REVIEW ARTICLE

Adv Psychiatry Neurol 2023; 32 (3): 167–174
DOI: https://doi.org/10.5114/ppn.2023.132508

Clinical diagnosis and case formulation in the psychotherapy of personality disorders

Lidia Cierpiałkowska

Institute of Psychology, Adam Mickiewicz University in Poznań, Poland

Correspondence to:
Lidia Cierpiałkowska
Institute of Psychology
Adam Mickiewicz University in Poznań
89AB Szamarzewskiego St.
60-568 Poznań, Poland
e-mail: lcierp@amu.edu.pl

Submitted: 20.02.2023
Accepted: 19.09.2023

Publication from the "Integralia 2022" conference, Warszawa–Łódź 25.11.2022

Abstract

Purpose: The article aimed to present a case conceptualization in two stages of therapy for PD patients qualifying for a specific therapy modality and diagnosis, including the conceptualization and monitoring of the process and mechanism of changes under the influence of specific therapeutic interventions. The problem is significant as there is a high level of treatment dropout among patients with various personality disorders.

Views: The article discusses the current state of knowledge and Kazdin's methodology of scientific research on the processes and mechanisms of change in patients under the influence of therapeutic interventions. Using the assumptions of this model, the author describes the six steps of a therapeutic procedure which aims at describing and monitoring the process and mechanism of therapeutic interventions, with a special emphasis on the significance of a mediator in the form of the therapeutic alliance. The therapeutic alliance is a significant mediator of changes leading to positive and/or negative therapy outcome and some of its components should be considered as moderators that may significantly modify the influence of the mediator on the strength of the links between a given therapy modality and its effectiveness.

Conclusions: Kazdin's model and diagnostic principles seem very useful and promising in clinical practice. At our current stage of knowledge and research, the diagnosing and monitoring of the process and mechanism of change in patients, resulting from specific therapeutic interventions, constitutes a considerable challenge for psychotherapists and clinicians.

Key words: case conceptualization, monitoring the process of change and mechanisms activated in therapy, therapy of personality disorders.

INTRODUCTION

The diagnosis of various aspects of mental health has usually different goals which are somehow interconnected, though in fact they are intended to perform different functions for an individual and their society. Hunsley and Mash [1] attempted to distinguish different types of diagnoses and goals of diagnostic research while emphasizing that, due to their specificity, they require particular professional competences from clinicians. They indicated seven types of diagnostic research which perform different functions: a) a diagnosis describing a person's mental health condition and its causes, without the necessity of references to a formal diagnostic or categorization system of mental and behavioral disorders (the descriptive and evaluative function); b) screening – identifying the characteristics of individuals at high risk for mental disorders (the predictive function); c) prognostic diagnosis concerning the course of a disorder in situations and contexts, e.g. entering and not entering treatment (the predictive function); d) case conceptualization/formulation, i.e. taking into account a comprehensive understanding of a patient's functioning (the explanatory function); e) diagnosis focused on treatment planning (the predictive function); f) monitoring the course of treatment (the explanatory and corrective function) and g) the evaluation of treatment outcome (the control function). Each of these kinds of diagnostic activity serves different functions on the individual and social planes. From the perspective of an individual, especially one suffering from mental health problems, clinical diagnosis is supposed to indicate effective treatment methods in the areas of psy-

chotherapy, pharmacotherapy and, in some cases, psychosocial rehabilitation. From the social perspective, diagnosis of the mental health of an individual or social groups is often made for prophylactic purposes, to enable an individual with a mental disorder to gain certain benefits they are entitled to, e.g., sickness allowance and other financial or community benefits, but also to restrict their civil rights in the name of higher values [2, 3].

