TRANS-DIAGNOSTIC AND TRANS-THEORETICAL THERAPY FOR PERSONALITY DISORDER

TERAPIA TRANSDIAGNÓSTICA Y TRANSTEÓRICA PARA EL TRASTORNO DE PERSONALIDAD

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ABSTRACT

This paper argues that evidence of limited efficacy of specialized therapies for personality disorder points to the need for trans-diagnostic and trans-theoretical treatment models. Current therapies largely adopt a diagnosis-specific and therapeutic schools approach to therapy development; each major school of thought tends to develop its own treatment model for specific diagnoses. The relevance of a diagnosis specific approach to treatment is challenged given the well-established problems with current diagnoses and growing recognition that the general features of personality disorder and severity are more useful in understanding prognosis than specific diagnoses. These developments point to the use of a trans-diagnostic treatment model. Similarly, a schools approach to treatment is questioned given the failure to demonstrate differences in efficacy across therapeutic models and evidence that these therapies do not yield better outcomes that supportive therapy or general clinical care. These finding point to the need for a more integrated approach. Implementation of trans-diagnostic and trans-theoretical treatment requires a more detailed assessment of personality pathology than is provided by current diagnoses in order to identify impairments that form the targets for change and a scheme for organizing therapy and coordinating the implementation of an eclectic array of interventions. The article outlines a practical way to conceptualize assessment for treatment purposes and a framework for organising and delivering therapy.

Keywords: *personality disorder, trans-diagnostic model, trans-theoretical model, psychological treatment*

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Resumen

Este artículo sostiene que la evidencia de la limitada eficacia de las terapias especializadas en el trastorno de personalidad apunta a la necesidad de modelos de tratamiento transdiagnósticos y transteóricos. Las terapias actuales adoptan para el desarrollo de la terapia, en gran medida, un enfoque de escuela terapéutica y diagnóstico específico; cada corriente de pensamiento principal tiende a desarrollar su propio modelo de tratamiento para diagnósticos específicos. La relevancia de un enfoque de diagnóstico específico para el tratamiento se ve cuestionada dados los problemas consolidados reflejados en los diagnósticos actuales y el creciente reconocimiento de que las características generales del trastorno de personalidad y su gravedad son más provechosas para comprender el pronóstico que los diagnósticos específicos. Estos avances sugieren el empleo de un modelo de tratamiento transdiagnóstico. De forma similar, se cuestiona el enfoque de las escuelas de tratamiento, ya que no se han demostrado diferencias en la eficacia entre los modelos terapéuticos, ni la evidencia de que estas terapias arrojen mejores resultados que la terapia de apoyo o la atención médica general. Estos hallazgos indican la necesidad de un enfoque más integrado. La implementación del tratamiento transdiagnóstico y transteórico requiere una valoración más detallada sobre la patología de la personalidad, que la proporcionada por los diagnósticos actuales, para identificar las deficiencias que conforman los objetivos de cambio, y un esquema para organizar la terapia y coordinar la aplicación de una matriz ecléctica de intervenciones. El artículo describe una forma práctica de conceptualizar la valoración con fines de tratamiento y un marco para organizar y administrar la terapia.

Palabras clave: *trastorno de personalidad, terapia transdiagnóstica, terapia transteórica, tratamiento psicológico*

The article has four sections. The first section outlines the case for trans-diagnostic treatment based on the conceptual and empirical limitations of current diagnostic classifications and the nature of personality pathology. This section also argues that trans-diagnostic treatment for personality disorder implies the use of a integrated or trans-theoretical treatment model. The second section offers further justification for trans-theoretical treatment based on the results of outcome studies and the conceptual and practical limitations of current therapies. The third section discusses the diagnostic assessment implications of trans-diagnostic and trans-theoretical treatment. The final section outlines a general framework of organizing and delivering trans-theoretical and trans-diagnostic therapy. and a tendency to organize textbooks on treatment around categorical diagnoses as if each required a radically different therapeutic approach. The merits of this strategy are challenged by two emerging themes. First, the value of basing treatment around specific diagnoses is questionable given: (i) the persistent failure to identify discrete diagnostic types; (ii) the limited clinical utility of current diagnoses; (iii) changes in diagnostic classification that emphasize the common or general features of personality disorder as opposed to discrete categories; and (iv) evidence that severity has more prognostic value than specific diagnoses. Second, the value of developing multiple therapies based on traditional schools of thought is challenged by accumulating evidence the different therapies do not produce clinically significant differences in outcome and that these therapies are not more effective than either supportive therapy or good clinical care. These findings point to the value of a more integrated and trans-theoretical mode of treatment.

