



Thèse de privat-docent

2018

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Mentalisation-Based Therapy for Borderline Personality Disorder: short review, implementation in French and future perspectives

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How to cite

PRADA, Paco Boris. Mentalisation-Based Therapy for Borderline Personality Disorder: short review, implementation in French and future perspectives. Privat-docent Thesis, 2018. doi: 10.13097/archive-ouverte/unige:112880

This publication URL: <https://archive-ouverte.unige.ch/unige:112880>

Publication DOI: [10.13097/archive-ouverte/unige:112880](https://doi.org/10.13097/archive-ouverte/unige:112880)



**UNIVERSITÉ
DE GENÈVE**

FACULTÉ DE MÉDECINE

Clinical Medicine Section

Department of Psychiatry

**“Mentalisation-Based Therapy for Borderline Personality Disorder:
short review, implementation in French and future perspectives”**

**Thesis submitted to the Faculty of Medicine of
the University of Geneva**

for the degree of Privat-Dozent

by

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Geneva

2018

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Summary

Borderline personality disorder (BPD) is therapeutically challenging for psychiatrists and psychotherapists. In the course of our clinical practice, both in outpatient and in inpatient settings, we are frequently brought into contact with patients who suffer from BPD. The difficulties we are met with are closely related to the key dimensions of this disorder, which are a perturbed sense of identity, emotional dysregulation, perturbed impulse control and interpersonal relationships marked by a tendency to idealisation and devaluation. The healthcare we provide is therefore characterised by heightened emotional intensity, frequent acting out, in particular in a self-damaging or suicidal manner, and early therapy discontinuations. These challenges have contributed to the emergence of specialised therapies. Among these, the mentalisation-based therapy (MBT) developed by Bateman and Fonagy has garnered a significant amount of interest. This study provides a short review of borderline personality disorder and mentalisation-based therapy, and goes on to describe the work conducted to adapt and import MBT into French. It concludes by describing the perspectives that the treatment offers in terms of our clinical practice as we work with patients suffering from borderline personality disorder, but also with other patients.

Foreword and acknowledgements

This study is the culmination of a decade of clinical activities and research conducted at the Department of Psychiatric Specialities, and specifically for the purpose of a programme specialising in healthcare for patients suffering from borderline personality disorders, the Emotional Regulation Disorders (ERD) programme. I describe herein the activities we undertake with these patients and, in particular, our use of MBT, which is the very first implementation of this therapy in French.

This work was conducted alongside two valued colleagues, whom I would like to take the opportunity of mentioning and to whom I extend my warmest thanks. First, my very good friend, Dr Nader Perroud, whom I was fortunate enough to meet to make all of this possible. Secondly, Professor Jean-Michel Aubry, whose support, trust and kindness I am very grateful for. My very dear colleagues from the ERD programme: Rosetta Nicastro, Karen Dieben, Venus Kaby, Gérald Bouillault, Caroline Waeber, Sophie Blin, Agnès Reymond, Roland Hasler, Eleonore Pham, Deborah Badoud, Julien Zimmermann, Eva Rüfenacht, Eleni Kalogeropoulou, Pierre Cole, and Sébastien Weibel. I would also like to thank those who left us along the way: Jean-Jacques Kunckler, to enjoy well-deserved retirement after having helped me set up our first mentalisation therapy groups. Finally, Brigitte Blanchon, whose sudden loss this summer came as a saddening shock to us all. Esteemed colleagues, I feel immensely privileged to have had the opportunity of sharing this time with you. This work is also yours and, in putting it down on paper, I was happy to look back on the long road we have travelled together, for all its beauty but also for the suffering we have shared along the way.

This work is the result of exceptional encounters and collaborations with great specialists in the field of personality disorders. I would like to thank Professor Martin Debbané and the team of the Anna Freud Centre in London, in particular Professor Peter Fonagy and Dr Anthony Bateman.

I would also like to thank all our patients for placing their trust in us. It has been a privilege and an incredible life lesson to support them throughout these therapies and to witness their immense courage as they face their difficulties. They are the ones who taught me the most.

I dedicate this work to Marina, Paloma and Lorenzo, my greatest loves. For my mother and father.

Introduction

Objectives

As we will see, the treatment of Borderline Personality Disorder (BPD) is therapeutically challenging for patients, for therapists and more broadly for the healthcare system. This is a field of psychiatry whose significance is undervalued, although it relates to a frequent disorder, the consequences of which are often severe. However, it is also a field rich in recent developments, in particular relating to psychotherapy, which is a feature that merits to be highlighted here.

This study examines the very first importation and implementation of mentalisation-based therapy (MBT) in a French-speaking centre, and is therefore a pioneering work in this area.

It is important to mention that this study was conducted in an adult outpatient psychiatry centre specialised in providing healthcare to patients suffering for BPD. Initially, the centre only offered one therapy modality: the dialectical behaviour therapy (DBT) developed by M. Linehan.

The first question that arises is also the first question we were faced with when we undertook this work and applied for funding: what is the purpose of importing a new therapy when the programme and its participating therapists are already specialised in a form of psychotherapy that is suited to the treatment of BPD? We saw several advantages in importing and implementing a new form of therapy in our centre. Firstly, despite all they have in common, these treatments follow different psychotherapeutic directions; DBT is a cognitive behavioural approach, whereas MBT follows a psychodynamic orientation. The idea was that by offering treatments in both psychotherapeutic approaches, our centre would broaden its skillset, enhance its psychotherapeutic culture, and break free from a form of isolation by bridging the gap between these two models that share many commonalities, as will be shown below (Swenson and Choi-Kain 2015¹). Our goal was to turn our centre into a facility recognised by therapists from both “sides”. Furthermore, our project allowed our centre to grow from a unit specialising in DBT and providing treatment to borderline patients, to a centre specialised in the psychotherapy of personality disorders in a broader sense. In fact, our experience has shown that by drawing on our expertise, we were able to develop versions of these therapies that are especially well suited to the treatment of another disorder, attention-deficit and hyperactivity disorder (ADHD). This has helped us extend our healthcare offering, making it more dynamic and modern, and has allowed us to share our newfound knowledge through training programmes. It has also served as a basis for new and exciting collaborations and partnerships with our colleagues in centres in France, Canada, England, and, of course, in other parts of Switzerland, including French-speaking Switzerland.

This paper therefore relates to a portion of our overall work. I have conducted a synthetic review of literature to better integrate our approach and our research in the modern context of BPD and the psychotherapies relating to this disorder. In conclusion, I share my insights into ways of furthering and developing these activities and describe future MBT applications that can be expected in our local Geneva healthcare system.

Borderline personality disorder and its treatment

To provide the reader with a better understanding of the MBT model, we will first examine the broader aspects of BPD. MBT shares some commonalities with other therapies that have been recognised as effective in treating patients with BPD. Most of these are described herein, whereas more specific elements are examined in the section relating to the detailed MBT model.

Definitions

Defining the terms “personality” and “personality disorder” is a complex task. Personality is defined as all of a person’s characteristics, making that person unique over the course of time, and providing him/her with a permanent character. It is all that contributes to an individual’s manner of being, both with respect to himself/herself and with respect to other human beings, in a manner that is specific to that individual. It includes biological, emotional, and psychological aspects (such as ideas, beliefs, and thoughts), as well as conscious and unconscious behaviours. It relates to the complex manner in which an individual is affected, reacts, thinks and behaves in different situations and interactions, which enables others to recognise that individual, and provides that individual with a core that remains stable through time (Kernberg 2016²).

Otto Kernberg describes personality as the result of various components (Kernberg 2016²). Temperament, which includes the reactivity of the organism on a psychomotor, cognitive and affective level, and therefore also comprises biological factors. Character, i.e. the usual behavioural reaction patterns displayed by a subject. Identity, i.e. the representation and experience of self with respect to another individual, which integrates relationship models formed during the subject’s childhood. The system of values, which can be more or less integrated and stems from the internalisation of “parent” figures and the rules and ideals they impose, and is important in terms of the psychotherapeutic prognosis. A contradictory and poorly-integrated system of values is associated with a poorer prognosis. Finally, intelligence, however difficult a concept it is to define, which is important in terms of the capabilities it provides to the individual.

Personality disorders are distortions of the personality characterised by a certain inflexibility of behavioural responses, inducing an inability to adapt, the inhibition of normal behaviours and excessive problematic behaviours, whereby the patient alternates between extreme and opposite reactions (for instance inhibited reactions and impulsive reactions). This leads to a vicious circle, where abnormal behaviours cause abnormal responses, which in turn serve to reinforce the initial abnormal behaviours (Kernberg 2016²).

Borderline personality disorder is defined in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5³) according to general criteria, i.e. criteria shared by all personality disorders, and according to criteria that are specific to BPD and that can be used to distinguish BPD from other disorders (DSM-5³).

The DSM-5 defines a personality disorder as follows: “An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, with at least two of the following areas affected: cognition, affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response), interpersonal functioning, and impulse control. This pattern is inflexible and pervasive across a broad range of personal and social situations. The enduring

pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning” (DSM-5).