The present article presents problems connected with the formulation of clinical descriptive diagnosis and clinical explanatory diagnosis and their functions in two stages of treatment of patients with a personality disorder qualifying them for treatment and monitoring the course of their psychotherapy. While we have considerable knowledge concerning diagnostic procedures and the formulation of various types of clinical diagnoses applied for the sake of treatment referrals, little is known about diagnostic procedures that include the monitoring of the processes taking place in psychotherapy and the subsequent use of this knowledge to predict treatment outcomes. Since most studies, including those on patients with personality disorders, have focused on the verification of treatment outcomes, we know much more about the effectiveness of various treatment modalities than about the positive and negative phenomena that occur in the process of therapy and may affect its ultimate outcome [4-6]. Currently, the diagnosis of the course of psychotherapy seems to pose the greatest challenge for researchers, methodologists and clinical practitioners.

TYPES AND FUNCTIONS OF CLINICAL DIAGNOSIS AT THE STAGE OF QUALIFYING A PERSON FOR TREATMENT

Psychological diagnosis, including the clinical one, is a complex and often multi-stage activity directed at goals agreed between a psychologist and an examined individual, and entailing the collection and integration of data according to the knowledge from psychology and related sciences as well as skills learned in specialized education which will be applied in accordance with a set goal [7-9]. Depending on the aim of the diagnostic process and the knowledge used by a clinician, three types of diagnosis are differentiated: the differential (categorial), the structural-functional, and the epigenetic. The first one is descriptive, the other two explanatory; each of them may have a more comprehensive or more selective form focused on the diagnosis of chosen aspects of an individual's psycho-social functioning.

The nosological diagnosis of personality disorders, similarly to other psychic disorders, involves: 1) collecting information based on a clinical interview and observation, self-reports and analysis of narration about repetitive traits and ways of experiencing oneself, as well as experiences and behaviors in relationships with others that are characteristic of a person, 2) integration of the collected data, including ambiguities and contradictions between outcomes arising from the use of different methods, 3) formulating a hypothesis about a type of psychic disorder and a hypothesis about an alternative disorder, if justified and 4) making a diagnostic decision based on the degree of similarity of a person's manifestations of functioning to the descriptions of personality disorders in ICD-11 [10, 11] and/or DSM-5 ([12]; cf. the alternative model in part III). Both classifications, instead of a typically categorial approach, use categorial-dimensional or dimensional approaches which find their bases in contemporary psychological conceptions of mature and disordered (i.e., having an unintegrated structure or organization) personality [13, 14]. The comparison in the first step should embrace the evaluation from the area of self (identity, self-esteem, self-description adequacy and self-direction ability) and the area of interpersonal relationships (interest in relationships with others, ability to initiate and maintain satisfactory relationships, the skills of taking into account and appreciating others' perspectives, coping with conflicts). The second step should constitute the identification of pathological personality traits, such as: negative emotionality, disinhibition, isolation, dissocial tendencies and anankastia, whereas the third one, not obligatory, is the determination of the presence or absence of BPD in a person. Based on the characteristics of a person pertaining to self and interpersonal relationships, a clinician decides if there exists a personality disorder, if so, how deep it is – mild, moderate or severe [11, 14]. The aim of the formulation of a descriptive diagnosis of a personality disorder and the evaluation of its severity is to plan the treatment, i.e., especially recommended (empirically confirmed) effective modalities of psychotherapy and, in special cases, pharmacotherapy. Whereas nosological diagnosis gives clinicians some basis on which to recommend various effective therapies to a person, structural-functional psychological diagnosis allows for the identification of those aspects of personality which can form the basis for a decision as to whether a person is qualified for a specific therapy modality.

Comprehensive structural-functional diagnosis, also called case conceptualization, is formulated in the context of a selected theoretical and/or empirical model. This, in turn, allows for the description and explanation of the dynamics of the activation and deactivation of the pathomechanism involved in the persistence and remission of various symptoms of a psychic disorder. In the structural-functional diagnosis of personality disorders, a clinician/therapist may refer to the assumptions of one of the prevailing theoretical paradigms, e.g., psychodynamic [15, 16], cognitive-behavioral [17, 18] or integrative [19], or to one of the paradigms constructed