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1. RATIONALE FOR TRANS-DIAGNOSTIC TREATMENT

The idea of organizing treatment around discrete diagnoses each requiring a distinct treatment strategy is not a viable or evidence-based way conceptualize the treatment of personality disorder. Current categorical taxonomies are little more that heuristics for organizing clinical information (Hyman, 2010) that lack the empirical support needed to provide a solid foundation for treatment development.

DIAGNOSTIC CLASSIFICATION

DSM-IV/5 and ICD-10 categorical diagnoses are poorly suited to organize treatment for multiple reasons. Briefly, these diagnoses are too broad be useful in planning treatment and selecting interventions because psychotherapeutic and pharmacological interventions are typically selected to target specific impairments such as deliberate self-injury, emotional dysregulation, and impulsivity rather than global diagnoses such as borderline or antisocial personality disorders (Sanderson & Clarkin, 2013). More fundamentally, contemporary taxonomies lack the scientific credibility needed to provide a solid foundation for treatment. These taxonomies fail to meet the design requirements of providing exclusive and exhaustive diagnostic classification. Rather being exclusive, diagnostic categories show extensive patterns of co-occurrence so that patients meeting criteria for a single diagnosis are comparatively rare. Rather than providing an exhaustiveness classification, they fail to capture many clinical presentations leading to extensive use of the *personality disorder not otherwise specified* diagnosis (Verheul & Widiger, 2004). Moreover, robust research shows that the features of personality disorder are not organized into discrete categories and that disorders merge with each other and with normal personality variation. Consequently, personality disorder taxonomies lack structural validity: empirical analyses fail to identify structures that resemble current diagnostic constructs (Jacobs & Krueger, 2015).

The multiple limitations of current taxonomies of personality disorder point to the need for more clinically useful taxonomic systems (Livesley, 2018). One trend in this direction pertinent to trans-diagnostic treatment is the increasing attention given to delineating the common features of personality disorder and defining severity. This suggests that personality disorder may be conceptualized as having two components: (i) core features common to all personality disorders, namely chronic interpersonal dysfunction and self/identify problems; and (ii) the specific features of different disorders (Livesley, 1998, 2003a, b). The significance of this trend is highlighted by evidence that severity is a more important prognostic indicator than type of disorder (Crawford, Koldobsky, Mulder, & Cottaux, 2011) and by the emphasis that DSM-5 places in assessing the core features of personality disorder.

COMPATIBILITY WITH PERSONALITY PATHOLOGY

Since trans-theoretical treatment is primarily concerned with specific impairments and the sequence for treating them rather than diagnosis *per se,* it is highly compatible with the multi-faceted psychopathology of personality disorder. The disorder is characterized by wide ranging impairments that vary in nature and severity across patients. This degree of heterogeneity presents a major challenge to protocol driven therapies based on specific diagnostic concepts. Effective management of such complex psychopathology requires a way to decompose global disorders into more specific domains of impairment because specific

inventions are largely selected to address specific impairments. The two-component structure of personality disorder described previously is consistent with this requirement. With this approach, diagnostic assessment focuses on assessing both the common features of general personality disorder including severity and individual differences in clinical presentations as represented by a profile of dimensions and, as will be discussed later, the assessment of specific domains of impairment.

LACK OF EVIDENCE FOR DIAGNOSIS SPECIFIC EFFECTS

A further reason to adopt trans-diagnostic treatment is lack of evidence of substantial diagnosis-specific effects. Although there is evidence of domain-specificity in treatment effects (Piper & Joyce, 2001), these differences apply to specific problems and impairments that cut across diagnoses rather than the diagnoses themselves. However, it should be noted that until fairly recently, few empirical studies of this problem were reported. The situation has changed with the publication of several studies showing that some therapies developed specifically for BPD are also effective in treating other personality disorders.