This pattern is stable and its onset can be traced back at least to adolescence or early adulthood, and it is not better explained as a manifestation or consequence of another mental disorder (DSM-5).

Still according to the DSM-5, BPD is characterised by a “pervasive pattern of instability of interpersonal relationships, self-image and mood, as well as marked impulsiveness appearing in late adolescence or early adulthood, and present in different contexts.” For a confirmed diagnosis, the patient must meet at least five of the nine criteria of the disorder. The nine criteria according to the DSM-5 are listed in table 1. To establish a BPD diagnosis, a patient must meet at least five specific criteria out of the nine that relate to the disorder. There are therefore 151 possible combinations of the diagnostic criteria that are used for the diagnosis (Lieb et al. 2004⁴). Potentially, this amounts to 151 different clinical tables, reflecting great clinical heterogeneity and complexity. Theoretically, two BPD patients might only share one single diagnostic criterion.

1	frantic efforts to avoid real or imagined abandonment
2	a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
3	identity disturbance: markedly and persistently unstable self-image or sense of self.
4	impulsivity in at least 2 areas that are potentially self-damaging (e.g. excessive spending, sex, substance abuse, alcoholism, pathological gambling, reckless driving, binge eating or anorexia)
5	recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour
6	Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days)
7	chronic feelings of emptiness
8	inappropriate, intense anger (rage) or difficulty in controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights, sudden and exaggerated anger).
9	transient, stress-related paranoid ideation or severe dissociative symptoms
Table 1: Diagnostic criteria according to the DSM-5 for borderline personality disorder, published in <i>Diagnostic And Statistical Manual of Mental Disorders, 5th ed.,</i> ; American Psychiatric Publishing; Arlington, VA, 2013.	

It should be noted that discussing the patient’s personality disorder with the patient is not tantamount to defining the patient’s overall personality; instead, it is the process of pointing out certain personality traits that cause repeated suffering in various areas.

The category-based approach of the DSM is often criticized, and among alternative approaches, some include interesting descriptors that can be useful in clinical practice (Skodol et al. 2002⁵). For example, patients suffering from BPD are prone to regression when they find themselves in non-structured situations, in which they are at risk of adopting childish attitudes. Primary defence mechanisms include separation, projective identification and acting out, in a context where the experience of attachment remains insecure and object relations are perturbed (Skodol et al. 2002⁵). As we will see further on, each specialised therapy also offers its own specific theoretical understanding of BPD.

Brief history

The history of this disorder is marked by the question of the limit or the margin (border), and by treatment failure. The term borderline is used to describe a population of patients who do not respond to treatment in the usual manner, or whose clinical evolution follows a complicated and unconventional path (Gunderson 2009⁶). Initially, it was used to describe patients who fail to respond to psychoanalysis in the same way as neurotic patients, but who also display clinical reactions that threaten the treatment, and that are in particular marked by a tendency to regression and acting out.

As an adjective, it has been successively associated with various disorders, but with little success (Gunderson 2009⁶). For example, borderline depression, a complex form of posttraumatic stress or an alternative version of bipolar disorder are terms that have also been used. It should be mentioned that such notions tend to die hard, as the general population and psychiatrists alike are still prone to confusing them with bipolar disorder.

Influenced in particular by the works by Otto Kernberg on his concept of borderline personality organisation (Kernberg 1967⁷) and by John Gunderson who sought to characterise this disorder (Gunderson and Singer 1975⁸, Gunderson and Kolb 1978⁹), BPD was soon to become a fully-recognised personality disorder. This kindled interest in its study, which resulted in numerous papers being written on the subject. It also led to the development of specialised treatments and randomised studies and trials to test their efficacy. Despite the emergence of new therapies since the 90s, this disorder remains highly stigmatised, both in terms of the patients, who are still considered as “particularly difficult to treat”, and in terms of healthcare and research policies. As an example, the funds allocated to BPD research in the US by the NIMH represent 2% of the funds apportioned to research into schizophrenia and 6% of those going to research into bipolar disorders, despite both these disorders being significantly less prevalent (Gunderson 2009⁶).

Epidemiology

BPD is a disorder that affects from 2 to 4% of the general population, according to various studies (Leichsenring et al. 2011¹⁰, Lenzenweger et al. 2007¹¹, Torgersen et al. 2001¹²). However, in the course of clinical practice, therapists are frequently called upon to treat such patients, as up to 10% of patients receiving treatment in outpatient psychiatric facilities, and up to 15% of patients hospitalised in psychiatric centres suffer from this disorder (Leichsenring et al. 2011¹⁰, Gunderson 2011¹³).

Self-damaging behaviours and repeated suicidal acts are particularly frequent in BPD. Up to 70% of patients suffering from BPD are prone to self-damaging behaviours (Lieb et al. 2004⁴). The mortality rate is dramatically high as it nears the 10% mark, which is 50 times higher than among the general population (Leichsenring et al. 2011¹⁰, Oldham 2006¹⁴).

Patients suffering from this disorder require additional mental health resources because of frequent crises and emergency consultations, in particular in the wake of self-damaging acts (Gunderson 2011¹³). These patients are often administered significant amounts of psychoactive drugs and have consulted numerous therapists over the course of their healthcare history (Linehan et al. 2006¹⁵). In many cases, it is a history marked by chaos, trauma, frequent ruptures of the therapeutic alliance and repeated hospitalisations. The therapy dropout rate is traditionally very high in non-specialised treatment facilities, being in excess of 50% (Bender et al. 2001¹⁶, Gunderson et al. 1989¹⁷). Therefore,

as the following statistics show, these patients are likely to change therapists frequently: In the US, 97% of patients suffering from BPD have been treated by six different therapists on average, and 72% of BPD patients have been hospitalised in a psychiatric facility (Linehan et al. 2006¹⁵). Public healthcare structures, hospitals and outpatient facilities are often adapted for patients suffering from schizophrenia or mood disorders (Gunderson 2009⁶). However, these facilities are unable to meet the specific requirements of patients suffering from BPD. In some cases, this gives rise to negative therapeutic responses, failure to comply with the treatment and repeated hospitalisations.

However, the spontaneous clinical development of the disorder is, in fact, more favourable than what was previously expected. In her cohort studies, Mary Zanarini was able to demonstrate that the evolution of symptoms was spontaneously favourable. After a 10-year evolution period, approximately 80% of patients no longer displayed enough diagnostic criteria to meet the BPD diagnosis (Zanarini 2006¹⁸). But this fortunate news comes with a drawback, as the suffering and disability persist (Skodol et al. 2005¹⁹, Grant et al. 2008²⁰). The disabilities associated with the disorder are significant and, in many instances, enduring. They translate into major issues affecting professional integration, social adjustment, overall functioning, parenting, general sense of satisfaction and overall health (Grant et al. 2008²⁰).

Psychopathology

BPD is therefore characterised by perturbations affecting the four following areas: identity (image or sense of self), affect regulation, interpersonal relationships and impulse regulation (Gunderson 2011¹³). Each of the nine diagnostic criteria therefore belongs to one of these different areas, as shown in table 2.

Interpersonal relationships	Frantic efforts to avoid abandonment
	Pattern of unstable and intense interpersonal relationships, idealisation and devaluation
Affect regulation	Emotional lability
	Inappropriate, intense anger or difficulty in controlling anger
	Chronic feeling of emptiness
Poor impulse control	Impulsivity in at least 2 areas that are potentially self-damaging
	Recurrent suicidal or self-mutilating behaviour
Self-image	Identity disturbance with persistently unstable self-image
	Transient paranoid ideation, dissociative symptoms
Table 2: BPD dimensions and DSM criteria published in Gunderson (2011) N Engl J Med	

The etiological model of the disorder is complex and, more often than not, viewed as a biopsychosocial model (Lieb et al. 2004⁴, Leichsenring et al. 2011¹⁰, Gunderson 2011¹³, Paris 2007²¹). It involves biological and genetic factors that reflect an estimated heritability of around 40-70% (Torgersen et al. 2000²²). During the course of the subject's early relationships, these vulnerability factors interact with a deficient or traumatic environment and create a breeding ground for the

disorder. The disorder is indeed associated with trauma and neglect suffered during childhood, possibly owing to the impact they have on the development of a sense of identity or emotional regulation abilities (Kuo et al. 2015²³). Sadly, this is evidenced by high rates of sexual abuse or emotional neglect, with 70% of patients reporting severe abuse during childhood (Paris et al. 1994²⁴, Zanarini 2000²⁵).

Differential diagnosis can be a complex endeavour, in particular because of the high rate of comorbidities (Grant et al. 2008²⁰) leading to an increased rate of diagnostic errors (Kernberg and Yeomans 2013²⁶). Notwithstanding this, we will mention several differential diagnoses. These include bipolar disorder, as it shares with BPD the dimension of impulsiveness and because rapid mood swings are often mistaken for emotional lability (Kernberg and Yeomans 2013²⁶). Other personality disorders feature difficulties affecting interpersonal relationships, a perturbed sense of self and a disrupted sense of reality, as seen in the narcissistic personality disorder (Kernberg and Yeomans 2013²⁶). ADHD shares the impulsiveness dimension (Prada et al. 2014²⁷), as it features behaviours that are often seen as self-damaging, thereby covering two diagnostic criteria of BPD. It also shares some emotional dysregulation, as seen for example in outbursts of anger that are reminiscent of a diagnostic criterion for BPD, once again matching two diagnostic criteria (Perroud et al. 2017²⁸).