© 2023 Institute of Psychiatry and Neurology. Production and hosting by Termedia sp. z o.o.
This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/)

based on empirical evidence [20]. Apart from certain exceptions, little is known about which rules should be used to integrate knowledge concerning the pathomechanism and pathogenesis derived from the paradigms and how they could be taken advantage of to diagnose the process of psychotherapy. Numerous researchers emphasize that it is the structural-functional diagnosis that creates valid premises for qualifying a person for the modalities of therapy likely to be effective for them. For instance, a person with a moderately severe personality disorder with the BPD pattern and suicidal behaviors, who is not very reflective, especially while experiencing strong emotions but is motivated to receive treatment, fulfills the conditions of achieving a positive change owing to dialectical behavioral therapy [19]. However, the same person, due to a specific way of thinking and serious difficulties with mentalization because he or she considers what they experience as reality (the pre-mentalization mode), cannot achieve a positive change in psychotherapy based on transference. In such a case change on the level of social functioning will be achieved in supportive psychotherapy [21, 22]. Each of these therapy modalities indicates the conditions that must be fulfilled for their specific procedures and therapeutic strategies to be effective and bring the expected changes.

THE AIMS AND FUNCTIONS OF DIAGNOSING IN THE PROCESS OF PSYCHOTHERAPY

Although research on treatment outcomes has confirmed the effectiveness of many psychotherapy modalities, it has not explained how the process of change actually takes place and what is its mechanism, i.e., how specific therapeutic interventions work. This problem seems especially significant when one considers the issue of the effectiveness of treatment for personality disorders, as not all cognitive-behavioral or psychodynamic therapies turn out to be effective for BPD or NPD patients [23, 24]. Numerous meta-analyses and research results from randomized samples have confirmed the effectiveness of psychodynamic psychotherapies for personality disorders, e.g., transference-focused psychotherapy (TFP) [22, 23] and mentalization-based therapy (MBT) [21, 24], as well as dialectical behavior therapy (DBT) [25, 26] and schema therapy (ST) [26, 27] in the cognitive-behavioral approach. The research also indicates what outcome one might expect on the level of symptoms and patterns of psychosocial functioning, e.g., in BPD patients in the case of an optimal course of therapy [23, 26].

However, the research on the mechanism of change in the therapeutic process is a relatively new issue, which requires not only theoretical reflection but also the scientific description of new research methodology and procedures. Generally speaking, this newer approach attempts to answer three groups of questions: what is the course of the process of change (what is the form of change?), which factors significantly moderate change (for whom and in what conditions does change take place?), and what are the mediators of change in the process of therapeutic intervention (why and which interventions, their configuration or consequences lead to change or inhibit it?) [4-6]. All of these questions are very significant. However, because of the aim of the article I am going to present only those issues that pertain to the question of which aspects of psychotherapy modalities should be diagnosed in the course of monitoring the process and mechanism of therapeutic changes in patients.

The first more comprehensive conceptions of research on the process and mechanisms of change in the course of therapy, with various propositions for methodology, appeared at the beginning of the current century. The model of the diagnosis of the process and mechanism of change in the case of an individual patient presented below is the attempt to integrate the knowledge coming from these conceptions with the research on the influence of specific and common healing factors in the psychotherapy of persons with personality disorders [5, 27, 28]. The assumptions connected with the methodology of the research on the mechanisms and processes of change in various psychotherapy modalities are used here to present these problems.

Kazdin [4, 5], the author of the methodology of research on the process of change in psychotherapy, claimed that the diagnosis of the process and mechanisms of such change should take place in the context of a specific theory of a personality disorder or an integrative, empirical model formed on the basis empirical evidence (assumption 1). While choosing an intervention, one should take into account empirically verified specific cause-and-effect relationships between a therapeutic intervention (A), activated by mediators (B) processes and healing mechanisms (assumption 2), and change in the form of a definite effect (C) (assumption 3), e.g., achieving a greater identity congruence or ability for self-direction. The evaluation of a cause-effect relationship between a therapeutic intervention and intrapsychic and/or behavioral change should occur in a specific timeline placed on the mediator-mechanism-outcome axis (assumption 4). One should also take into account those moderators which can affect the different outcomes of the influence of specific interventions on the activated healing process and the effects achieved owing to it (assumption 5). The knowledge about the processes and mechanisms of change and their outcome allows for the monitoring of the influence of therapeutic interventions in the case of an individual patient, and the conclusions drawn from the diagnosis can form a basis for implementing change related to significant mediators introduced by a therapist (assumption 6) [4-6].