For example, Bamelis, Evers, Spinhoven, and Arntz (2014) investigated the effectiveness of schema-focused therapy (Young, Klosko, & Weishaar, 2003) in treating a variety of personality disorders including borderline, antisocial, schizotypal, or schizoid personality disorder. Outcome did not differ significantly across disorders. Similarly, Clarke, Thomas, and James (2013) showed that cognitive analytic therapy (Ryle, 1997; Ryle & Kerr, 2002) was effective in treating various forms of personality pathology. There is also evidence that cognitive behavioural therapy for personality disorder (Davidson, 2008) is equally effective for borderline and antisocial personality disorders (Davidson, Tyrer, Tata, Cooke, Gumley, Ford, et al., 2009). Although evidence remains limited, it consistently suggests that commonly used therapies are effective across most forms of personality disorder not just the one that they were specifically developed to treat.

CONCLUSION

The wide-ranging limitations of current classifications and increased concern with assessing the common features of personality disorder and domains of impairment point to the importance of thinking about treatment in trans-diagnostic terms. Since trans-diagnostic treatment focuses on identifying specific impairments that often cut across traditional diagnostic categories that are targeted with specific interventions. Ideally, these interventions would be selected based on evidence of efficacy. However, initially many interventions would need to be selected on the basis of rational considerations because little empirical information is available. An unfortunate consequence of diagnosis-driven treatment is that outcome research has primarily focused on whether the efficacy of a given therapy for a given diagnoses rather than on what works for different domains of impairment. Implementation of trans-diagnostic treatment would also require a more integrated

and trans-theoretical treatment model because the diverse and multi-facetted impairments associated with personality disorder requires a more comprehensive array of interventions than is provided by a single therapeutic model.

2. RATIONALE FOR TRANS-THEORETICAL TREATMENT

The rationale for trans-diagnostic treatment fits well with the results of treatment outcome studies. Evidence that specialized therapies for personality disorder do not show clinically significant differences in outcome suggests it may be more effective to integrate these therapies rather than rely on a single model. This approach is also supported by a consideration of the conceptual and practical limitations of current therapies: most therapies focus primarily on a limited set of impairments using narrow array of treatment methods and none offer the range of interventions needed to treat the diverse components of personality disorder.

SIMILAR OUTCOME ACROSS THERAPIES

All therapies for personality disorder evaluated to date produce significant change and are more effective than treatment as usual or treatment by experts (Koons et al., 2001; Budge et al., 2014; Doering, Hörz, Rentrop, Fischer-Kern, Schuster, Benecke, et al. 2010; Linehan et al. 2006; Verheul et al., 2003). Randomized controlled trials testify to efficacy of dialectical behavior therapy (DBT; Linehan, 1993), cognitive analytic therapy (CAT; Ryle, 1997), schema-focused therapy (SFT; Young, Klosko, & Weishaar, 2003), cognitive therapy for PDs (CBTpd; Davidson, 2008), mentalization-based therapy (MBT; Bateman & Fonagy, 2004, 2006), systems training for emotion predictability and problem solving (STEPPS; Black & Blum, 2017), and transference-focused psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 1999, 2006). Although these therapies differ in conceptual approach and primary treatment methods, they do not yield clinically significant differences in outcome (Bartak et al., 2007; Budge et al., 2014; Cristea et al., 2017; **Leichsenring** & Leibing, 2003; **Leichsenring,** Leibing, Kruse, New, & Leweke, 2011; Mulder & Chanen, 2013). Claims are occasionally made that some therapies are superior to others. For example, SFT is said to show fewer dropouts and produce better outcomes that TFT (Giesen-Bloo (Yeomans, 2007).

Besides lack of evidence of important differences in efficacy, the specialized therapies are not more effective than supportive therapy or well-defined, manualized general psychiatric care. For example, a comparison of TFP, DBT, and supportive dynamic treatment over 1 year and found few differences across multiple outcome measures (Clarkin, Levy, Lenzenweger, and Kernberg (2007), DBT is not demonstrably more effective than general psychiatric management (McMain et al., 2009), MBT is not significantly better than structured clinical management (Bateman & Fonagy, 2009), and CAT is not significantly better than manualized good clinical care (Chanen et al., 2008). Similarly, comparisons between specialized therapies and supportive therapy failed to find differences in effectiveness: supportive

therapy produced similar results to both TFT and DBT (Clarkin et al, 2007) and MBT (Jorgensen et al., 2013; Jørgensen et al., 2014).