There is a very high rate of comorbidities among patients suffering from BPD (Grant et al. 2008²⁰). In fact, this rate is so high that comorbidities are the general rule rather than the exception. For example, mood disorders are reported among 85% of BPD patients (including 10% with a bipolar 1 disorder), other personality disorders are reported among approximately 70% of BPD patients, posttraumatic stress is reported among approximately 40% of BPD patients and attention-deficit and hyperactivity disorder affects between 10 to 30% of BPD patients, with approximately 50% of the BPD population suffering from substance abuse disorders and the same amount affected by eating disorders (Leichsenring et al. 2011¹⁰, Skodol et al. 2002⁵, Zimmerman et al. 2013²⁹).

Clearly, this compounds the clinical assessment and treatment of the disorder. Patients are frequently able to identify the comorbidity and tend to complain more about its symptoms than that of the actual personality disorder they are suffering from. Therapists are therefore at risk of missing the BPD diagnosis if they fail to conduct a systematic evaluation. In this case, the personality disorder only becomes apparent because of the resistance the patient shows to the treatment. BPD, when it is comorbid, worsens the evolution prognosis of the other disorders (Skodol et al. 2002⁵). Most treatments targeting other mental disorders, regardless of whether they follow a psychopharmacological or psychotherapeutic approach, prove to be less efficient for patients suffering from borderline personality disorder, as is the case with the administration of antidepressants to treat a severe depressive episode (Biskin and Paris 2012³⁰).

However, as far as treatment priorities are concerned, the personality disorder is the first condition to address according to applicable guidelines (APA Guidelines³¹, NICE Guidelines³², Euleer et al. SSPP Guidelines³³). This is the case as a general rule, although some exceptions exist, like the presence of a particularly intense substance abuse disorder, a non-stabilised bipolar disorder, a severe eating disorder, or a florid psychotic disorder (NICE Guidelines³²).

The clinical assessment must include a careful evaluation of the symptoms of the actual disorder. For this purpose, a semi-structured interview advantageously complements the clinical interview and increases the reliability of the diagnosis. There are several interviews available, in particular the

Structured Clinical Interview for axis II disorders (SCID II), which we use systematically (First et al. 1994³⁴). Its reliability is comparable with that of other specific tools, such as the International Personality Disorder Examination (Loranger et al. 1994³⁵) and the Diagnostic Interview for Personality Disorder (Zanarini et al. 2000³⁶).

Sharing the diagnosis with the patient is both a difficult and an important step, as seen in the discomfort it causes to many psychiatrists. Approximately 60% of psychiatrists admit that they occasionally choose to withhold their diagnosis, and 40% of them admit having failed to record the diagnosis in the patient's medical files. They are much more comfortable in diagnosing a mood disorder or a bipolar disorder than giving a BPD diagnosis (>90% vs. 40%) (Sisti et al. 2016³⁷). As justification for this omission, they mention stigmatisation risks, diagnostic uncertainty or the elevated comorbidity rate (Sisti et al. 2016³⁷). However, patients and their relatives often find it relieving and useful to be correctly informed of the diagnosis. It allows them to develop a suitable treatment plan, and to be more realistic in their expectations, which improves compliance (Gunderson 2011¹³).

A therapeutic challenge

It is a well-recognised fact that the therapy to treat BPD rests essentially on a psychotherapeutic treatment (APA Guideline³¹, NICE Guideline³²). The efficacy of the pharmacological treatment of BPD is disappointing to say the least, and the subject of fiery debate (Lieb et al. 2010³⁹). Meta-analyses relating to these treatments have failed to demonstrate their true efficacy. Current recommendations are that pharmacological treatments should be used to treat comorbidities (Kendall et al. 2010⁴⁰), hence the importance of a proper evaluation. As far as BPD symptoms are concerned, it is recommended to avoid pharmacological treatment, except in the event of a crisis (agitation, anxiety, major impulsiveness for instance), in which case it should be administered for a short period only (Euler et al. 2018³³). Overmedication of BPD patients is all too frequent, and probably reflects an attempt to maintain their emotional reactions under some sort of control, but without yielding any real benefit. Furthermore, there is a significant iatrogenic potential with, on one hand, the very real danger of developing an addiction, and on the other hand, the risk of giving the patient medication that he/she might be tempted to abuse of when giving in to suicidal or self-damaging acts.

However, the psychotherapeutic treatment remains complex. Therapists are faced with a significant number of issues specific to BPD, all of which constitute a therapeutic challenge. The tendency towards idealisation and devaluation, the emotional lability and the modalities governing interpersonal relationships result in a highly intense therapeutic relation, marked by highs and lows, and generate strong emotions that either encourage or frighten the therapist, but rarely leave him/her indifferent. The conflicts and disappointments they cause are partly to blame for extremely high therapy dropout rates. Frequent episodes of acting out and recurrent crises generate a sense of constant worry, as well as difficulties in abiding by a strict therapeutic structure (Biskin and Paris 2012³⁰). A certain ability to adapt to such moments and to make oneself available in emergency situations is therefore required. The high number of hospitalisations also leads to frequent treatment interruptions. Moreover, these hospitalisations are rarely beneficial, as patients with BPD display severe self-damaging behaviours in hospital environments (Biskin and Paris 2012³⁰). The heterogeneous nature of the symptomatology also causes BPD to be mistaken for other types of disorders. Finally, the presence of an identity disorder sometimes translates into a tendency by the

patient to try and satisfy the presumed expectations of the therapist, but in a superficial manner which has no actual benefit for the patient when he/she is facing highly-charged emotional interactions. These numerous difficulties and challenges have driven therapists to adapt their models and to develop specialised approaches, both in terms of the therapeutic context and in terms of psychotherapeutic theory they are based on, as evidenced by MBT. In this study, two other therapies are briefly mentioned: the DBT developed by M. Linehan and the transference-focused psychotherapy (TFP) developed by O. Kernberg.

However, more often than not, there is no specific treatment for patients suffering from BPD available in the centres that treat the majority of these patients, regardless of whether they are treated in an outpatient or in an inpatient setting (Gunderson 2009⁶). It is both useful and necessary to improve the understanding of this disorder among patients, therapists and the general population (Gunderson 2009⁶). In Geneva, there are signs that this is starting to take shape this year, with a postgraduate training module specialising in BPD included in the mandatory training of internists. Furthermore, over the past few years, we have contributed to the implementation of specialised DBT and MBT training in Geneva and Paris for therapists and healthcare teams interested in this field (mentalisation.unige.ch). Finally, a psychoeducation group will be created later this year for the relatives of patients suffering from BPD. With the idea of raising awareness as to this disorder, and of facilitating access to proper practices, some years ago we developed Emoteo, a smartphone app designed to help the user become aware of his/her current emotions (Prada et al. 2017⁴¹). It was met with positive reactions in the media and its popularity among the general population (in excess of 20'000 downloads) is evidence of existing needs in this field. Also in Geneva, systematic screening for borderline personality disorder has been implemented in programmes specialising in mood disorders, anxiety disorders and eating disorders. We believe that our approach has contributed to the growing recognition of this disorder. This dynamic is also seen in Lausanne, where our colleagues at Centre Hospitalier Univesitaire Vaudois (CHUV - University Hospital Centre of Canton Vaud) offer TFP-specific training.

Psychotherapeutic developments

Since the first works by Otto Kernberg, several BPD-specific therapeutic models have been developed, the two most important of which are examined further on. These models share some common features, but their psychotherapeutic orientations and their BPD model are different (Biskin and Paris 2012³⁰, Clarkin et al. 2007⁴²). The features shared by these therapies are a manual-based, explicit and structured framework that describes precisely the therapeutic goals and means. The therapeutic attitude must remain as neutral as possible, while retaining the possibility of being activated when the patient's life is at risk or if the therapeutic integrity comes under threat. An active attitude is also adopted by the therapist for the purpose of session management, for example in his/her role in maintaining the therapeutic focus. The therapy is rooted in the present rather than turned towards the past. The treatment plan is clear and explicit, as are the conditions for following the treatment and those that will lead to the treatment's termination. Finally, a crisis management plan is in place (Weinberg et al. 2011⁴³).

Specialised models

In this section, we will examine two models: DBT, since it is the other therapeutic model offered in our centre, and TFP. The purpose here is to demonstrate how these different models provide

elements that relate to and highlight other aspects of BPD, and to remain consistent with our approach, which is to develop a psychotherapeutic culture in a broader sense.