Which mediators of the process of change resulting from specific procedures of psychodynamic psychotherapy (e.g., TFP, MBT) or cognitive-behavioral therapies (e.g., DBT, ST) should be taken into account in persons with various personality disorders? Research on the outcomes of different therapy modalities revealed specific and common healing factors owing to which the expected outcome is achieved [28-31]. Specific healing factors are activated by particular strategies and therapeutic procedures characteristic of a specific therapy modality; these are the following: clarification, confrontation and interpretation in psychodynamic psychotherapy; and behavioral skills training (e.g. relaxation, assertiveness or solving interpersonal conflicts training), modelling, positive and negative reinforcement, Socratic dialogue and other techniques of cognitive reappraisal in integrative cognitive-behavioral therapies. According to the assumptions of object relations theory and the research on the outcomes of psychodynamic therapies (e.g. TFP, MBT) it is confirmed that these applied interventions and procedures activate such processes and mechanisms of change as: catharsis, realization of unconscious conflicts (through interpretation of associations, dreams, fantasies; positive and negative transference in the therapeutic relationship and resistance to transference), transforming immature defense mechanisms (splitting, projection and projective identification) into those that are more mature (e.g. suppression, rationalization, sublimation), and developing the ability to reflect and mentalize [32, 33]. On the other hand, according to the assumptions and results of the bulk of research on the outcomes of cognitive-behavioral therapies (DBT and ST) in the treatment of personality disorders, intervention strategies and procedures activate such processes of change as skills in the monitoring and controlling of negative emotions and self-destructive behaviors; transformation of automatic thoughts and maladaptive core beliefs into more adaptive ones; and recognition and monitoring of mistakes in transforming information about oneself and others [17, 19].

At present the greatest attention in the diagnosis of the process and mechanisms of change in psychotherapy for patients with personality disorders is focused on the common factors, mainly on the therapeutic relationship and alliance, which significantly affect the course of, mechanisms of change in and persistence with therapy. One of the greater problems in treatment of patients with personality disorders from cluster B of the DSM-5 is the difficulty with staying in the therapeutic relationship, i.e., the high dropout rate. The links between the therapeutic alliance and positive treatment outcome in various psychic and behavioral disorders, regardless of the modality, have been consistently confirmed [34-36]. Researchers make attempts to create a methodology that will allow for the assessment of a dynamic interaction between specific and non- specific healing factors, as opposed to the hitherto-existing method of a separate assessment of each of these factors in the context of processes of change in a patient.

Psychodynamic psychotherapy differentiates three main elements of the therapeutic relationship: 1) the patient's transference, activating early unconscious representations of the self-object relationship in the relationship with the therapist, 2) the therapist's countertransference, activated under the influence of identification with aspects of self and/or object projected by the patient and 3) a real, more conscious motivation for treatment [37]. In cognitive-behavioral approaches the therapeutic relationship is most often defined as the patient's readiness for cooperation and involvement in the agreed goals of therapy, which is very unstable in the case of personality disorders [19, 31, 38]. The instability of the relationship and of the therapeutic alliance induced the creators of DBT and ST to formulate additional conditions providing or restoring accurate cooperation and motivation for working on change (e.g., dialectical strategies in DBT) [19, 38]. Both of these therapeutic approaches, especially in comparative and clinical research, extensively use Bordin's transtheoretical model [39, 40], which generated reliable and valid research tools (e.g., Working Alliance Inventory). This model indicates three aspects of the alliance: the bond between the patient and therapist, the goals of the therapy, and the tasks of the therapy. The quality of the working therapeutic alliance is evaluated as the level of the patient's cooperation with the therapist, which is determined not only by the strength of their bond (the affective component of the alliance – a sense of being liked, accepted and understood) but also by the level of the patient's participation in agreeing to more important treatment goals (the cognitive component) and the more important tasks necessary for the achievement of these goals.

