trial.

SYSTEMS TRAINING FOR EMOTIONAL PREDICTABILITY AND PROBLEM SOLVING

A lack of interventions reducing self-harm, acting out, and hospitalization rates in BPD patients (Blum, Pfohl, St. John, Monahan, & Black, 2002), prompted a group of authors to develop Systems Training for Emotional Predictability and Problem Solving (STEPPS), a modification and expansion of the psycho-educational program described in "A Systems Approach to Treatment: Borderline Personality Disorder Skills Training Manual" (Bartels & Crotty, 1998).

Central to STEPPS is the underlying belief that BPD reflects, more than anything else, a defect in the individual's internal ability to regulate emotional intensity. It is this inability to fully regulate emotional intensity that is deemed responsible for many of its manifestations, such as frequent mood swings, self-harming behavior, anger outburst, or disrupting relationships (Van Wel et al., 2006).

The first goal of STEPPS was to develop an integrated social and professional support system, and to teach patients how to use this effectively (Blum et al., 2002). This system component of the treatment consists of meetings with the system of BPD patients (family members, significant others, health care professionals) to educate them about BPD and motivate them for participation with the program. Second, a detailed session-by-session treatment manual was developed in order to simplify training of group leaders and insure model fidelity (Black, Blum, Pfohl, & St. John, 2004).

The treatment starts with enhancing the individual's awareness of illness. As STEPPS assumes that the core deficit in BPD is in a patient's internal ability to regulate emotional intensity (Black et al., 2004), the treatment emphasizes cognitive-behavioral techniques and skills training, helping patients to develop specific emotion (e.g., distancing, distraction) and behavior management skills (e.g., goal-setting, avoidance of abuse). Additionally, a maintenance program called STAIRWAYS was developed in order to maintain what was learned and to teach new skills.

A survey research of effectiveness of the STEPPS program suggested reduction in negative behaviors and affect, though no significant improvement of positive behavior and affect was found (Blum et al., 2002). Another study from the Netherlands showed a significant improvement on depression, anxiety, and interpersonal sensitivity ratings. Notwithstanding these effects, the study showed a high drop-out rate of 34% (Freije, Dietz, & Appelo, 2002). Randomized controlled trials are now underway in the United States, as well as in the Netherlands to compare STEPPS to treatment as usual.

TRANSFERENCE FOCUSED PSYCHOTHERAPY

Transference-Focused Psychotherapy (TFP) is based on ego psychology, object relations theory, and contemporary attachment theory. The main starting point of TFP is that thinking, feeling, and acting is guided by basic schemata, i.e. representations of the self and important others or "objects." According to object relations theory, self and object representations are linked to specific affects, resulting in *object relation dyads* (Yeomans, Clarkin, & Kernberg, 2002), which are the primary units of psychic life.

TFP suggests that the core problem of patients with a borderline personality *organization* (including BPD; see Kernberg, 1980) consists of poorly defined and fragmented rather than integrated self and object representations, resulting in identity diffusion. Furthermore, these patients are characterized by the use of primitive defense mechanisms (e.g., projective identification, denial, omnipotence) and an essentially intact but vulnerable reality testing (Yeomans et al., 2002).

The ultimate goal of TFP is a better integration of the fragmented inner representations of borderline patients. TFP treatment focuses primarily on the dominant affect-laden themes that emerge in the relationship between therapist and patient in the here-and-now of the transference (Clarkin et al., 2001). It relies on the techniques of clarification, confrontation and interpretation in order to achieve change in the underlying personality structure as well as in behavior. At the start of treatment a hierarchy of issues is established: (1) containment of suicidal and self-destructive behaviors, (2) the various ways of destroying the treatment, and (3) the identification and recapitulation of dominant object relational patterns as experienced in the transference relationship (Yeomans et al., 2002). An important distinction is made in TFP between contract setting and actual treatment.

A preliminary study showed decreases in suicide attempts, medical risk and severity of medical condition following self-injurious behavior, hospitalization rate and number of days of psychiatric hospitalization compared with the year prior to treatment (Clarkin et al., 2001). In a recent multicenter, randomized study comparing TFP and SFT, TFP proved to be effective in reducing borderline psychopathology and improving quality of life, though less than SFT (Giesen-Bloo et al., 2006). A study comparing TFP and DBT showed positive change in depression, anxiety, global functioning, social adjustment, and suicidality for both treatments, as well as improvement in suicidality, anger, and impulsivity specific for TFP (Clarkin, Levy, Lenzenweger, & Kernberg, 2007).

MENTALIZATION-BASED TREATMENT

Mentalization-Based Treatment (MBT) was developed in the last decade and is based on the attachment theory. MBT incorporates aspects of both cognitive and psychodynamically oriented therapies (Bateman & Fonagy,

2003a). This treatment focuses on the capacity to mentalize, i.e., being able to focus on mental states (beliefs, wishes, feelings, thoughts, etc.) in oneself or in others, particularly in explanations of behavior, of having a "theory of mind" (Fonagy & Target, 1997). MBT theory suggests that this capacity develops through a process of experiences during childhood in which one sees oneself in the mind of another within an attachment relationship, usually this is a context of a secure and playful parent-child relationship (Bateman & Fonagy, 2004).