Dialectical behaviour therapy

DBT was developed by M. Linehan, a US psychologist, for a population of suicidal patients (Linehan 1991⁴⁴). In DBT, the concept of BPD rests on the model of biopsychosocial theory (Linehan 1993⁴⁵): the emotional vulnerability of the subject (which translates into increased emotional sensitivity, heightened emotional reactivity and a slow return to a state of reduced emotional tension) is compounded by the environment, described as “invalidating”, in which the subject grows up. This environment is invalidating because it tends to minimise, punish or repress the expression of emotions and to oversimplify the means implemented to achieve given goals, thereby making these goals unrealistic. The subject is then unable to learn how to regulate his/her emotional experience, which causes cognitive and interpersonal dysregulation, emotional inhibition alternating with emotional outbursts, impulsiveness and self-damaging behaviours. The latter are considered as poorly-adapted ways of regulating emotional tension. The therapy rests on the constant dialectic balance between change and acceptance (Linehan 1993⁴⁵). M. Linehan proposes to work on acquiring new skills of mindfulness and acceptance, in order to tolerate emotional states. She also proposes to work on change skills, in areas like emotional regulation and interpersonal relationships. The therapy tries to meet targets that are set in a clear hierarchical order. Firstly it relates to life-endangering behaviours, secondly it pertains to behaviours that are detrimental to the therapy, and finally it concerns behaviours that reduce quality of life (Linehan 1993⁴⁵). The stated goal here is to achieve a life worth living. The therapy relies on individual sessions and group sessions, team consultation sessions for the therapists, and a hotline to help with crisis resolution. Clinical tests have shown that this therapy is effective in reducing therapy dropout rates, suicidal episodes, hospitalisations and psychoactive drug treatments (Linehan et al. 2006⁴⁶). It was successfully imported into our programme more than 15 years ago (Perroud et al. 2010⁴⁷).

Transference-focused psychotherapy

Developed by O. Kernberg and his colleagues in New York, TFP is an analytically-oriented therapy. According to its model, object relations (the relationship with others) during the childhood of the patient suffering from BPD are the focus of attention (Clarkin et al. 2007⁴⁸). These object relations can be schematically summarised as follows: the child experiences object relations, on a moment-by-moment basis and in a total manner. In other words, they experience each moment of the object relation as an emotion, this emotion being either totally pleasant or totally unpleasant. The object, seen as responsible for the emotion, therefore becomes a pleasant or unpleasant representation. The same applies to the representation of self as experienced by the child. Consequently, the child/object dyad (for example the relation to a parent) is constantly linked to an emotion that qualifies the representation of the object and of self as either “good” or “bad” (these representations being subject to further cleavage). Over the course of subsequent interactions, when the object is sufficiently good (and insufficiently bad) the child integrates divided representations in the form of a single representation, which is more realistic and therefore less idealised. According to the model, this key step is considered to be incomplete, owing to trauma that affects the relationship, and is therefore the focus of the therapy (Yeomans et al. 2013⁴⁹). The therapy therefore centres on representations the patient has of the therapist (transference) and of himself/herself, moment by

moment, to identify variations between good and bad, idealised and devalued dyads, to progressively integrate a more realistic image. It is an individual therapy conducted with two weekly sessions and that includes, in its therapeutic framework, strict rules relating to the risk of acting out and designed to prevent self-damaging behaviours. Clinical trials have demonstrated that this therapy is effective, in particular in improving mentalisation capacities (Clarkin et al. 2007⁴²).

Generalist models

It seems obvious that owing to the high prevalence of BPD, and also to the disparity in terms of access to specialised structures, not all patients suffering from BPD can be treated in specialised centres (Biskin et al. 2012³⁰). This is also true in Geneva, despite the considerable means the city enjoys. As an example, the capacity of our programme is limited by the number of therapy groups and the number of places they offer. As far as BPD is concerned, this number is of around 16 places for MBT, and of 24 places for DBT (it being specified that our groups can accommodate eight participants, due to the configuration of our rooms). Because of limited treatment availability and the risk of iatrogenicity, it is essential to highlight and share proper generalist practices that are easy to implement. There are other guidelines or recommendations by national associations, the best-known ones being the guidelines issued by the American Psychiatric Association (APA Guidelines³¹) and those issued by the National Institute for Health and Care Excellence (NICE Guidelines³²). Recently, recommendations for the treatment of patients suffering of BPD were issued by a panel of experts on behalf of the Swiss Psychiatry and Psychotherapy Association (Euler et al. 2018³³). The overall purpose of these guidelines is to promote proper practices in the treatment of BPD, regardless of current psychotherapeutic trends.

Good psychiatric management

In this context, John Gunderson developed a psychiatric treatment model called good psychiatric management (GPM). This treatment groups the relevant aspects of psychodynamic or cognitive behavioural therapies (Gunderson et al. 2018). Clinical interventions rest on six principles that help maintain the general therapeutic direction. These principles are as follows: being active; being encouraging and validating; focusing on “getting a life”; considering the therapeutic relationship as real and professional; change is expected; finally, the patient must be a collaborator in the treatment (Gunderson et al. 2018). This approach is also interesting for non-specialised structures, for facilities that are, by nature, more generalist, or for centres that enjoy limited financial means.

Mentalisation-based therapy

Mentalisation-based therapy was developed in the 90s in London by Anthony Bateman, Peter Fonagy and their colleagues at the Anna Freud Centre. These two psychoanalysts wanted to develop a therapy with a psychodynamic orientation for patients suffering from BPD. Working at the Anna Freud Centre, which historically specialises in child healthcare, they bring a developmental dimension to the treatment of BPD and focus their attention on parenting issues and developmental considerations. Their therapy proved to be very successful and many centres offer their treatment in English-speaking countries, but also in the Netherlands, in Spain and in Italy. As far as French-speaking countries are concerned, we were forerunners in importing and developing this treatment.

Definition

According to Bateman and Fonagy, mentalising is a mental and imaginative activity that we are all capable of and that consists in connecting the visible behaviours of individuals to their mental states through hypotheses that we formulate, more or less consciously (Bateman and Fonagy 2010⁵¹). Mental states are complex and are made of emotions, thoughts, motivations, desires, beliefs, past experiences and knowledge. As they are not entirely conscious, they partially elude us. Mentalising is maintaining some curiosity and doubt as to mental states; it is the process of respecting their complex, changing and unconscious nature. The image often used by Bateman and Fonagy is as follows: “Mentalising is seeing the others from the inside, and seeing ourselves from the outside” (Bateman and Fonagy 2015⁵²). It is the process of looking for the link between a given behaviour and a mental state on one hand, and between an interaction and its effect on the other hand, and through which our behaviours and mental states make sense in relation to others. The representation we have of ourselves and of others depends on our ability to mentalise. Mentalising is a bit like trying to maintain a tenuous balance on different axes: an axis between attention focused on oneself or on someone else, an axis between attention to external signs (behaviours and attitudes) and internal signs (emotions), an axis between an automatic reaction mode (implicit) and a controlled reaction mode (explicit), and finally an axis between a rational mode of experience and an emotional mode of experience (Bateman and Fonagy 2015⁵²). Schematically, when we momentarily lose this capacity, we become polarised on these axes. We might then choose to suppress our emotions and their significance to behave in a highly rational manner. Or we can feel overwhelmed by these emotions, to the point of experiencing them as the only reality. It is also possible to live in a very tangible reality, in which only actions are real and have an impact on the regulation of our inner states. In this case, the manner in which we perceive ourselves and others is superficial or caricatured (Bateman and Fonagy 2015⁵²).

Variations in our ability to mentalise are real for everyone. However, people suffering from BPD display a weakened ability to mentalise in certain situations, and in particular in relationships that stimulate the attachment system (Bateman and Fonagy 2010⁵¹). The ability to mentalise is acquired throughout life, but more specifically in early childhood. As we will see, this ability stems from the experience of having oneself been the object of mentalising attention and of having been considered as an actual subject, with complex mental states that merit being discovered. This attitude of curiosity as to mental states is fundamental to MBT (Debbané 2016⁵³).

Model of the personality disorder

The theoretical model of BPD according to MBT is complex and involves various elements, in particular the attachment theory developed by John Bowlby. The link between attachment and mentalisation can be explained in the following manner, according to the works of Bateman, Fonagy and Debbané (Bateman and Fonagy 2015⁵², Debbané 2016⁵³, Fonagy et al. 1999⁵⁴). When a child is faced with an environment that generates a feeling of insecurity, their attachment system is stimulated. It sends out signals to a person who is considered to be an attachment figure. These signals trigger a response from the attachment figure, which should secure the child’s environment (real or affective) and soothe the child’s attachment system (figure 1). If the attachment figure fails to respond in a regular and predictable manner, or if the attachment figure generates further insecurity instead of a sense of safety, the attachment system is at risk of being perturbed, in which case the attachment is considered to be insecure. Schematically, the child might then become

hyperactive (the intensity of the signals is increased) or inhibited (the intensity of the signals is reduced). This causes increased stress for the child. Therefore, the activation of attachment in particular when it is insecure, reduces the ability to mentalise in the moment and generally hinders the development of this ability (Badoud et al. 2018⁵⁵).