Because of the high rate of treatment dropout of patients with cluster B personality disorders, especially those with narcissistic, borderline and histrionic personality disorders (patients with the remaining personality disorders from clusters A and C can rarely be found in the research group), a substantially greater significance is attributed to the influences of the therapeutic alliance, including patients' capacity to form more satisfactory interpersonal relationships. In a group of these patients, researchers have observed greater fluctuations of the strength of the therapeutic alliance than in other psychic disorders, which often led to treatment dropout [41-44]. In focusing on the explanation of the influence of the therapist and patient on the fluctuating dynamics of the therapeutic alliance, on the one hand there was an attempt to indicate those therapeutic interventions which activate changes in the strength of the alliance in patients, while on the other hand researchers were interested in the answer to the question of which traits

© 2023 Institute of Psychiatry and Neurology. Production and hosting by Termedia sp. z o.o.
This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/)

of patients with personality disorders are significant mediators of processes and mechanisms of change [45, 46] that affect the decision to stay in treatment or drop out. It was determined that there is a greater impairment of the strength of the therapeutic alliance in every treatment modality when the therapist applies interventions that ignore (and in consequence invalidate) the patient's complaints about feeling bad or experiencing stress (e.g. when the patient complains of being mistreated by their boss again) or when the therapist concentrates mainly on confrontation and the interpretation of the patient's functioning at home and in the therapeutic relationship in such a situation. On the other hand, the strength of the alliance increases when the therapist listens with acceptance, understands and reflects on negative emotions or when interventions, in the form of interpretation, nd confrontation are adjusted to the state of the patient with PD. Stricker and Gold ([47], p. 225) concluded that when deciding on an intervention the therapist must take into account the "level of suffering and ability to tolerate that suffering, capacity to delay gratification, and his or her psychological sophistication and interest in self-understanding". This claim has found confirmation in numerous studies of prototypical therapeutic processes, e.g., in TFP and DBT [46, 48], which resulted in greater activity on the part of the therapist in the area of building the therapeutic relationship, especially in the initial phase of the process. It has been confirmed that patients with more severe personality disorders are characterized by a greater dominance of insecure attachment styles (e.g., ambivalent or disorganized), a lower threshold of frustration tolerance, greater difficulties in the regulation of negative emotions, especially anger and aggression, and a greater emotional vulnerability [42, 49].

While analyzing the effect of the therapeutic alliance on the process and mechanisms of change one must differentiate between the outcomes achieved when the alliance is treated as a trait from that in which it is treated as a state. This distinction seems important both for statistical reasons (as, generally speaking, neither of these two outcomes can be entirely inferred from the other one) and conceptual ones (each of them may serve different functions in treatment and have different implications for clinical practice) [46, 48]. The ability to form the therapeutic alliance can be treated as a trait on the basis of which one can predict treatment outcome, as some of its components (e.g., forming a bond with the therapist) indicate an individual's general ability to form satisfactory social relationships. On the other hand, the patient-therapist alliance as a state can induce a therapeutic change by itself by developing a patient's ability to form more satisfactory social relationships; the mechanism of change activated by the alliance as a state resulted in such change as the ability to form a more satisfactory relationship not only with the therapist, but also with other people outside treatment (and reduction of the symptoms of a personality disorder as a result).

For instance, the therapist usually expects some difficulty in maintaining the therapeutic relationship with a patient having the ambivalent attachment style characteristic of BPD patients. However, the therapist's working through a rupture in the therapeutic alliance with the patient contributes, as we already know from the research [42, 44], to activating such changes in the patient as greater stress tolerance due to catharsis and expanding the skill to consider the other's perspective (as different from one's own) in the understanding of a conflict (the ability to mentalize), as well as to attempt to understand the sources of misunderstanding, which leads to a greater stability in social relationships (without the necessity of their immediate devaluation). It turns out that the therapeutic alliance is a significant mediator of changes that lead to positive and/or negative treatment outcomes. What is more, some of the components of the therapeutic alliance should be considered as moderators which can significantly change the influence of the mediator on the strength of the links between a modality of psychotherapy and its outcome.