The results of outcome studies paint a compelling picture. Treatments for personality disorder are modestly effective but it does not seem to matter what treatment is used: specialized therapies, good clinical care, and supportive therapy produce comparable results. Thus, nothing appears to be gained from using a specialized therapy: the important factor seems to be the use of a structured approach (Critchfield & Benjamin, 2006) that was designed specifically for personality disorder. These findings point to the importance of change mechanisms common to all therapies as opposed to mechanisms specific to a given approach. This is consistent with the results of psychotherapy generally showing that outcomes for the treatment of most mental disorders and psychological problems is similar across all therapies (Beutler, 1991; Castonguay & Beutler, 2006a,b, Luborsky, Singer, & Luborsky, 1975). The findings provide a cogent rationale for adopting an trans-theoretical approach that combines the essential components of all effective therapies.

LIMITATIONS OF CURRENT THERAPIES

Outcome research has largely focused on efficacy assessed using relatively global criteria and hence limited information is available on what changes these therapies bring about and what impairments remain after treatment. However, two general conclusions seem warranted. First, change does not occur uniformly across all aspects of personality pathology. Therapy primarily leads to symptomatic improvement, reduced self-harm, decreased hospital admissions including those for medical problems. Second, substantial functional impairments remain following treatment (McMain et al., 2009; Kröger, Harbeck, Armbrust, & Kliem, 2013) and overall functioning, social adjustment, and quality of life remain poor (Cameron, Palm Reed, & Gaudiano, 2014). For example, McMain and colleagues (2012) noted that although both DBT and general psychiatric managment lead to improvment across a broad range of outcome variables, 53% of their patients were neither employed nor in school, 39% were receiving psychiatric disability support after 36 months, and participants continued to exhibit high levels of functional impairment. A meta-analysis by Cristea and colleagues (2017) concluded that outcome change was modest and not very stable. These are important observations that suggest the need to rethink how we are approaching the treatment of these disorders.

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Although these findings are largely based on studies of DBT (McMain et al., 2009; Kröger et al., 2013), they also occur with other therapies (McMain, et al., 2012). Nevertheless, the fact that substantial residual problems remain after DBT is important because this therapy is the most extensively investigated therapy and often considered the treatment of choice. Such findings suggest the need therapeutic

models that are more effective in treating impaired social adjustment and self and interpersonal pathology. Attention also needs to be given to improving patient retention: the high dropout associated with all treatments (Cameron et al., 2014) is serious because those who drop out of therapy tend to do badly (Karterud, et al., 2003).

CONCLUSIONS

Although common change mechanisms form the basic structure of integrated treatment, they are not sufficient. A second approach to psychotherapy integration is technical eclecticism which uses effective interventions from all effective therapies. This approach is also pertinent to personality disorder because it would help to ensure comprehensive coverage of all components of personality pathology. As noted earlier, although none of the current therapies is comprehensive, if combined they include interventions that cover most personality impairments. This approach would also ensure that all effective interventions are used regardless of their conceptual lineage. However, implementation of trans-*diagnostic and trans-theoretical* treatment would require changes in diagnostic assessment and the construction of a preliminary framework for conceptualizing and delivering treatment. These are the themes of the next two sections (Grencavage, 1989; Norcross & Newman, 1992; Stricker, 2010). Since these mechanisms account for the greatest proportion of outcome change, there are strong reasons for making these mechanisms the foundation of trans-theoretical therapy. This idea seems especially pertinent to treating personality disorder because the strong focus on relationship factors that a common factors approach entails is especially pertinent to treating a disorder that is characterized by chronic interpersonal dysfunction (Livesley, Schroeder, Jackson, & Jang, 1994; Livesley, 1998, 2003b).

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3. DIAGNOSTIC ASSESSMENT FOR TRANS-THEORETICAL TREATMENT

The central diagnostic question for planning the overall approach to treatment is whether the individual has personality disorder and, if so, what is the level of severity. The presence of personality disorder determines the broad directions of treatment and the primary methods used whereas severity influences the relative balance between change-focused and supportive/generic interventions, and treatment intensity and dosage. In general, with increasing severity, greater use in made of more supportive and generic interventions as will be discussed later and less intense treatment. The distinction between change-focused and support interventions is similar to the traditional psychodynamic distinction between expressive and supportive therapy. This readily achieved using two-component model of personality disorder discussed earlier. With this structure assessment establishes: (i) the presence of personality disorder and level of severity; (ii) individual differences in clinically significant personality dimensions including impairments across domains of personality functioning (Livesley, 2017; Livesley & Clarkin, 2015; Clarkin, Livesley, & Meehan, 2018).