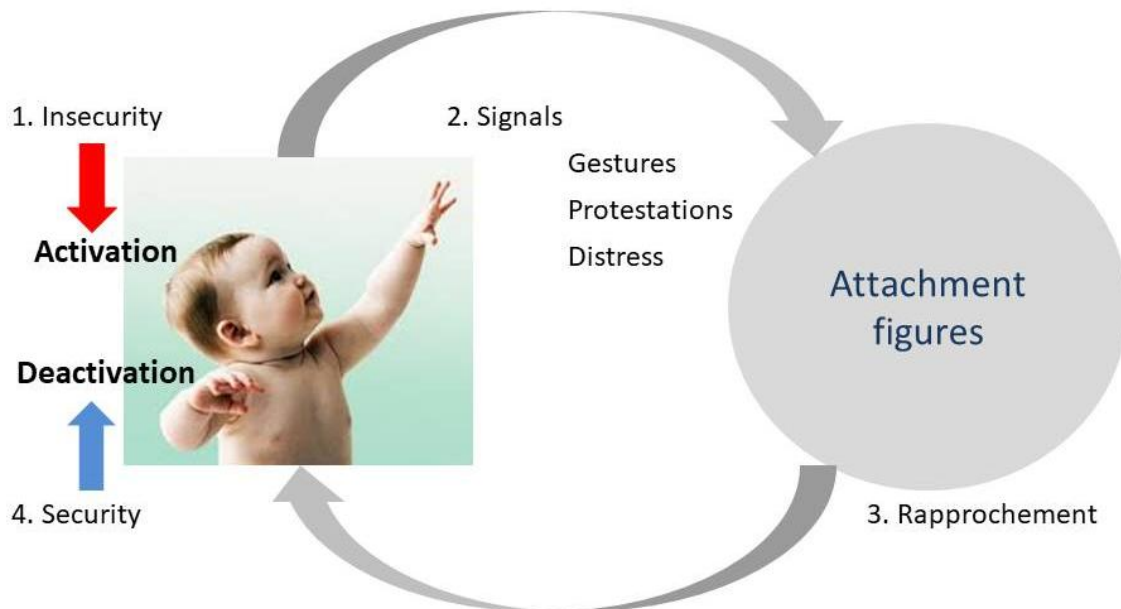


Figure 1: the attachment system (adapted from Debbané M. *Mentaliser. De la théorie à la pratique clinique*. Editions De Boeck, Bruxelles, 2016.)

Another factor is the early relationship with a caregiver (Bateman and Fonagy 2015⁵², Debbané 2016⁵³). In this relationship, over the course of different interactions, the individual forges his/her ability to mentalise as he/she experiences being the object of someone else's mentalisation. In this interaction, the child depends on the caregiver to modulate their experience and develop a secondary representation. For this purpose, the caregiver adopts a mirroring attitude. The caregiver sends the child's own experience back to the child, modulated by the caregiver's own psychic representation. For the response to be sufficiently appropriate, it must be contingent, congruent and marked. It must be contingent in the sense that the temporality or the delay between the signal and the response must be reasonable. It must be congruent in the sense that the content of the representation must be sufficiently similar to the experience of the child. Finally, it must be marked, i.e. the caregiver must make it clear that he/she is speaking of the child's experience and not his/her own (for example by adopting a different tone of voice, by mimicking, etc.). Failed mirroring not only leaves the child with representations that do not match the experience of the child, and are therefore impossible to integrate, it also leaves the child prey to an experience that is not modulated. These non-representable experiences are distortions that perturb the sense of self, the sense of others and the regulation of emotions (Fonagy 1995⁵⁶).

So, when mirroring is deficient over the course of many interactions, the experience and the representation thereof, as proposed by the caregiver, can be of various kinds. They can be

disconnected if the caregiver fails to consider them and offers a response on a cognitive and intellectual level. This gives rise to a non-mentalising way of thinking, described as pretend mode, wherein the world of thoughts is disconnected from the world of affects. In this mode, it is possible to describe internal states in some complexity, without actually experiencing them. Inversely, if the caregiver responds to the child's emotion with his/her own emotion, not only does he/she fail to modulate the child's affect, he/she also sends back the message that the affect is just as real on the outside (for example when the child is scared and the caregiver's response is that the situation is, in fact, very scary). Emotions are then experienced as the only reality and are not modulated by their expression; the experience is mistaken for reality. This mode of thinking is called psychic equivalence (Bateman and Fonagy 2015⁵², Debbané 2016⁵³). Finally, if the reactions of the caregiver are tangible, behavioural, and if they offer action-based solutions, then they reinforce the experience that actions signal intentions and that only concrete actions have an influence on affects. This mode of thinking is the teleological mode (Bateman and Fonagy 2015⁵², Debbané 2016⁵³). In these cases, the experience is alienated from its representation, and when a similar experience occurs, the subject cannot truly experience it in an integrated manner and his/her ability to mentalise is affected by it.

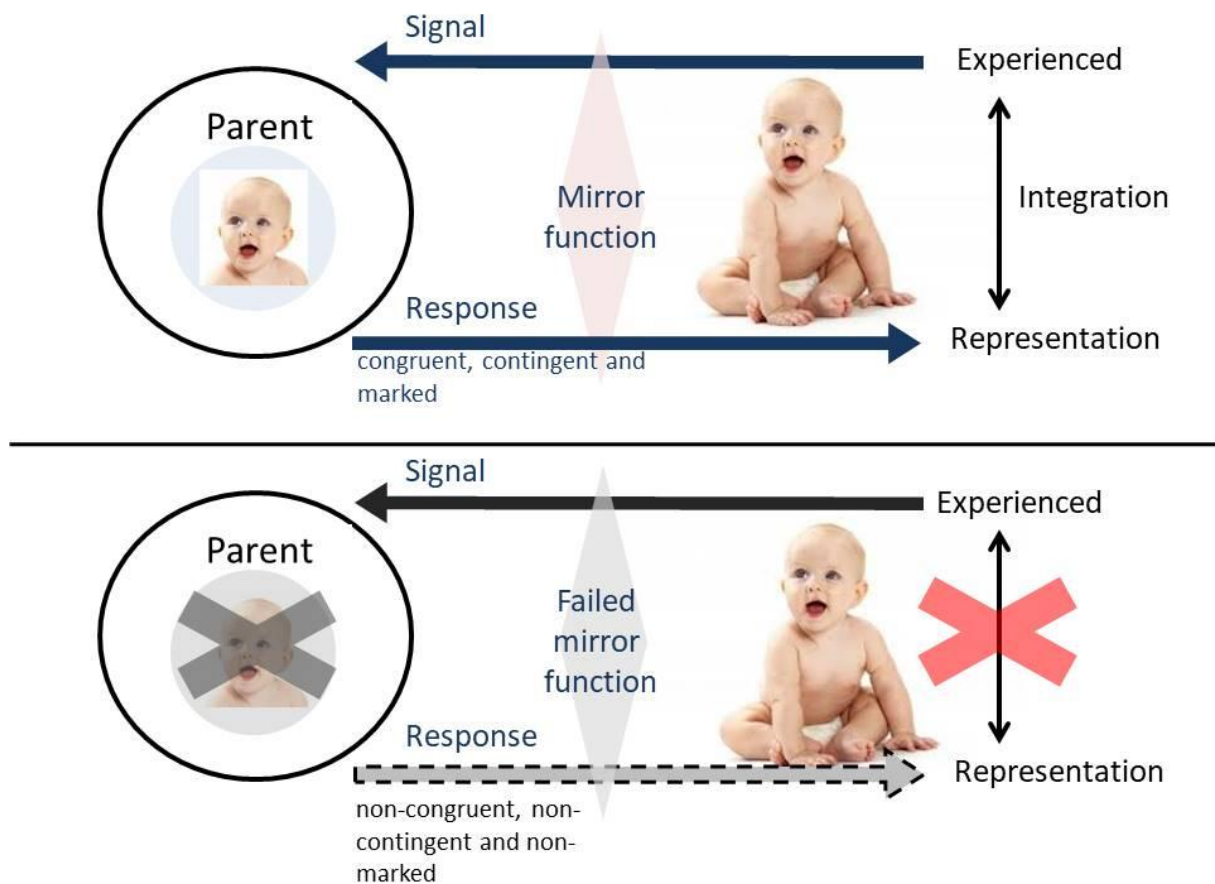


Figure 2: mirroring and failed mirroring (adapted from Debbané M. *Mentaliser. De la théorie à la pratique clinique.* Editions De Boeck, Bruxelles, 2016.)

According to this model, mentalisation difficulties are the root cause of the BPD symptomatology. A perturbed sense of identity is associated with non-mentalised representations of self, with an excessive divide between the experience and its representations that act like “alienated” parts of oneself (Bateman and Fonagy 2015⁵², Debbané 2016⁵³). Representations of others are also affected,

alternating between idealisation and devaluation, as they are partial, cognitive or affective, but never fully integrated, which generates significant interpersonal issues. Emotional lability stems from difficulties in modulating affects, which leads to impulsiveness, since resorting to action is often the only option available to regulate an emotion. Finally, self-damaging behaviours are understood as being an attempt to mitigate the suffering associated with this alienated part of the experience of self (Bateman and Fonagy 2015⁵², Debbané 2016⁵³).