From an attachment perspective, MBT argues that the affective cluster (inappropriate and intense anger, affective instability, unstable and intense relationships), the cluster of identity symptoms (identity disturbance, emptiness, fear of abandonment, paranoid distortions), and the cluster of impulsive borderline pathology (self-harm and suicidality, recklessness) all result from an instability of the self-structure (Bateman & Fonagy, 2003a). Constitutionally vulnerable individuals who experience developmental trauma in an attachment context (in which emotional experience is not adequately mirrored by the caregiver), become psychologically vulnerable in later attachment contexts as a result of this instability of the self. In an attempt to cope, the individual decouples the mind from others' minds (the mentalizing capacity being inhibited) and relies on earlier psychological mechanisms to organize the experience and in doing so reveals fragments of the self.

The overall goal of treatment is stabilizing the self-structure by developing stable internal representations, formation of a coherent image of the self, and the capacity to create secure relationships (Bateman & Fonagy, 2004). To accomplish this, treatment should focus on enhancing the capacity of mentalization, especially within attachment contexts. An increased capacity to mentalize resulting in an increased affect control can only be brought about if the environment of treatment is relative safe and nonpunitive (Bateman & Fonagy, 2003a).

A RCT comparing mentalization-based partial hospitalization treatment for BPD patients with general psychiatric care, showed MBT to be superior over treatment-as-usual in decreasing self-harming behaviors, inpatient admissions, and use of psychotropic medication. It showed significant improvement on self-report ratings of depression, anxiety, general symptom distress, interpersonal functioning and social adjustment (Bateman & Fonagy, 1999). A second study showed that improvements were maintained, and continued to improve, at an 18-month follow-up (Bateman & Fonagy, 2001). A health care utilization analysis suggested that day-hospital treatment for BPD is equally expensive as general psychiatric care and shows considerable cost-savings after treatment (Bateman & Fonagy, 2003b).

INTERPERSONAL RECONSTRUCTIVE THERAPY

Interpersonal Reconstructive Therapy (IRT) was developed from interpersonal theories, most importantly from Allport's theory of personality and

from the interpersonal models of Henry Murray, Timothy Leary, Earl Schaefer, and Harry Stack Sullivan. The basic idea behind IRT is that "problem behaviors and their associated symptoms represent *attachment gone awry*" (Benjamin, 2003, p. v, italics in original). This idea rests on the assumption that imitation is a basically omnipresent determinant of behavior, as well as attachment, showing itself for example in the persistence of generation-to-generation abuse even though this will appear to be maladaptive to objective observers.

According to IRT four main features are usually, but not necessarily, present in the developmental history of the borderline patient. First, the families of borderline patients are characterized by chaos, leading the future BPD patient to seek out or create crises when feeling bored and empty. Second, frequently occurring abandonment experiences are linked with the idea of being *bad*. This idea sets off an intense fear of being abandoned forever and at the same time leads to frantic efforts to physical proximity. Third, independency or happiness is punished and the internalization of the punisher produces a self-sabotaging behavior in order to escape attacks in the future. Finally, the BPD patient learns that being needy and miserable elicits care and nurturance, leading to escalating symptomatology (Benjamin, 1996).

The Structural Analysis of Social Behavior (SASB), a method for operationalizing interpersonal and intrapsychic concepts relevant for therapy, invokes Sullivan's hypothesis that the self-concept arises directly from interpersonal experience with significant others (Benjamin, 1996). The SASB approach is a method of developing individual case formulations for each patient, and is used as a clarifying lens in identifying key patterns related to DSM symptoms and predictive principles link patterns to important persons in the patient's past and present life (Benjamin, personal communication).

The IRT case formulation is a method for linking presenting problems to social learning and context. It details what must be targeted in treatment for each individual patient; consistent use of it optimizes interventions on a moment to moment basis (Benjamin, personal communication). Using this method, IRT helps patients to identify the nature and the purpose of their interactive patterns. With the development of cognitive and affective understanding of the origins and purposes of his interactive patterns, the patient slowly comes to terms with the question of whether he wants to give up old adaptations (Benjamin, 1996).

The therapist can draw from a wide range of therapeutic techniques, as long as these lead to one of five, hierarchically ordered, "categories of correct treatment": interventions that (1) facilitate collaboration between therapist and patient, (2) help the patient recognize past and present patterns and the relationship between these, (3) block maladaptive patterns, (4) strengthen the patient's will to give up old, destructive wishes and fears, and (5) help the patient learn new, more adaptive patterns (Benjamin, 2003).

Preliminary data of IRT effectiveness showed a reduction in suicidal actions, days in hospital and number of hospitalizations. Though this set of data "hardly constitutes a formal clinical trial" (Benjamin, 2003, p. 343), empirical evidence of the effectiveness of the five categories of correct treatment, as mentioned above, does exist (Benjamin & Pugh, 2001), and future studies (randomized clinical trials and validating studies) are planned.

METHOD OF COMPARISON

The psychotherapeutic treatments reviewed above will be compared with respect to formal characteristics and therapeutic techniques. The formal characteristics include Setting, Duration, and Frequency, Modality of Treatment, Adherence, and Structure.