Diagnosis of general personality disorder is based on impairments in self and interpersonal functioning, an approach also adopted by DSM-5 and proposed for ICD-11. When assessing the self-pathology, the factors to consider are whether the patient has: (i) a rich variety of variety of schemas and other constructs to represent the self as opposed to an impoverished sense of self (ii) a self structure that

The individual differences in personality pathology component of the two-component model of personality disorder involves assessing: (a) the patient's salient personality traits; and (b) impairment across different domains of personality functioning. Although a variety trait models of personality disorder have been proposed, a practical approach for treatment purposes suggests that it is sufficient to evaluate of three broad trait constellations: emotional dysregulation (anxiousness, fearfulness, insecure attachment, submissive-dependency, and social apprehensiveness), dissocial behaviour (aggressivity, impulsivity, sensation seeking, callousness, dominance, disregard for social and cultural norms, and grandiosity), and social avoidance (low affiliation, restricted emotional expression, and self-reliance). These constellations are consistently identified in statistic analyses of personality disorder They also resemble the five-factor model dimensions of neuroticism, negative agreeableness, and introversion, respectively. Assessment of these broad features is structure that is integrated or fragmented and unstable; (iii) the capacity for self-directedness as opposed to having difficulty setting and attaining goals (Livesley, 2003a; Livesley & Clarkin, 2015). The assessment of severity (personality disorder versus severe personality disorder) is also based on these features. Assessment of chronic interpersonal dysfunction – the second component of general personality disorder – is based on the patients ability to sustain intimate relationships. This ability is readily evaluated from information

obtained when taking a personal history. Those with less severe disorder usually have a history of relationships but they never seem to work out whereas those with more severe disorder show either little evidence of lasting relationships or a tendency to form enmeshed and symbiotic relationships. When assessing severity, it should be noted that severity refers to the level of personality impairment not degree of symptomatic distress because the two are often confused.

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The first pathway involves a relatively prolonged initial engagement and containment phase with high therapist activity to contain and settle the unstable emotions and impulses associated with suicidality, deliberate self-harm, violence, acting-out tendencies, and aggressiveness. Once containment is achieved and crisis behaviors settle, attention is given to a the relatively lengthy process of building emotion and impulse control. Although the self-regulation impairments associated with these constellations differ, both involve difficulty with identifying emotions, emotional tolerance, anger management, effortful control, and emotion regulation. Following improved emotion and impulse control, the treatment pathways for the two constellations diverge. The pathway for the emotional dysregulation constellation focuses on the core interpersonal conflict between dependency and attachment insecurity and fear of rejection whereas the dissocial pathway focusing more on building empathy and prosocial behaviour and modulating entitlement and callousness. propose two broad treatment pathways: a common pathway for patients with emotional dysregulation and dissocial traits at least during the early phases of treatment, and a different pathway for patients with the socially avoidant traits.

The pathway proposed for patients with constricted emotions and social avoidance involves a more prolonged emphasis on engagement and a different level of therapist activity. The initial emphasis is almost entirely on establishing contact

with the patient and building a reasonable working treatment alliance with less concern with containment. Progress is often slow and depends on a nonintrusive approach to avoid causing further withdrawal. As the alliance improves, it may be possible to focus gradually on building emotion tolerance and fostering emotional awareness. However, with many patients

Although trait assessment is useful, the most importance aspect of individual differences for integrated treatment is the assessment of different domains of impairment because this is the basis for selecting interventions throughout therapy. The impairments associated with personality disorder are extensive and include all aspects of the personality system. Although these impairments may be described in a variety of ways, clinical accounts of personality pathology typically refer to four broad domains of functional impairment:ith many patients treatment largely involves promoting acceptance of key personality traits and finding ways to help the patient to use these traits more adaptively with a view to helping the patient to construct a lifestyle that is compatible with their basic personality characteristics.

1. Symptoms such as dysphoria, self-harm, quasi-psychotic symptoms, rage. ese impairments may be described in a variety of ways, clinical accounts of personality pathology typically refer to four broad domains of functional impairment:
2. Regulation and modulation problems, including difficulty regulating emotions and impulses and impaired metacognitive processes, leading to problems with self-reflection and effortful control. Regulatory impairments are manifested as either under-control of emotions and impulses, which leads to unstable emotions and impulsive behavior as seen in patients with emotional dysregulation (
3. Interpersonal problems, including difficulty establishing relationships, intimacy and attachment problems, conflicted and constricted interpersonal patterns, unstable relationships, entitlement, and disregard for others.) pathology, or over-control, leading to emotional constriction as observed with social avoidance (schizoid-avoidant and obsessive-compulsive) pathology.
4. Self- or identity impairments, involving difficulty regulating self-esteem, maladaptive self-schemas, unstable sense of self or identity, and a poorly developed self-system. and constricted interpersonal patterns, unstable relationships, entitlement, and disregard for others.