Structure of the therapy

MBT is a highly structured therapy (figures 3 and 4) (Bateman and Fonagy 2015⁵², Debbané 2016⁵³). The first step is a structured clinical assessment (figure 3) in which we assess the presence of BPD and possible comorbidities during a clinical interview and then using semi-structured tools, namely the completion of a SCID II and a diagnostic interview relating to other disorders (DIGS). At the end of this step, we propose a series of interviews to share our diagnosis with the patient, to explain the disorder through psychoeducation, and to summarise our therapeutic propositions.

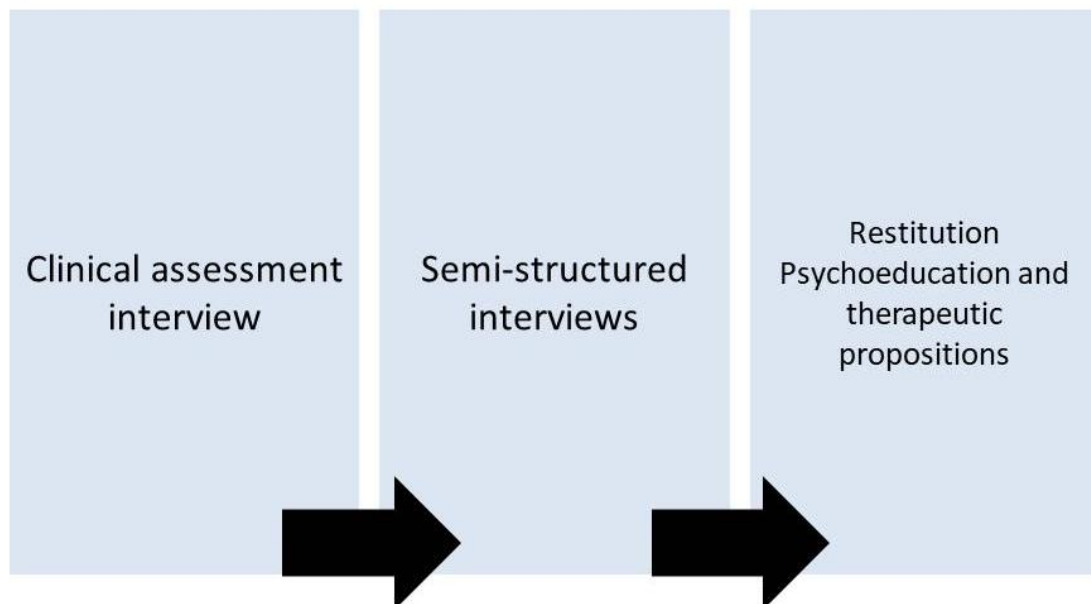


Figure 3: structured assessment (adapted from Bateman A, Fonagy P. *Mentalisation et trouble de la personnalité limite, guide pratique*. Editions De Boeck, Bruxelles, 2015)

If the BPD diagnosis is confirmed, and there are no comorbidities that must be treated in priority, we can then suggest MBT. Before starting the therapy, we work with the patient on formulating his/her problems in terms of mentalisation issues (figure 4). The purpose of this work is to develop a shared language and to provide some psychoeducation about mentalisation, so that no doubt remains as to what is happening in the therapy. This counters the tendency patients have to resort to idealisation and then to devaluation. We also explain the modalities surrounding the therapy, such as its structure (frequency, duration and session schedule), the management of the psychoactive drug treatment, the conditions for taking part in the therapy and the conditions that are not conducive to the therapy, and the emergency plans (hotlines and other crisis situations). All these steps must be completed before the beginning of the therapy, because it is common for problems to occur at all of

these levels, as is the case with any form of therapy. Later on, it is more difficult to come back on these elements if they haven't been properly explained. The therapy comprises a 50-minute individual session and a 90-minute group session every week. There are two different groups: the introduction group and the mentalisation group. The introduction group comprises 12 psychoeducation sessions. Each session provides the opportunity of discussing theoretical elements and illustrating them with clinical vignettes so that the participants may develop together a mentalising culture as they get to know each other. These sessions have been directly translated from those provided by the Anna Freud Centre. We have made them available on the mentalisation.unige.ch site, along with other useful references. The themes that are examined are, in particular, mentalisation, attachment or emotions (Bateman and Fonagy 2015⁵², Debbané 2016⁵³).

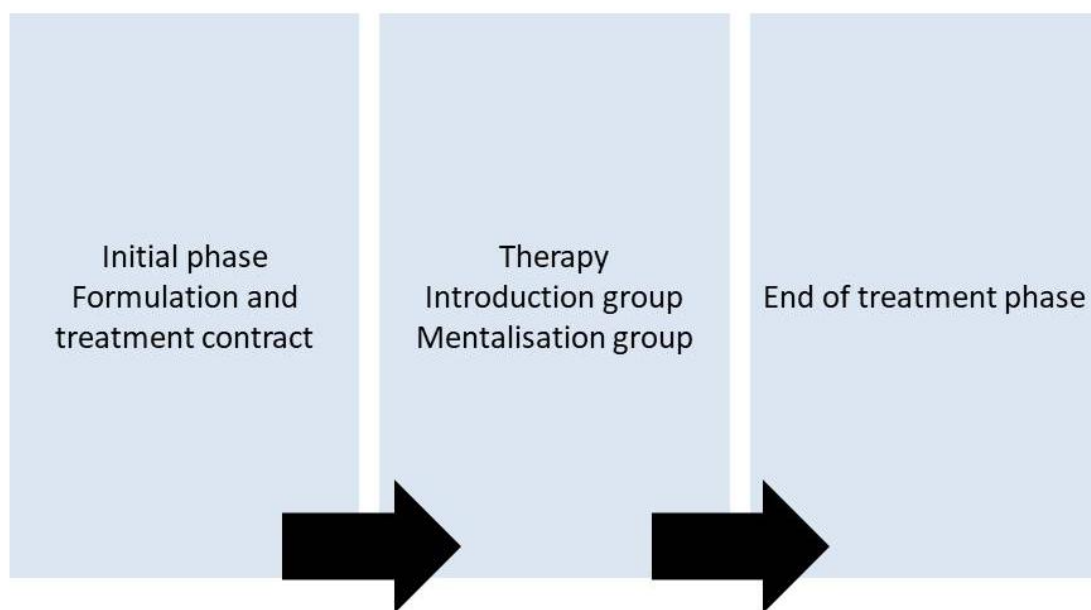


Figure 4: therapy steps (adapted from Bateman A, Fonagy P. *Mentalisation et trouble de la personnalité limite, guide pratique*. Editions De Boeck, Bruxelles, 2015)

In the mentalisation group, the notions that were examined theoretically are now put into practice. After a short review of the themes discussed during the previous session, we select situations that are problematic to the patients and, going around the table, we try to explore these situations, together, adopting mentalising attitudes. This provides the opportunity of practising identifying faults in the mentalising process and restarting the process. The mental states of each participant are the focus of attention and when some certainty about them begins to emerge, the time has come to question this certainty in order to reveal differences that can be used to modulate it. The duration of this group is of about one year, which, when breaks are factored in, amounts to a total duration of approximately 18 months (Bateman and Fonagy 2015⁵², Debbané 2016⁵³). The clinical evolution is monitored, in particular through repeated self-administered questionnaires, upon admission, at the end of the introductory group, and upon completion of the mentalisation group.

As the duration of these groups is limited, a review or final session brings the therapy to an end. If the clinical evolution is positive, the patient can continue working with a private therapist. If not, the patient can repeat an MBT cycle.

Psychotherapeutic principles

It is impossible to provide a detailed description of the psychotherapeutic principles in this paper, which is why we will simply provide a summary thereof, drawn from relevant therapy manuals (Bateman and Fonagy 2010⁵¹, Bateman and Fonagy 2015⁵², Debbané 2016⁵³). The underlying principle is to encourage the mentalisation process, i.e. to be interested in the mental states of the patient so that he/she may experience someone who is interested in his/her mind. For patients suffering from BPD, this is a fragile process that is regularly interrupted to give way to pre-mentalising modes of thinking. The purpose is to bring the patient to recover his/her mentalisation powers in conditions where such a recovery would otherwise be impossible. The therapeutic focus is therefore on the process (in terms of mental states), rather than on the explicit content of the stories and narratives that the patient brings to the session (Bateman and Fonagy 2015⁵², Debbané 2016⁵³).

The therapy is rooted in the here and now of the session, or in recent past (the last few days for example). The goal is to work on mental states and emotions that are present in the room and that are not presumed, remembered or ancient. Priority is given to self-damaging or truly problematic events that have occurred recently, or to events that are marked by a significant loss of mentalisation. The purpose is then to explore these events, to understand and validate the mental states and the emotional experience. If this “mentalised” exploration can happen, where there was certainty and suffering, alternative perspectives will emerge, and a changed representation of self and of others will begin to appear (figure 5).