For a comparison of psychotherapeutic techniques, we used some of the categories of the Comprehensive Psychotherapeutic Interventions Rating Scale (CPIRS; Trijsburg et al., 2002). The CPIRS could not be used in its original format, because some interventions could not be coded with the CPIRS (e.g., psycho-education), and some interventions forming one factor in CPIRS (e.g., self-disclosure, exploration of activities, explain direction in session, summarizing, and challenging, are categorized as directive process interventions), are used in different degrees or differ in importance within a treatment model. Therefore, we chose to categorize psychotherapeutic interventions and techniques from the CPIRS in a way most fitting to a comprehensive list of techniques, specifically for BPD.

From the CPIRS we used the specific intervention categories of Behavioral, Cognitive, Psychodynamic, and Experiential Techniques. To these, we added common factor categories of Affective and Interpersonal Techniques, which fit the DSM-IV manifestations of personality disorder of affectivity and interpersonal dysfunctioning in personality disordered patients, BPD-patients in particular. Although these techniques overlap with the five common factor categories of the CPIRS already mentioned, the latter system seems less useful for our purposes. Next, we chose to include mindfulness techniques, as these are relatively new and could not be coded with CPIRS. Finally, we added Psycho-Education, Motivational, and Nonverbal Techniques, as these were (frequently) mentioned as distinct forms of techniques in treatment manuals. All techniques will be outlined below:

1. *Psychoeducation* refers to all modules with an educational goal, typically about causal and maintaining factors of the disorder, according to the theory underlying the treatment model.

2. *Motivational techniques* are characterized by interventions focused on increasing patients *and* therapists' commitment to treatment (e.g., motivational interviewing, clarification of interventions, paradoxical interventions).

3. *Behavioral techniques* include procedures based on learning theory or experimental-psychological paradigms (e.g., modeling, exposure, "field experiments" with new behaviors, breathing exercises, skills-training).

4. *Cognitive techniques* embrace interventions focused on analyzing of and creating insight in patterns of, respectively, thinking, feeling, and be-

having, and their influence on everyday functioning (e.g., Socratic dialogue, exploring personal meaning of beliefs, investigating the relation between thoughts and feelings, challenging beliefs).

5. *Affective techniques* refer to the use of techniques by which to teach the patient to identify, control, and express their emotions in a more fitting and adaptive way (e.g., clarifying and naming feelings, increasing positive events).

6. *Interpersonal techniques* can be defined as interventions in which the focus is on the improvement of a patient's (understanding of) patterns of functioning with other people (e.g., exploration of early relationships, role playing).

7. *Psychodynamic techniques* refer to those techniques most commonly used in psychoanalytic and psychodynamic treatments, and comprise interventions such as the recognition, exploration, and interpretation of defenses or transference phenomena (e.g., confrontation, linking hypotheses).

8. *Mindfulness techniques* derive mostly from Zen Buddhism and include "what" skills (e.g., observing, describing) and "how" skills (e.g., focusing, taking a nonjudgmental stance) used to balance states of mind within the individual.

9. *Experiential techniques* mostly derive from experiential and Gestalt therapies and include interventions centered on the activation of affectivity to quicken learning and unlearning (e.g., reliving childhood events, imagery, empty chair technique).

10. In *nonverbal techniques* patients use art, drama, or other expressive therapies to allow "the internal to be expressed externally so that it can be verbalized at a distance through an alternative medium and from a different perspective" (Bateman & Fonagy, 2004, p. 172).

Formal characteristics were scored as "–" (this characteristic never applies to treatment), "±" (infrequent or optionally), or "+" (frequent or always). The importance of interventions within the framework of a particular treatment was scored as "––" (unimportant), "–" (possibly unimportant), "+" (possibly important), and "++" (important).

In order to obtain reliable scores, the first author reviewed all treatment manuals or high citation-ranked review articles when no manual existed, and scored the occurrence of formal characteristics and importance of psychotherapeutic techniques. As a second step we contacted an expert of each of the treatments to verify our scores. In case these experts disagreed with our scoring, we followed their opinion, provided they could point out the relevant text in their manual(s) that supported their arguments.

SIMILARITIES AND DIFFERENCES BETWEEN TREATMENTS FOR BPD

Scoring of occurrence of formal characteristics of psychotherapeutic treatments of BPD can be found in Table 1. As can be seen, treatment for BPD is offered in a variety of ways, from outpatient sessions once a week for

TABLE 1. Occurrence of Formal Characteristics in Psychotherapeutic Treatments for Borderline Personality Disorder