These domains are sufficient to organize a patient's diverse impairments in a way that facilitates treatment planning and delivery (Livesley, 2003a, 2017). In general, each domain is treated with a different set of specific intervention modules. For example, symptoms may be treated with medication and specific cognitive interventions and problems in the regulation domain are best treated with cognitive-behavioural modules that enhance skills in self-regulating emotions such as emotion recognition, distress tolerance, and attention control. Decomposing

personality disorder into domains is helpful in establishing the sequence for treating the different components of personality pathology and hence for using specific intervention modules. Domains differ in stability and the possibility for change either with or without treatment (Tickle et al., 2001). Hence treatment can be organized as a sequence in which the most changeable domains are addressed first because this increases the probability of progress early in therapy. Symptoms are the most variable and treatable domain; many symptoms fluctuate naturally and many resolve early in treatment. Thus, an early focus on symptom reduction, helps to build the alliance and motivation for change. Regulatory and modulatory impairments are more stable but also tend to change relatively early in treatment, as evidenced by the results of studies of cognitive-behavioral therapies. This suggests that this domain should be addressed once symptomatic stability is achieved, a strategy that is consistent with emerging research that enhanced emotion regulation is a critical component of change (Gratz, Levy, & Tull, 2012; Gratz, Bardeen, Levy, Dixon-Gordon, & Tull, 2015; McMain et al., 2013). The greater stability resulting from symptomatic improvement and increased self-regulation then permits more attention to the interpersonal domain. The most stable domain is self/identity, which appears to change relatively slowly. Since many interventions are specific to a given domain of impairment, the sequence for addressing domains helps to coordinate the use of specific interventions.

4. A FRAMEWORK OF ORGANIZING TRANS-THEORETICAL AND TRANS-DIAGNOSTIC TREATMENT

Intervention modules consist of general treatment modules based on change mechanisms common to all effective therapies and specific treatment modules consisting of interventions drawn from the various specialized therapies to target specific problems and impairments. The distinction between general and specific modules is important. General modules are used with all patients throughout treatment to create the basic structure of therapy. Specific modules are added to this structure as needed to treat the problems of individual patients. Since the problems addressed in therapy change as therapy progresses, the specific interventions used also changes as therapy progresses. The distinction between general and specific modules implies that interventions fall into a hierarchy. Interventions needed to ensure safety of the patient and others have priority. Once safety is assured, general treatment methods are used to promote engagement, build an effective alliance, and establish conditions for change. When these conditions are met, specific interventions are used as needed to treat the problem at hand. descriptive model of how personality pathology changes during therapy.

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The second component of IMT, the *phases of change model*, proposes that treatment typically progresses though five phases: (i) safety, (ii) containment, (iii) regulation and modulation, (iv) exploration and change, and (v) integration and synthesis. Each phase primarily addresses a different domain of personality pathology and hence each phase is typically associated with a different set of specific interventions.

GENERAL TREATMENT MODULES

Strategies and interventions based on common change mechanisms may be conceptualized in different ways. With ITM, these interventions are organized into six general treatment modules: (i) structure, (ii) treatment relationship, (iii) consistency, (iv) validation, (v) self-reflection, and (vi) motivation. The first four modules are primarily concerned with establishing the conditions within therapy know to be associated with positive outcomes whereas the other modules are more concerned with promoting the within-patient conditions needed for change to occur.

Module 1: Establish a Structured Treatment Process: A major therapeutic factor linked to positive outcomes is the use of a highly structured approach based on a clearly defined conceptual framework (Critchfield & Benjamin, 2006) which allows therapy to be delivered in a consistent and coordinated way. All effective treatments for BPD emphasize the importance of a structured process based on an explicit treatment model and a well-defined treatment frame consisting of the therapeutic stance and treatment contract. The stance refers the interpersonal behaviours, attitudes, responsibilities, and activities that determine how the therapist relates to the patient. Based on current evidence, IMT adopts a supportive, empathic, and validating stance (Livesley, 2003). A key ingredient of structure is the therapeutic contract established prior to treatment that defines collaborative treatment goals and the practical arrangements for therapy.