CONCLUSIONS

The article presents the issue of the significance of a descriptive and explanatory clinical diagnosis in two stages of therapy for persons with personality disorders who qualify for a specific treatment modality and diagnosis which relies on the conceptualization and monitoring of the process and mechanism of changes caused by specific therapeutic interventions. Numerous studies and meta-analyses have corroborated the effectiveness of psychodynamic psychotherapies – TFP and MBT, as well as the integrative cognitive-behavioral therapies DBT and ST – in the treatment of personality disorders (e.g., [23], [26], [27], [33]). Little is known, however, about which processes and mechanisms of change are activated in patients by therapeutic interventions in various therapeutic modalities, i.e., how the process of change actually runs in a patient. Without this knowledge therapists are not able to sufficiently monitor and direct the activation of the processes of change in patients, especially those that are undesirable from the perspective of treatment outcomes.

Based on the existing knowledge from scientific research on the processes and mechanisms of change in patients with personality disorders, derived from Kazdin's model [4, 5], I have presented the general assumptions of a diagnostic procedure of case conceptualization, indicating those aspects of therapeutic interventions and therapeutic relationship that should be taken into account while monitoring the course of an individual's treatment.

As far as the diagnostic model monitoring the therapeutic process and mechanisms of change is concerned,

special attention should be paid to five procedural principles: 1) case conceptualization should be made on the basis of the assumptions of a specific psychopathological theory or a specific empirical model of a personality disorder (most accurately, the same theory/model was referenced and used in the conceptualization of the pathomechanism and pathogenesis of a disorder); 2) the choice of a monitored intervention should take into account knowledge about the cause-effect relationships between a therapeutic intervention and change in the form of activating specific processes in PD patients, which can be significantly modified by the therapeutic alliance understood as a state or trait; 3) the therapeutic alliance as a state is activated in the therapist-patient relationship; this alliance as a trait is an important moderator of therapy outcome, i.e. a predictor of the quality of the relationship and therapeutic alliance (the quality of the therapeutic relationship is considered a manifestation of secure or insecure attachment); 4) the examination of the influence of interventions on the process and mechanism of intrapsychic and/or behavioral change should include patient-therapist interactions in a specific time frame; 5) the knowledge gained about the activation of desirable and undesirable processes and mechanisms of change in a patient, as well as the knowledge about the quality of the therapeutic alliance, is the basis for the possible continuation or alteration of therapeutic interventions (e.g. discussing the causes of a rupture of the therapeutic alliance).

There is no credible psychotherapy without a credible diagnosis [50]. At our current stage of knowledge and research, the diagnosing and monitoring of the process and mechanism of change in patients, resulting from specific therapeutic interventions, constitutes a considerable challenge for psychotherapists and clinicians.

Conflict of interest

Absent.

Financial support

Absent.