Formal characteristics	CT	DBT	SFT	CAT	STEPPS	TFP	MBT	IRT
Setting								
In-patient	–	±	–	±	–	–	±	+
Day-hospital	–	±	–	±	–	±	+	–
Out-patient	+	+	+	+	+	+	±	+
Duration								
Long (>1 year)	+	±	+	–	–	+	+	+
Average (6–12 months)	±	+	–	+	–	–	–	–
Short (<6 months)	–	–	–	–	+	–	–	–
Frequency								
High (>2 a week)	–	±	–	–	–	–	+	+
Average (1–2 a week)	+	+	+	+	+	+	±	+
Low (<1 a week)	±	±	–	–	±	–	–	–
Modality								
Individual therapy	+	+	+	+	–	+	+	+
Group therapy	–	+	±	±	+	–	+	–
System approach	–	+	–	±	+	±	–	±
Adherence								
Training of therapists	+	+	+	+	±	+	±	+
Inter- and supervision of therapists	+	+	+	+	+	+	+	+
Adherence checks	±	+	±	+	±	+	+	+
Structure								
Manual	+	+	+	+	+	+	+	+
Treatment contract	+	+	+	+	+	+	±	+
Easy access to therapist	±	+	+	–	–	–	±	+
One primary therapist	+	+	+	+	–	+	+	+
Crisis intervention protocol	+	+	+	+	–	+	+	+
Drop-out prevention	+	+	+	±	–	±	+	+
Maintenance treatment	+	+	+	+	±	±	+	+

Index: "+" frequent/always, "±" infrequent/optionally, "–" never

less than six months (e.g., STEPPS) to day hospital or inpatient treatment more than twice a week for longer than a year (e.g., MBT). Clearly, there is some in-treatment variability, especially in setting and frequency of treatment sessions (e.g., CAT usually takes place in an outpatient setting, though optionally in a day hospital of inpatient setting; the same goes for DBT). However, most of the reviewed treatments take place in an outpatient setting for a period of at least one year with one or two sessions a week.

All treatments offer individual sessions, with the exception of STEPPS, which exists of only group sessions. Group sessions on top of individual sessions are offered in DBT, MBT, PM-PD, and are optional in SFT and CAT. DBT and STEPPS also incorporate a system approach, in which family members or partners are involved in treatment; such an approach is optional in CAT, TFP, and IRT.

All therapists of the reviewed treatments have been trained, though STEPPS and MBT-therapists in a less structured and well-described manner than therapists of the other treatments. Inter- and supervision of therapists is offered in all treatments. Adherence checks are standard in DBT, CAT, TFP, MBT, and IRT, but occur infrequently in CT, SFT, and STEPPS.

As shown, a manual is available for all treatments, and all treatments

make use of a treatment contract, with the exception of MBT, in which a treatment contract is optional. Patients can easily access their therapists in DBT, SFT, and IRT, and infrequently in CT and MBT. CAT, STEPPS, and TFP-therapists hardly ever allow their patients to contact them outside work hours. Only in STEPPS do borderline patients *not* have one primary therapist (as STEPPS is a group treatment and is offered in addition to an individual treatment). The same goes for a crisis intervention protocol (in STEPPS, patients can turn to their individual therapists in case of an emergency). Active drop-out prevention occurs frequently in CT, DBT, SFT, MBT, and IRT, infrequently in CAT and TFP and seldom in STEPPS. As for maintenance treatment, this is offered in all treatments but STEPPS and TFP, in which a maintenance treatment is optional after regular treatment.

Scoring of the importance of psychotherapeutic techniques of treatments of BPD can be found in Table 2. Clearly, Psychoeducation and Motivational Techniques are important aspects of all treatments for BPD, albeit some (e.g., DBT) stress these aspects more than others. More variability can be seen for Behavioral Techniques: these are especially important in CT, DBT, and STEPPS, somewhat less but still quite important in SFT, CAT, and IRT, and hardly important in TFP and MBT. Cognitive Techniques on the other hand, are deemed important according to all treatment manuals, albeit a bit less in TFP, MBT, and IRT. As for Affective Techniques, these are considered especially important in DBT, SFT, CAT, and STEPPS, somewhat less but still fairly important in CT, MBT, and IRT and not so important in TFP.

All treatments stress the importance of Interpersonal Techniques in treating borderline patients, though CT, STEPPS, and TFP less so than other treatments. Psychodynamic Techniques are foremost propagated by TFP and MBT, and less so by SFT, CAT, and IRT. CT and DBT find Psychodynamic Techniques not so important, and STEPPS finds these not important at all. A great deal of variability in importance is shown for Mindfulness and Experiential Techniques. DBT obviously stresses the importance of Mindfulness Techniques, as well as CAT but the latter less so. CT, STEPPS, and IRT judge these techniques as not so important, while SFT,

TABLE 2. Importance of Psychotherapeutic Techniques in Treatments for Borderline Personality Disorder

Techniques	CT	DBT	SFT	CAT	STEPPS	TFP	MBT	IRT
Psychoeducation	++	++	++	+	++	+	+	+
Motivational techniques	+	++	+	+	+	+	+	++
Behavioral techniques	++	++	+	+	++	−−	−−	+
Cognitive techniques	++	++	++	++	++	+	+	+
Affective techniques	+	++	++	++	++	−	+	+
Interpersonal techniques	+	++	++	++	+	+	++	++
Psychodynamic techniques	−	−	+	++	−−	++	++	+
Mindfulness techniques	−	++	−−	+	−	−−	−−	−
Experiential techniques	+	++	++	+	−	−	++	+
Nonverbal techniques	−−	+	−−	−	−	−−	+	−

Index: "++" important, "+" possibly important, "–" possibly unimportant, "––" unimportant

TFP, and MBT consider Mindfulness Techniques least important. As for Experiential Techniques, these are regarded as important by DBT, SFT, and MBT, less so but still quite important by CT, CAT, and IRT, and not so important by TFP and STEPPS. Finally, Nonverbal Techniques are important only in DBT and MBT, but no so in CAT, STEPPS, and IRT, and hardly in CT, SFT, and TFP.