Module 3: Maintain a Consistent Treatment Process: Effective outcomes also depend on maintaining a consistent treatment process. Consistency is defined simply as adherence to the frame of therapy. This is why the treatment contract is so important: it provides a frame of reference that helps the therapist to monitor

treatment and identify deviations from the frame by either the patient or therapist. Violations of the frame are relatively common when treating personality disorder and it is important that they are addressed promptly and supportively. collaborative relationship provides support, builds motivation, and predicts outcome. With most patients with personality disorder, it takes time and effort to build a truly collaborative relationship and, in many ways, collaboration is more the result of effective treatment than a prerequisite for treatment. Although a collaborative relationship is basic to treating any mental disorder, it has additional significance with personality disorder because impaired relationships characterise the disorder and even greater attention needs to be given to promoting the alliance. Also, a sustained focus on the alliance is useful in maintaining consistency, providing support and validation, and developing trust. It also provides a vehicle to change maladaptive schemas involving distrust, abandonment, rejection, intimacy, and control that are a feature of most cases. A good relationship and the associated sense of safety also promotes openness to new ideas, reduces the rigidity that is a characteristic feature of personality disorder (Fonagy & Lutyen, 2018), and promotes the intrinsic motivation needed for change (Ryan & Deci, 2000). Finally, an important part of building and maintaining an effective alliance is the therapist's ability to monitor the alliance carefully and intervene promptly when problems emerge (Safran, Muran, & Samstag, 1994; Tufekcioglu & Muran, 2015).

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Module 5: Enhance Self-Knowledge and Self-Reflection: Most therapies encourage patients to develop a better understanding of how they think, feel, and act, and become more aware of the links between their mental states and problem behaviour. The extent and depth of self-knowledge and self-understanding depend on self-reflection: the capacity to think about and understand one's own mental states and those of others. Impaired self-reflection hinders the development of important aspects of the self that are constructed by reflecting in depth on one's own mental processes. Self-reflection also underlies the capacity for self-regulation and effective goal-directed action.the empathy and support needed to build a collaborative alliance. At the same time, they counter the self-invalidating way of thinking, which is often instilled by asverse developmental experiences.

Module 6: Build and Maintain Motivation for Change: A second within-patient factor necessary for effective outcomes is motivation of change. Patients need to be motivated to seek help and work consistently on their problems. Unfortunately, passivity and low motivation are common consequences of

psychosocial adversity. For this reason, motivation cannot be a requirement for treatment. Instead, therapists need to become skilled in building motivation and to make extensive use of motivation-enhancing techniques.

Implementation of the general modules means that treatment is organized around a strong therapeutic relationship characterized by support, empathy, consistency, and validation. Priority is given to the relationship due to the serious problems most patients have experienced with attachment relationships and their consistent difficulties with interpersonal relationships. The objective is to establish a treatment process that provides a continuous corrective therapeutic experience to counter the lasting effects of psychosocial adversity. This is an important aspect of therapy: change is brought about not only by interventions of one kind or another but also by the way therapy is organized and delivered.: A second within-patient factor necessary for effective outcomes is motivation of change. Patients need to be motivated to seek help and work consistently on their problems. Unfortunately, passivity and low motivation are common consequences of psychosocial adversity. For this reason, motivation cannot be a requirement for treatment. Instead, therapists need to become skilled in building motivation and to make extensive use of motivation-enhancing techniques.

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PHASES OF CHANGE MODEL

The sequence for addressing domains partly reflects the clinical priority given to symptoms including suicidality and self-harm and partly the degree to which problems associated with a given domain are amenable to change (Tickle et al., 2001). In general, the sequence of symptoms, regulation and modulation, interpersonal, and self/identity reflects increasing stability of personality pathology and its resistance to change with the regulation of emotions and impulses and the development of skills and strategies needed to improve self-regulation. With further progress, the focus moves to interpersonal issues and later to self-pathology and building a life worth living. This sequence serves as a guide for selecting specific interventions. A challenge for trans-theoretical treatment is to coordinate the use of a diverse array of specific interventions with different theoretical origins without therapy becoming confusing and disorganized. The phases of change model resolves this problem because each phase addresses a different domain of impairment

and hence requires different specific intervention modules. The first two phases, safety and containment, primarily deal with the symptom domain. The third phase, control and modulation, continues the focus on symptom resolution but deals primarily with emotion and impulse dysregulation and associated suicidal and self-harming behaviour. Phase four, exploration and change, focuses primarily on interpersonal impairments using a more diverse array of interventions, and phase five, integration and synthesis, deals with the self/identity domain.