References

1. Hunsley J, Mash RJ. Developing criteria for evidence-based assessment: an introduction to assessments that work. In: Hunsley J, Mash RJ (eds.). A Guide to Assessments That Work. New York: Oxford University Press; 2018, pp. 3-16.
2. Brzeziński J, Kowalik S. Diagnoza kliniczna w kontekście praktyki społecznej. In: Sęk H (ed.). Społeczna psychologia kliniczna. Warszawa: PWN; 2000, pp. 187-212.
3. Cierpiałkowska L, Sęk H, Soroko E. Postępowanie diagnostyczne psychologa klinicznego a konteksty i sytuacje społeczne tworzenia diagnozy. In: Cierpiałkowska L, Sęk H (eds.). Psychologia kliniczna. Warszawa: PWN; 2016, pp. 217-234.
4. Kazdin AE. Mediators and mechanisms of change in psychotherapy research. Annu Rev Clin Psychol 2007; 3: 1-27.
5. Kazdin AE. Understanding how and why psychotherapy leads to change. Psychother Res 2009; 19: 418-428.
6. Laurenceau JP, Hayes AM, Feldman GC. Some methodological and statistical issues in the study of change processes in psychotherapy. Clin Psychol Rev 2007; 27: 682-695.
7. Paluchowski WJ. Diagnoza psychologiczna. Podejście ilościowe i jakościowe. Warszawa: Wydawnictwo Naukowe Scholar; 2001.
8. Stęplewska-Żakowicz K. Diagnoza psychologiczna. Diagnozowanie jako kompetencja profesjonalna. Warszawa: GWP; 2009.
9. Cierpiałkowska L, Soroko E, Sęk H. Modele diagnozy a problemy diagnostyczne. In: Cierpiałkowska L, Sęk H (eds.). Psychologia kliniczna. Warszawa: PWN; 2016, pp. 195-216.
10. Tyrer P, Mulder RT, Kim YR, Crawford MJ. The development of the ICD-11 classification of personality disorders: an amalgam of science, pragmatism, and politics. Annu Rev Clin Psychol 2019; 15: 481-502.
11. Bach B, Simonsen S. How does level of personality functioning inform clinical management and treatment? Implications for ICD-11 classification of personality disorder severity. Curr Opin Psychiatry 2021; 34: 54-63.
12. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: American Psychiatric Association; 2013.
13. Clarkin JF, Caligor E, Sowislo JF. An object relations model perspective on the alternative model for personality disorders (DSM-5). Psychopathology 2020; 53: 141-148.

© 2023 Institute of Psychiatry and Neurology. Production and hosting by Termedia sp. z o.o.
This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/)