DISCUSSION

Results show that, though treatment is offered in a variety of ways, most of the reviewed psychotherapeutic treatments for BPD take place in an outpatient setting for a period of at least one year with one or two sessions a week. Almost all of the treatments offer individual treatment, with group sessions and a system approach as add-on or optional. Most striking is the high importance given to a well structured treatment, as can been seen in, for example, the utilization of treatment manuals and contracts by all or most of the reviewed treatments.

Psychoeducation and Motivational Techniques are shown to be important in all BPD treatments, as well as Cognitive and Interpersonal Techniques. More variability exists for Behavioral and Affective Techniques, which are also important but less so in more psychodynamically orientated treatments as TFP and MBT. The opposite is true for Psychodynamic Techniques, which are less important in more cognitive-behavioral orientated treatments as CT, DBT, and STEPPS. The importance of Experiential Techniques is shown to be diverse. As for Mindfulness and Nonverbal Techniques, these techniques are not deemed very important overall, but are endorsed in specific treatments only.

The present overview is (one of) the first to assess the importance of groups of techniques in various psychotherapeutic treatments for BPD. An earlier study focused on the utilization of specific techniques employed in treatment for BPD, such as Cognitive Restructuring, Problem-Solving, and Anger Management (Sharp et al., 2005). Selection and analysis of these techniques and the ones in the present study diverge too much to be compared.

Consistent with other literature on BPD treatments and employed techniques, is that many of the reviewed treatments are shown to use techniques outside of their predominant approach (e.g. Sharp et al., 2005; Livesley, 2005). The most prominent example of this is the overall importance of Cognitive Techniques, as well as the importance of Experiential Techniques in most treatments. Though differences in theoretical orientation and beliefs about the origin and development of BPD may be great, in actual treatment of BPD the similarities seem to outnumber these differences. The outnumbering of similarities to differences in techniques deemed important—and we may assume therefore *used* in treatments of BPD, suggests that different therapies have common elements associated with successful outcome (e.g., Norcross & Newman, 1992; Paris, 2005; Livesley, 2007).

CLINICAL IMPLICATIONS

The literature shows that no treatment for personality disorder or BPD in particular stands out as more effective than the rest (e.g., Livesley, 2004), though contains suggestions that some treatments are more effective in managing specific problems, and with that in treating specific BPD-patients, than others. For example, deliberate self-harm and heightened impulsivity seem most responsive to Cognitive and Behavioral Techniques (e.g., Linehan et al., 1991), while dysfunctional patterns of interpersonal behavior are probably best treated by Interpersonal and Psychodynamic Techniques (Livesley, 2007). Taken into account that different treatments seem to share common elements of treatment associated with successful outcome, an eclectic and integrated approach to treatment is recommended that combines effective and efficacious techniques from different treatment models within a framework that accentuates common elements of treatment.

A framework consistent with this approach to treating patients with BPD is Livesley's integrated treatment of personality disorders (e.g., Livesley, 2004). Livesley's approach to treating patients with personality disorder is based on the belief that a comprehensive treatment of personality disorder requires an eclectic approach, i.e., an integrated delivery of an array of interventions drawn from different therapeutic models, based on empirical knowledge about the origins and the structure of personality disorder, and about efficacious interventions (Livesley, 2003; Livesley, 2004; Livesley, 2007). This approach is organized around generic interventions designed to maximize nonspecific components of therapy, among which the therapeutic alliance stands out, in order to manage core pathology with more specific interventions.

This integrated treatment is based upon three principles, the first of which is the distinction between generic and specific interventions, which holds that specific interventions are used only when conditions created by the first are met (Livesley, 2003). Generic interventions are tailored to the treatment according to four strategies: building collaboration, maintaining consistency, validation, and building motivation (Livesley, 2005; Livesley, 2007).

The second principle is the division of the process into five phases: (1) safety, characterized by interventions that ensure the safety of the patient and others; (2) containment, aimed at settling crisis behavior and containing impulses and affects; (3) control and regulation, targeted at reduction of symptoms and acquiring skills to manage and control affects and impulses; (4) exploration and change, addressing issues typically including maladaptive schemata; and (5) integration and synthesis, involving development of more adaptive self and interpersonal systems (Livesley, 2003).

The third principle describes the process of changing specific behaviors, as defined by a stages of change model (Livesley, 2003; Livesley, 2007), i.e., (1) problem recognition (recognizing and accepting problems and developing commitment to change), (2) exploration (development of an un-

derstanding of a given problem and its related feelings and thoughts), (3) acquisition of alternatives (identification of new ways of responding to situations and handling of feelings and impulses), and (4) consolidation and generalization (i.e., ensuring that learning is strengthened and applied in everyday situations). During early phases and/or stages, structured behavioral and cognitive interventions and medication predominate; later on, less structured supplementary psychodynamic, interpersonal, and constructionist strategies will be used (Livesley, 2005).