Phase 1. Safety: Treatments that begin with patients in a decompensated crisis state are usually concerned initially with safety issues. This is achieved primarily by providing structure and support. Interventions are largely generic and non-specific – providing the support and structure as needed to keep the patient safe until the crisis resolves – although medication may also be used in some instances.its resistance to change.

Phase 2. Containment: The safety phase is typically short and progresses rapidly

Phase 2. Containment: The safety phase is typically short and progresses rapidly and seamlessly to containment where the goal is to contain and settle emotional and behavioural instability and restore behavioural control. The goals is to help the patient to return to his or her pre-crisis level of functioning as quickly as possible and engage the patient in therapy. As with the safety phase, this is achieved through support, empathy, and structure, supplemented if necessary with medication. The safety and containment phases compose what is typically described as crisis management.

Phase 3. Regulation and Control: Crisis resolution is usually accompanied by increased stability and the beginnings of an effective treatment relationship. These developments allow therapy to progress to a focus on improving emotional dysregulation, decreasing impulsivity, and reducing symptoms including deliberate self-harm, suicidality, uncontrolled anger, and the consequences of trauma. Specific interventions are used to: (i) provide psychoeducation about emotions and emotional dysregulation; (ii) increase awareness, acceptance, and tolerance of emotions; (iii) improve emotion regulation; and (iv) enhance the capacity to process emotions. Emphasis is placed on cognitive-behavioural interventions because of evidence of the effectiveness of these interventions in reducing deliberate self-harm and increasing emotion-regulating skills (Linehan et al., 1991, STEPPS (Blum et al., 2008; Black & Blum, 2017) and CBT (Davidsonet al., 2006; Evans et al., 1999). However, skill development is not considered sufficient: it is also important to improve the ability to process emotions more adaptively. Although cognitive-behavioural interventions are also useful for this purpose, they usually need to be supplemented with interventions that promote meta-cognitive functioning and methods that help patients to construct meaningful narratives about their emotional life. Inevitably, this work begins to involve interpersonal problems that are linked to and often trigger intense emotional reactions and hence treatment gradually

moves to the next phase.

Phase 4. Integration and Synthesis: The final phase deals primarily with the self/identity domain. In general terms, the goal is to help patients to "get a life." This involves developing a more adaptive life script, creating a more satisfying and rewarding way of living, and acquiring greater purpose and direction to their lives. Although only a few patients reach this stage, all patients need help throughout therapy with building a more congenial lifestyle to help them to maintain the changes they have made. Consequently, throughout treatment, therapists need to be aware of the importance of helping patients to construct a personal niche that allows them to express their personal hopes and aspirations, talents, interests, and personality attributes and to avoid circumstances and relationships that activate their conflicts and vulnerabilities. Nevertheless, the formulation of a more adaptive identity is largely the accomplishment of the latter part of treatment that becomes possible as a result of the

Phase 5. Integration and Synthesis: The final phase deals primarily with the self/identity domain. In general terms, the goal is to help patients to "get a life." This involves developing a more adaptive life script, creating a more satisfying and rewarding way of living, and acquiring greater purpose and direction to their lives. Although only a few patients reach this stage, all patients need help throughout therapy with building a more congenial lifestyle to help them to maintain the changes they have made. Consequently, throughout treatment, therapists need to be aware of the importance of helping patients to construct a personal niche that allows them to express their personal hopes and aspirations, talents, interests, and personality attributes and to avoid circumstances and relationships that activate their conflicts and vulnerabilities. Nevertheless, the formulation of a more adaptive identity is largely the accomplishment of the latter part of treatment that becomes possible as a result of the resolution of more distressing problems. Although it is difficult to construct a coherent self-structure and there is little empirical research to help identify effective strategies, consistent application of the general therapeutic strategies plays an important part in the process by creating a treatment environment that challenges core schemas and promoting self-understanding by providing consistent and veridical feedback. It also creates the safe and trusting relationship that allows patient to be more open to new information and explore new possibilities. These developments are critical to self-development and to the use of narrative methods build a more adaptive self story.

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