To achieve this, the posture of the therapist must be one of not-knowing (Bateman and Fonagy⁵¹). This means that the therapist can expose what he/she thinks he/she knows, without inferring the mental states of the patient, thereby breaking from what therapists view as common practice. The idea is to explore, together with the patient, his/her mental states. Highlighting moments of mentalisation and non-mentalisation is key, not only to understanding the difference between these states, but also to making the therapy process as explicit as possible.

Simultaneously, the therapist is active in the exploration, in maintaining the focus on affects and mental states, and in managing the session and the way it is conducted. The content of a session is an exploration of moments that are relevant to the patient that follows a relatively precise trajectory (figure 5).

Session trajectory

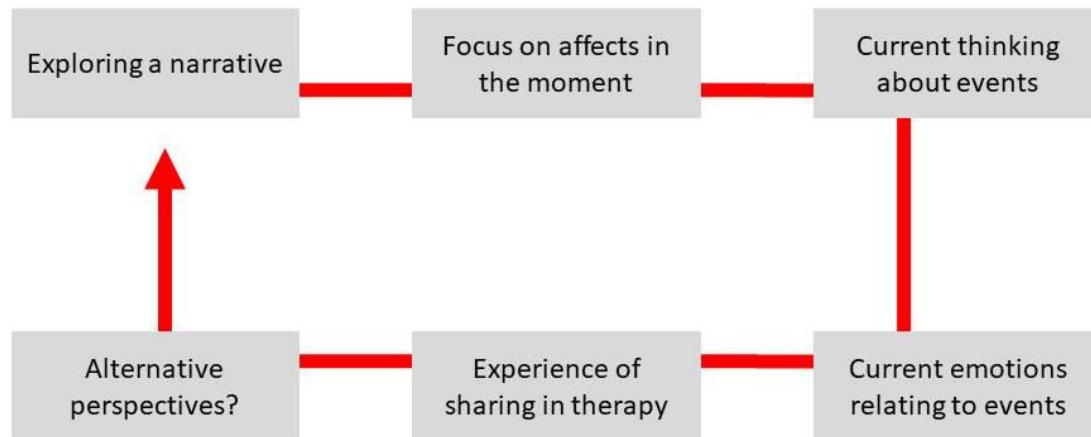


Figure 5: Trajectory during the session (adapted from Debbané M. *Mentaliser. De la théorie à la pratique clinique.* Editions De Boeck, Bruxelles, 2016.)

The therapist must regulate the level of emotional tension during the session (Debbané 2016). If there are too few emotions, there is the risk of lapsing into pretend mode, which is intellectualised but disconnected from the affects, and if there are too many emotions, their intensity can become difficult to contain. The therapist must therefore adapt his/her interventions. Exploratory interventions, in particular at moments of the narrative that feature low emotional intensity, are neutral and lower the emotional temperature. Inversely, working on problematic interpersonal events or on the relationship between the patient and the therapist and the impact they have on one another, might increase the emotional tension and hinder the mentalisation capacities of the patient and of the therapist. As we have seen, focusing our attention on the relationship stimulates attachment and emotions, which reduces the ability to mentalise. It is therefore a rigorous work of observing the process to identify interruptions (for example heightened emotions), and of interrupting the discussion to return briefly and explore what caused the loss of mentalisation. Once this has been done, it is possible to resume the narrative until the next disruption of the process occurs. The therapist is therefore required to look out for signs of disrupted mentalisation, which is characterised by the emergence of pre-mentalising thought modes, and to explore the causes of the disruption. This back and forth and this interest in mental states and what affects them are integrated over the course of time. The patient begins to display an attitude of curiosity and not-knowing about himself/herself, with respect to his/her own mental states and with respect to that of others (Debbané 2016).

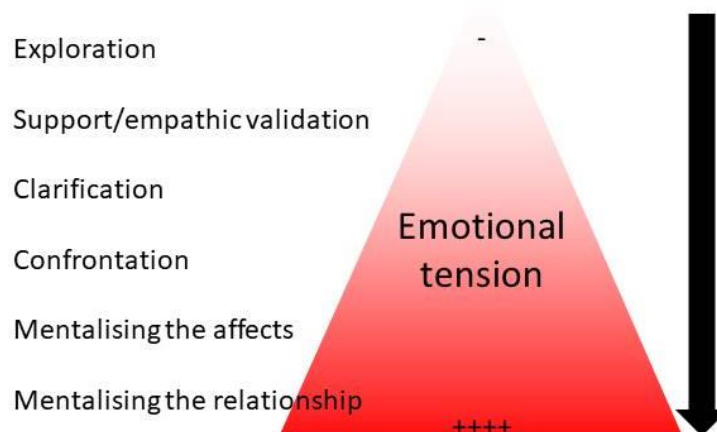


Figure 6: Therapeutic interventions and their impact on emotional tension (adapted from Debbané M. *Mentaliser. De la théorie à la pratique clinique*. Editions De Boeck, Bruxelles, 2016.)

Efficacy

It is now a well-established fact that this therapy is effective in the treatment of patients suffering from BPD. Several studies in English conducted by the developers of this therapy, and also in other languages and in other centres, have demonstrated its efficacy (Bateman and Fonagy 1999⁵⁷, Bateman and Fonagy 2001⁵⁸, Bateman and Fonagy 2008⁵⁹, Bateman and Fonagy 2009⁶⁰, Laurensen et al. 2018⁶¹). MBT has proved to be efficient in the format presented herein, but also in outpatient settings (Bateman and Fonagy 1999⁵⁷, Laurensen et al. 2018⁶¹). The indicators that have evolved positively include the severity of depressive symptomatology, the reduction of self-damaging behaviours and suicidal acts, the reduction of hospitalisation days and the improvement of social and interpersonal functioning (Bateman and Fonagy 1999⁵⁷, Bateman and Fonagy 2001⁵⁸, Bateman and Fonagy 2008⁵⁹, Bateman and Fonagy 2009⁶⁰). Based on mounting evidence of its efficacy, this therapy features among those that are recommended as reference treatments (Biskin and Paris 2012³⁰, NICE Guidelines 2009³²).

Clinical adaptations

As we have just mentioned, the popularity of this therapy has grown considerably in the past years. In addition to being extensively used in England and in the UK, this treatment has been successfully imported in non-English-speaking countries such as Holland (Laurensen et al. 2018⁶¹) or Norway (Kvarstein et al. 2015⁶²). The growing appeal of this therapy is not only geographical, as it has also been extended to other clinical areas, as seen in the following examples. It has been adapted to other disorders that are often comorbid with BPD, such as antisocial personality disorder (Bateman et al. 2016⁶³) or mood disorders (Bateman et al. 2015⁶⁴), as well as eating disorders (Robinson et al. 2014⁶⁵). A study is currently underway to examine how it can be used with patients suffering from a psychotic disorder (Weijers et al. 2016⁶⁶). MBT has also been implemented among patients displaying self-damaging behaviours (Rossouw et al. 2012⁶⁷) or among pregnant women, as a preventive measure relating to postpartum complications (Markin 2013⁶⁸). We are therefore implementing the treatment in a context of intense activity surrounding mentalisation.

French-speaking implementation

The implementation of this treatment in our centre required several years of work. The main difficulty was training a sufficient number of therapists to form a healthcare team, as some of them do not speak English. It was only possible for a small group of therapists to be trained in London, at the Anna Freud Centre. The group then had to work with Matrin Debbané on the French translation of reference books. In this context, we translated “Mentalisation-Based Therapy: a Clinical Guide” (Bateman and Fonagy 2015⁵²). The following year, Martin Debbané published another manual, “Mentaliser”(Debbané 2016⁵³). We participated in the first training sessions for therapists given in French, initially in Geneva and then in Paris. Progressively, we were able to set up our entire team of therapists and provide MBT with its traditional modalities, i.e. group therapy and individual therapy. This also helped with the widespread circulation of MBT in French, with around 200 therapists coming to our centre to be trained. We regularly monitored our team, filmed our sessions and made sure to adhere to, and remain within, the therapeutic model.

In the first two years, we were able to complete two full therapy cycles, the results of which were published recently. These results relate to the psychoeducational part, i.e. the 12 first weeks of the therapy with the MBT introduction group (Sisti et al. 2018⁶⁹). The results of the full mentalisation group are currently being assessed and will be published at a future date. A summary of these results is provided below.

We were able to include 14 female participants in the two first groups. All the participants provided their written consent, and the study was approved by the ethics committee. It should be noted that in our centre, the large majority of patients are women. They all suffer from borderline personality disorder, as at least five of the nine diagnostic criteria were met with the SCID II (with an average of seven out of nine criteria, see table 3). Furthermore, the structured assessment of comorbidities (DIGS) did not reveal any exclusion criteria (for example a substance abuse disorder, or a psychotic disorder). To monitor their clinical evolution over the course of the 12 weeks of the first therapeutic intervention phase, the participants filled in self-administered questionnaires before the therapy and at the end of the psychoeducation group.