An integrated treatment as described above shows great promise at a theoretical level, nevertheless practical implementation might be a hazard. Also, some authors (e.g., Bateman & Fonagy, 2000) suggest that the consistent application of a coherent theory (and matching techniques) in treatment is one of the necessary components for effective therapy. In that case the use of one comprehensible (though perhaps imperfect) model would be preferred over the use of various elements of various models. Therefore, one vital question remains: do the advantages of an integrated approach outnumber those of specific models? Unfortunately this question cannot be answered by means of this article.

RESEARCH IMPLICATIONS

Research on the effectiveness of BPD treatments over the past decades has focused mostly on comparing one specific treatment with another or with treatment as usual. What is missing in this, though hopeful and promising picture, is a contrast analysis, which may provide leads as to which treatment has the most impact on BPD patient subgroups in terms of specific domains of borderline psychopathology (e.g., Clarkin, Levy, Lenzenweger, & Kernberg, 2004).

Otherwise stated: "What are the specific effects of specific aspects of the models?" (Bateman, Ryle, Fonagy, & Kerr, 2007, p. 61). Mere comparisons of different treatments are unlikely to answer this question. The task at hand is to pinpoint those interventions and techniques effective for tackling different domains of psychopathology that characterize BPD. Only this is what is going to advance the field, not comparisons of different models as if each were a comprehensive way to treat the disorder (Livesley, personal communication).

LIMITATIONS

The evidence in the present study is either descriptive or qualitative, relying more on experts' views than controlled, quantitative research. This study focused on reviews of treatment manuals and/or high-citation ranked review articles about psychotherapeutic treatments of BPD instead of, for example, questionnaires in which treatment practitioners scored the use of specific techniques (as did Sharp et al., 2005). To secure objectivity

of scoring as much as possible, we contacted an expert of each of the reviewed treatments to verify our scores and to reach consensus with. This way, no treatment was favored over another.

We have tried to include all important features in our comparison of the different treatments, but still, some aspects important to psychotherapeutic treatments of BPD (e.g., an empathic and active therapeutic stance, encouragement of a powerful attachment relationship; see, for example, Bateman & Fonagy, 2000) have not been listed in the tables. The reason for this is that these aspects could not be scored without bias and/or with certainty of existence. Treatment manuals only tell us so much.

As for a comparison of psychotherapeutic techniques, several instruments for systematically comparing treatments have been developed in the past. For instance, the Psychotherapy Process Q-Set (PQS) offers a rating procedure for the description of the therapist-patient interaction (e.g., Jones & Pulos, 1993, Ablon & Jones, 1999). Other examples include the Collaborative Study Psychotherapy Rating Scale (CSPRS; Hill, O'Grady, & Elkin, 1992) addressing treatment-adherence, the Coding System of Therapeutic Focus (CSTF; Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997) addressing treatment focus, and the Verbal Response Mode (VRM) taxonomy (Stiles, Shapiro, & Frith-Cozens, 1988). These instruments did not fit this articles' goal however, in that they do not offer an at-first-view comprehensible overview of treatment techniques. To compare the different treatments of BPD on importance of therapeutic techniques, we therefore adapted the CPIRS (Trijsburg et al., 2002) in order to keep this list of techniques as comprehensible as it can get.

CONCLUSIONS

The similarities of psychotherapeutic treatments for BPD concerning occurrence of formal characteristics of treatment and importance of therapeutic techniques outnumber the differences by far. This suggests that treatments share common elements (and techniques) associated with successful outcome, though specific treatments or treatment techniques may be preferable for addressing specific psychopathology domains.

An eclectic and integrated approach to treatment of BPD (or any other personality disorder) is recommended that combines effective techniques from different treatment models within a framework that accentuates common elements of treatment. Generic interventions designed to maximize nonspecific components of therapy are to be employed, in order to manage core pathology with more specific interventions (e.g., Livesley, 2007). Where research has focused on the effectiveness of different treatment models compared to others, future research should focus instead on what specific treatment techniques are effective in treating specific problems or problem domains. As said before: "What we need to know is what kind of intervention works with what kind of problem and with what kind of patient" (Livesley, 2004, pp. 190–191).

REFERENCES

Ablon, J. S., & Jones, E. E. (1999). Psychotherapy process in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 67,* 64–75.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (text rev.). Washington, DC: Author.

Bartels, N., & Crotty, T. (1998). *A systems approach to treatment: The borderline personality disorder skills training manual.* Winfield, IL: EID Treatment Systems.

Bateman, A. W., & Fonagy, P. (2000). The effectiveness of partial hospitalization in the treatment of Borderline Personality Disorder: A randomized controlled trial. *American Journal of Psychiatry, 156,* 1563–1569.

Bateman, A. W., & Fonagy, P. (2000). Effectiveness of psychotherapeutic treatment of personality disorder. *British Journal of Psychiatry, 177,* 138–143.

Bateman, A. W., & Fonagy, P. (2001). Treatment of Borderline Personality Disorder with psychoanalytically oriented partial hospitalization: An 18-month follow-up. *American Journal of Psychiatry, 158,* 36–42.