14. Mulder R. ICD-11 personality disorders: utility and implications of the new model. Front Psychiatry 2021; 12: 655548. DOI: 10.3389/fpsyt.2021.655548.
15. Kernberg OF, Caligor E. A Psychoanalytic theory of personality disorders. In: Lenzenweger MF, Clarkin JF (eds.). Major theories of personality disorder. New York: Guilford Press; 2007; pp. 114-156.
16. Fonagy P, Target M. The mentalization-focused approach to self-pathology. J Pers Disord 2006; 20: 544-676.
17. Young JE, Klosko JS, Weishaar ME. Schema therapy: a practitioner's guide. New York: Guilford Press; 2003.
18. Bach B, Lockwood G, Young JE. A new look at the schema therapy model: organization and role of early maladaptive schemas. Cogn Behav Ther 2018; 47: 328-349.
19. Linehan MM. Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press; 1993.
20. Hopwood ChJ. Interpersonal dynamics in personality and personality disorders. Eur J Pers 2018; 32: 499-524.
21. Fonagy P, Bateman AW. Mentalization-based treatment of BPD. J Pers Disord 2008; 18: 36-51.
22. Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF. The Personality Disorders Institute/Borderline personality disorder research foundation randomized control trial for borderline personality disorder: Rationale, methods, and patient characteristics. J Pers Disord 2004; 18: 52-72.
23. Leichsenring F, Klein S. Evidence for psychodynamic psychotherapy in specific mental disorders: a systematic review. Psychoanalytic Psychotherapy 2014; 28: 4-32.
24. Vogt KS, Norman P. Is mentalization-based therapy effective in treating the symptoms of borderline personality disorder? A systematic review. Psychol Psychother 2019; 92: 441-464.
25. Bedics JD, Atkins DC, Comtois KA, Linehan MM. Treatment differences in the therapeutic relationship and introject during a 2-year randomized controlled trial of dialectical behavior therapy versus nonbehavioral psychotherapy experts for borderline personality disorder. J Consult Clin Psychol 2012; 80: 66-77.
26. Oud M, Arntz A, Hermens MLM, Verhoef R, Kendall T. Specialized psychotherapies for adults with borderline personality disorder: a systematic review and meta-analysis. Aust N Z J Psychiatry 2018; 52: 949-961.
27. Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, Asselt T, et al. Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs transference-focused psychotherapy. Arch Gen Psychiatry 2006; 63: 649-658.
28. Mulder R, Murray G, Rucklidge J. Common versus specific factors in psychotherapy: opening the black box. Lancet Psychiatry 2017; 4: 953-962.
29. Wampold BE. How important are the common factors in psychotherapy? An update. World Psychiatry 2015; 14: 270-277.
30. Czabała C. Czynniki leczące w psychoterapii. Warszawa: PWN; 2020.
31. Wampold BE. How important are the common factors in psychotherapy? An update. World Psychiatry 2015; 14: 270-277.
32. Goodman G, Anderson K, Diener AJ. Processes of therapeutic change in psychodynamic therapy of two inpatients with borderline personality disorder. J Psychot Integ 2014; 24: 30-45.
33. Gabbard GO, Horowitz MJ. Insight, transference interpretation, and therapeutic change in the dynamic psychotherapy of borderline personality disorder. Am J Psychiatry 2009; 166: 517-521.
34. Leibovich L, Front O, McCarthy KS, Zilcha-Mano S. How do supportive techniques bring about therapeutic change: The role of therapeutic alliance as a potential mediator. Psychotherapy 2020; 57: 151-159.
35. Flückiger C, Del Re AC, Wampold BE, Horvath AO. The alliance in adult psychotherapy: a meta-analytic synthesis. Psychotherapy 2018; 55: 316-340.
36. Baier A, Kline AC, Feeny NC. Therapeutic alliance as a mediator of change: a systematic review and evaluation of research. Clin Psychol Rev 2020; 82: 101921. DOI: 10.1016/j.cpr.2020.101921.
37. Freud S. On the beginning of treatment: Further recommendations the technique of psychoanalysis. In: Strachey J (ed.). The Standard Edition of the Complete Psychological Works of Sigmund Freud. Vol. 12. London: Hogarth Press; 1994, pp. 122-144.
38. Beck A, Freeman A, Davis DD. Cognitive therapy of personality disorders (2nd). New York: Guilford Press; 2004.
39. Bordin ES. The generalizability of the psychoanalytic concept of the working alliance. Psychother Theory Res Pract 1979; 16: 252-260.
40. Bordin ES. Theory and research on the therapeutic working alliance: new directions. In: Horvath AO, Greenberg LS (eds.). The Working Alliance. Theory, Research, and Practice. New York: John Wiley & Sons, Inc.; 1994, pp. 13-37.
41. Horvath AO, Symonds BD. Relation between working alliance and outcome in psychotherapy: a meta-analysis. *J Couns Psychol* 1991; *38:* 139-149.
42. Perry JC, Banon E, Lanni F. Effectiveness of psychotherapy for personality disorders. Am J Psychiat 1999; 156: 1312-1321.
43. Muran JC, Safran JD, Gorman BS, Samstag LW, Eubanks-Carter C, Winston A. The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. Psychotherapy (Chic) 2009; 46: 233-248.
44. Safran JD, Muran JC, Eubanks-Carter C. Repairing alliance ruptures. In: Norcross JC (ed.). Psychotherapy relationships that work: evidence-based responsiveness. New York: Oxford University Press; 2011, pp. 224-238.
45. Eubanks CF, Muran JC, Safran JD. Alliance rapture repair: a meta-analysis. Psychotherapy 2018; 55: 508-519.
46. Zilcha-Mano S, Errázuriz P. Early development of mechanisms of change as a predictor of subsequent change and treatment outcome: the case of working alliance. J Consult Clin Psychol 2017; 85: 508-520.

47. Stricker G, Gold J. Assimilative psychodynamic psychotherapy. In: Norcross JC, Goldfried MR (eds.). Handbook of Psychotherapy Integration. 2nd ed. New York: Oxford University Press; 2005, pp. 221-240.
48. Goodman G. Is mentalization a common process factor in transference-focused psychotherapy and dialectical behavior therapy sessions? J Psychother Integ 2013; 23: 179-192.
49. Wallin DJ. Attachment in psychotherapy. New York: Guilford Press; 2007.
50. Paluchowski WJ. Evidence-based assessment – do we need "Polish Buros". Roczn Psychol 2010; 13: 7-26 [In Polish].

© 2023 Institute of Psychiatry and Neurology. Production and hosting by Termedia sp. z o.o.
This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/)