Table 3	N=14	
	Average	DS
Age	32.92	9.25
SCID-II	7	1.24
Years of study	15.14	3.67
	N	%
Lives alone	11	78.57
Jobless	11	78.57
Has children	8	57.14

Table 3: demographic and clinical data (published in Prada et al. Encéphale 2018⁶⁹).

SCID-II: Structured Clinical Interview for Axis II Diagnosis

The dropout rate was of 28.6%, with four participants leaving the group (their demographic or clinical data was similar to that of the other participants). This rate is encouraging as it is below the 30% mark, and in the same range as the rate achieved in specialised therapies.

Through these self-administered questionnaires, we sought to assess the evolution of BPD symptomatology (borderline symptoms list (BSL-23), ref), of depressive symptomatology (Beck depression inventory (BDI-II), ref) and of the feeling of hopelessness (Beck hopelessness scale (BHS), ref) as global indicators of the clinical state. Improved capacity for self-mentalisation should be reflected by awareness and emotional regulation, which is why we examine emotional reactivity (emotional reactivity scale (ERS) ref), the cognitive dimension of emotional regulation (cognitive emotional regulation questionnaire (CERQ), ref) and strategies of cognitive avoidance (cognitive avoidance questionnaire (CAQ), ref). Finally, mentalisation of others should translate into an ability to empathise (basic empathic scale (BES), ref) and a capacity for reflective functions (reflective function questionnaire (RFQ), ref).

Despite the small size of our study sample and the short duration of the therapeutic intervention, the results are encouraging in several regards, with a positive evolution of relevant variables (table 4). We recoded an improvement in depression and hopelessness scores that is indirectly indicative of clinical improvement. In terms of self-mentalisation, although the emotional reactivity scores remain unchanged, it should be noted that the strategies for emotional regulation evolved favourably with a reduced tendency towards blame, an increased ability to centre on positive aspects (positive centring) and to substitute cognitively an unpleasant interpretation of a thought for another. In terms of mentalisation of others, a positive impact was observed on empathy, through its cognitive dimension in particular, as well as reduced uncertainty as to the mental states of others, as revealed by the reflective function questionnaire.

Of course these are intermediary results that need to be confirmed with a bigger sample. However, they attest to the feasibility of the French implementation of this therapy, and demonstrate its efficacy. This project is highly stimulating and will certainly lead to others, which are described below.

Table 4		<i>Before</i>		<i>After</i>		<i>b</i>	<i>p</i>
		<i>Average</i>	<i>DS</i>	<i>Average</i>	<i>DS</i>		
BDI-II		33.87	10.30	29.30	10.46	-0.5	0.054
QEC	Substitution	11.00	2.65	14.38	4.78	0.71	0.022
	Transformation	7.86	2.41	10.66	4.92	0.53	0.078
	Distraction	15.43	6.05	13.75	4.20	-0.27	0.389
	Avoidance	9.57	3.64	11.00	4.72	0.3	0.47
	Suppression	13.71	6.21	15.00	5.68	0.11	0.659
BHS		13.18	5.65	7.63	4.37	-0.94	0.009
ERS	Sensitivity	30.44	6.25	31.00	6.21	0.03	0.812
	Emotional intensity	22.56	4.33	22.25	3.73	-0.01	0.944
	Persistence	12.56	3.71	12.75	3.24	0.02	0.878
CERQ	Self-blame	15.71	3.68	13.75	3.20	-0.72	0.019
	Acceptance	13.00	4.32	13.63	3.81	0.15	0.418
	Ruminating	15.86	3.76	14.38	4.00	-0.37	0.311
	Positive centring	7.57	4.16	10.75	3.45	0.81	0.0001
	Centring on action	11.43	6.27	11.88	3.76	0.12	0.699
	Positive reassessment	11.00	6.61	11.88	3.76	0.2	0.531
	Putting things into perspective	10.86	6.20	11.58	4.08	0.17	0.477
	Dramatizing	11.10	5.22	10.50	4.34	-0.27	0.156
	Blaming others	10.29	3.68	8.25	5.15	-0.45	0.221
	Adaptive regulation	53.86	25.32	59.71	16.28	0.33	0.195
	Non-adaptive regulation	52.95	9.09	46.88	10.49	-0.66	0.089
BSL-23		2.03	0.85	1.78	0.63	-0.31	0.49
BES	Cognitive	31.43	2.70	33.63	2.33	0.83	0.039
	Affective	40.43	7.37	45.50	5.93	0.71	0.077
	Total	71.86	8.67	79.13	7.30	0.84	0.047
RFQ	Certainty	0.57	0.48	0.60	0.56	-0.02	0.919
	Uncertainty	1.28	0.55	1.10	0.53	-0.52	0.044

Table 4: assessment scales before and after 12 weeks of the introduction group, published in Prada et al. Encéphale 2018⁶⁹ (BDI-II: Beck depression inventory v.2; CAQ: cognitive avoidance questionnaire; BHS: Beck hopelessness scale; ERS: emotional reactivity scale; CERQ: cognitive emotional regulation questionnaire; BSL-23: borderline symptoms list; BES: basic empathic scale; RFQ: reflective functions questionnaire).

Future perspectives

The implementation of this treatment in our programme proved to be extremely stimulating and helped generate associated projects. We are currently working on adaptations of MBT for other clinical populations and situations.

The first of these is an MBT adaptation for another clinical population treated in our centre: adult sufferers of ADHD. This project falls quite naturally into our line of research, at the interface between BPD and ADHD (Prada et al. 2014²⁷). For these patients and for borderline patients, at the heart of their difficulties lie emotional dysregulation issues and perturbed interpersonal relations, to the extent that it becomes difficult to distinguish one disorder from the other. Furthermore, these disorders are often comorbid, with the subgroup of patients suffering from both disorders displaying an increased level of impulsiveness and aggression (Prada et al. 2014²⁷). It is often difficult to detect the comorbidity or to distinguish one disorder from the other, especially as there are no or few structured tools suited to the task (Weibel et al. 2018⁷⁰). An efficient treatment of ADHD, in particular based on psychostimulants, leads to clinical improvement in this subgroup, especially when its members also participate in dialectical behaviour therapy (Prada et al. 2015⁷¹). When examining their ability to mentalise, assessed through the reflective function, it appears that ADHD patients constitute an intermediary group between control subjects and patients suffering from BPD (Perroud et al. 2017²⁸), with the more impulsive patients scoring relatively poorly on the reflective function. Arguments therefore exist in favour of adapting MBT to this population. We must develop the skills necessary to treat these two disorders. This project is already well underway, with the first introduction groups for ADHD having started under the leadership of Nader Perroud, Deborah Badoud and Eva Rüfenacht. This is the first adaptation of MBT for ADHD sufferers. A version of this therapy is currently being prepared for adolescents suffering from ADHD in collaboration with Deborah Badoud and Martin Debbané.

Our institute provides regular MBT-related training to an increasing number of therapists, and we are now considering using MBT in other settings. We have also written a paper describing how MBT can be adapted for liaison psychiatry (Prada et al. 2017⁷²). Suffering from a somatic illness that requires a stay in hospital often leads to a form of “dependence” on the healthcare team, which activates attachment and weakens mentalisation capabilities. MBT provides a framework for understanding these situations and enables healthcare specialists to identify pre-mentalising modes of thinking, both in themselves and in the patient. This can be useful to resume a mentalised interaction and, as we postulate, to reduce the feeling of being misunderstood, the suffering, and potential misunderstandings, thereby lowering the risk of therapeutic failure.

Finally, we are working on introducing MBT in the treatment of patients who are going through a crisis, in particular a suicidal crisis. In the crisis unit that has recently come under our responsibility (UITB-2JC, Liaison Psychiatry and Crisis Intervention Service, HUG), intensive crisis assessment and intervention care is provided to patients who require a short hospitalisation. This work consists in updating the determinants of the psychic crises our patients are going through, so that they can be made aware of them, which enables us to provide proper treatment. The idea is not to eliminate the symptoms, as these can point us to their underlying causes. There are many ways in which MBT is suited to crisis interventions. Firstly, most of the patients who come to our crisis unit suffer from BPD. Secondly, the suicidal act can be understood as a desperate attempt to reduce the suffering

caused by repeated mentalising failures, and as an acute episode of non-mentalisation. Finally, the interview techniques of MBT are particularly well suited to a crisis intervention, the purpose of which is to explore, validate and formulate a shared understanding of the issues, and to work on the representations of self and on the representations of others that caused the crisis. As far as we can ascertain, there are at present no crisis units working with the MBT model. This is a direction we are currently taking. We have implemented regular MBT monitoring and are currently training our healthcare staff to use this approach. Our goal is to adapt MBT to this setting so that we can study its efficacy in the prevention of subsequent suicidal or self-damaging behaviours.

Conclusion

We are able to state that, in the past few years, we have actively contributed to the development, in French, of mentalisation-based therapies. However, as this study discloses, it is an on-going process. A particular feature of this project that we are keen to underscore is that it also leads to other associated projects. We have mentioned some of these, but there are many others initiated by our French-speaking colleagues. This is in keeping with the spirit of the MBT model. The process is indeed particularly important. The objective, however, changes and evolves in the course of the process.

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