Bateman, A. W., & Fonagy, P. (2003a). The development of an attachment-based treatment program for Borderline Personality Disorder. *Bulletin of the Menninger Clinic, 67,* 187–211.

Bateman, A. W., & Fonagy, P. (2003b). Health service utilization costs for Borderline Personality Disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care. *American Journal of Psychiatry, 160,* 169–171.

Bateman, A. W., & Fonagy, P. (2004). *Psychotherapy for Borderline Personality Disorder: Mentalization-Based Treatment.* Oxford: Oxford University Press.

Bateman, A. W., Ryle, A., Fonagy, P., & Kerr, I. B. (2007). Psychotherapy for borderline personality disorder: Mentalization based therapy and cognitive analytic therapy compared. *International Review of Psychiatry, 19,* 51–62.

Beck, A. T., Freeman, A., Davis, D. D., & Associates. (2004). *Cognitive therapy of personality disorders* (2nd ed.). New York: The Guilford Press.

Bender, D. S., Dolan, R. T., Skodol, A. E., Sanislow, C. A., Dyck, I. R., McGlashan, T. H, et al. (2001). Treatment utilization by patients with personality disorders. *American Journal of Psychiatry, 158,* 295–302.

Benjamin, L. S. (1996). *Interpersonal diagnosis and treatment of personality disorders* (2nd ed.). New York: The Guilford Press.

Benjamin, L. S. (2003). *Interpersonal reconstructive therapy: An integrative, personality-based treatment for complex cases.* New York: The Guilford Press.

Benjamin, L. S., & Pugh, C. (2001). Using interpersonal theory to select effective treatment interventions. In W. J. Livesley (Ed.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 414–436). New York: The Guilford Press.

Bennett, D., & Parry, G. (1998). The accuracy of reformulation in cognitive analytic therapy: A validation study. *Psychotherapy Research, 8,* 405–422.

Black, D. W., Blum, N., Pfohl, B., & St. John, D. (2004). The STEPPS group treatment program for outpatients with Borderline Personality Disorder. *Journal of Contemporary Psychotherapy, 34,* 193–210.

Blum, N., Pfohl, B., St. John, D., Monahan, P., & Black, D. W. (2002). STEPPS: A cognitive-behavioral systems-based group treatment for outpatients with borderline personality disorder: A preliminary report. *Comprehensive Psychiatry, 43,* 301–310.

Bohus, M., Haaf, B., Simms, T., Limberger, M. F., Schmahl, C., Unckel, C., et al. (2004). Effectiveness of in-patient dialectical behaviour therapy for Borderline Personality Disorder: A controlled trial. *Behaviour Research and Therapy, 42,* 487–499.

Bohus, M., Haaf, B., Stiglmayr, C., Pohl, U., Böhme, R., & Linehan, M. M. (2000). Evaluation of in-patient dialectical behavioral therapy for borderline personality disorder: A prospective study. *Behaviour Research and Therapy, 38,* 875–887.

Clarkin, J. F., Foelsch, P. A., Levy, K. N.,

Hull, J. W., Delaney, J. C., & Kernberg, O. F. (2001). The development of a psychodynamic treatment for patients with borderline personality disorder: A preliminary study of behavioral change. *Journal of Personality Disorders, 15,* 487–495.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2004). The personality disorders institute/borderline personality disorder research foundation radomized control trial for borderline personality disorder: Rationale, methods, and patient characteristics. *Journal of Personality Disorders, 18,* 52–72.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry, 164,* 922–928.

Davidson, K., Tyrer, P., Gumley, A., Tata, P., Norrie, J., Palmer, S., et al. (2006). A randomized controlled trial of cognitive behaviour therapy for borderline personality disorder: Rationale for trial, method, and description of sample. *Journal of Personality Disorders, 20,* 431–449.

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 9,* 679–700.

Freije, H., Dietz, B., & Appelo, M. (2002). Behandeling van de Borderline Persoonlijkheidsstoornis met de VERS: De Vaardigheidstraining Emotionele Regulatiestoornis. *Directieve Therapie, 4,* 367–378.

Giesen-Bloo, J., Van Dyck, R., Spinhoven, P., Van Tilburg, W., Dirksen, C., Van Asselt, T., et al. (2006). Outpatient psychotherapy for borderline personality disorder: Randomized trial of schema-focused therapy vs. transference-focused psychotherapy. *Archives of General Psychiatry, 63,* 649–658.

Goldfried, M. R., Castonguay, L. G., Hayes, A. M., Drozd, J. F., & Shapiro, D. A. (1997). A comparative analysis of the therapeutic focus in cognitive-behavioral and psychodynamic-interpersonal sessions. *Journal of Consulting and Clinical Psychology, 65,* 740–748.

Hill, C. E., O'Grady, K. E., & Elkin, I. (1992). Applying the Collaborative Study Psychotherapy Rating Scale to rate therapist adherence in cognitive-behavior therapy, interpersonal therapy, and clinical management. *Journal of Consulting and Clinical Psychology, 61,* 73–79.

Jones, E. E., & Pulos, S. M. (1993). Comparing the process in psychodynamic and cognitive-behavioral therapies. *Journal of Clinical and Consulting Psychology, 61,* 306–316.

Kernberg, O. F. (1980). *Internal world and external reality: Object relations theory applied.* New York: Jason Aronson.

Koons, C. R., Robins, C. J., Tweed, J. L., Lynch, T. R., Gonzelez, A. M., Morse, J. Q., et al. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy, 32,* 371–390.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *The Lancet, 364,* 453–461.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: The Guilford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48,* 1060–1064.

Linehan, M. M., Comtois, K .A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63,* 757–766.

Linehan, M. M., Heard, H. L., & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatments for chronically parasuicidal borderline patients. *Archives of General Psychiatry, 50,* 971–974.

Linehan, M. M., Tutek, D. A., Heard, H. L., & Armstrong, H. E. (1994). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry, 151,* 1771–1776.

Livesley, W. J. (2003). *Practical management of personality disorder.* New York: The Guilford Press.

Livesley, W. J. (2004). Changing ideas about the treatment of borderline personality disorder. *Journal of Contemporary Psychotherapy, 34,* 185–192.

Livesley, W. J. (2005). Principles and strategies for treating personality disorder. *Canadian Journal of Psychiatry, 50,* 442–450.

Livesley, W. J. (2007). An integrated approach to the treatment of personality disorder. *Journal of Mental Health, 16,* 131–148.

Norcross, J. C., & Newman, J. C. (1992). Psychotherapy integration: Setting the context. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 3–45). New York: Basic Books.

Oldham, J. M. (2006). Borderline personality disorder and suicidality. *American Journal of Psychiatry, 163,* 20–26.

Paris, J. (2005). Treatment of borderline personality disorder. *Canadian Journal of Psychiatry, 50,* 435–441.

Ryle, A. (1997). *Cognitive analytic therapy and borderline personality disorder: The model and the method.* Chichester: John Wiley & Sons.

Ryle, A., & Beard, H. (1993). The integrative effect of reformulation: Cognitive analytic therapy with a patient with borderline personality disorder. *British Journal of Medical Psychology, 66,* 249–258.

Ryle, A., & Golynkina, K. (2000). Effectiveness of time-limited cognitive analytic therapy of borderline personality disorder: Factors associated with outcome. *British Journal of Medical Psychology, 73,* 197–210.

Ryle, A., & Kerr, I. B. (2002). *Introducing cognitive analytic therapy: Principles and practice.* Chichester: John Wiley & Sons.

Ryle, A., & Marlow, M. J. (1995). Cognitive analytic therapy of borderline personality disorder: Theory and practice and the clinical and research uses of the self states sequential diagram. *International Journal of Short-term Psychotherapy, 10,* 21–34.

Scheel, K. R. (2000). The empirical basis of dialectical behavior therapy: Summary, critique, and implications. *Clinical Psychology: Science and Practice, 7,* 68–86.

Sharp, I. R., Henriques, G. R., Chapman, J. E., Jeglic, E. L., Brown, G. K., & Beck, A. T. (2005). Strategies used in the treatment of borderline personality disorder: A survey of practicing psychologists. *Journal of Contemporary Psychotherapy, 35,* 359–368.

Shearin, E. N., & Linehan, M. M. (1994). Dialectical behavior therapy for borderline personality disorder: Theoretical and empirical foundations. *Acta Psychiatrica Scandinavia, 89,* 61–68.

Stiles, W. B., Shapiro, D. A., & Frith-Cozens, J. A. (1988). Verbal response mode use in contrasting psychotherapies: A within-subjects comparison. *Journal of Consulting and Clinical Psychology, 56,* 727–733.

Trijsburg, R. W., Frederiks, G.C.F.J., Gorlee, M., Klouwer, E., den Hollander, A. M., & Duivenvoorden, H. J. (2002). Development of the comprehensive psychotherapeutic interventions rating scale (CPIRS). *Psychotherapy Research, 12,* 287–317.

Van den Bosch, L.M.C., Koeter, M.W.J., Stijnen, T., Verheul, R., & van den Brink, W. (2005). Sustained efficacy of dialectical behavior therapy for borderline personality disorder. *Behaviour Research and Therapy, 43,* 1231–1241.

Van Wel, B., Kockmann, I., Blum, N., Pfohl, B., Black, D. W., & Heesterman, W. (2006). STEPPS group treatment for borderline personality disorder in the Netherlands. *Annals of Clinical Psychiatry, 18,* 63–67.

Verheul, R., van den Bosch, L.M.C., Koeter, M.W.J., De Ridder, M.A.J., Stijnen, T., & van den Brink, W. (2003). A 12-month randomized clinical trial of dialectical behavior therapy for women with borderline personality disorder in the Netherlands. *British Journal of Psychiatry, 182,* 135–140.

Yeomans, F. E., Clarkin, J. F, & Kernberg, O. F. (2002). *A primer of transference-focused psychotherapy for the borderline patient.* New York: Jason Aronson.

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach* (3rd ed.). Sarasota, FL: Professional Resource Press.

Young, J. E. (2002). Schema-focused therapy for personality disorder. In G. Simos (Ed.), *Cognitive behaviour therapy: A guide for the practising clinician* (pp. 201–222). Sussex: Brunner-Routledge.