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Investigating The Challenges In Treatment Of Individuals With Borderline Personality Disorder: A Clinician's Perspective

Sania Shahzad	Psychology Department Air university Islambad. Email: saniashahzad4002@gmail.com , Phone: +923260705443
Fatima Bangash	Psychology Department Air university Islambad. Email: 221923@students.au.edu.pk
Maryam Bokhary	Psychology Department Air university Islambad. Email: 221919@students.au.edu.pk
Mahk Arshad	Psychology Department, Air university Islambad. Email: 221924@students.au.edu.pk
Dr Wajiha Yasir	Psychology Department Air university Islambad. wajeehayasir@gmail.com

Abstract: *This study examines the experiences of clinical psychologists working with individuals diagnosed with Borderline Personality Disorder (BPD) in Pakistan. BPD is a complex and emotionally intense condition, often causing instability in relationships, identity, and mood. The study uses a qualitative, phenomenological approach to interview five practicing psychologists in Lahore, each with at least three years of experience. The findings reveal that clinicians often face emotional challenges such as helplessness, burnout, and countertransference. They struggle with maintaining therapeutic boundaries, managing crises, and navigating treatment resistance. Despite these challenges, many clinicians find meaning in their work through mindful practice, peer support, supervision, and a commitment to helping clients build healthier lives. The research underscores the need for greater institutional support, specialized training, and culturally relevant interventions.*

Keywords: Borderline Personality Disorder, Clinical Psychologist, Therapeutic Challenges, Emotional Burnout, Qualitative Research, Pakistan

Introduction

This chapter provides an overview of the current study; specifically, it will briefly explore and define the clinical diagnosis of borderline personality disorder and its prevalence within the mental health community and in the general community at large. Further, it will aim to introduce the current trends in literature specific to symptomatology, diagnosis, and treatment. Secondary to this aim is the introduction of challenges clinicians might face when working with individuals diagnosed with borderline personality disorder. Finally, this chapter will introduce the main research questions and hypothesis of the study. It is the intention of this research to better understand therapists' experience of working with individuals diagnosed with borderline personality disorder.

Borderline Personality Disorder (BPD) is characterized by "a pervasive pattern of instability in interpersonal relationships, self-image, and affects, along with marked

impulsivity, beginning by early adulthood and present in a variety of contexts." This pattern includes intense fear of abandonment, unstable and intense relationships, identity disturbance, impulsivity, recurrent suicidal behavior or self-harm, emotional instability, chronic feelings of emptiness, inappropriate anger, and transient stress-related paranoia or dissociation (Diagnostic and Statistical Manual of Mental Disorders, 5th ed., Text Revision [DSM-5-TR]; American Psychiatric Association, 2022)

Borderline Personality Disorder (BPD) is a prevalent disorder with a 1.6% point prevalence and 5.9% lifetime prevalence globally. It affects 2-6% of US adults. Despite treatment, BPD patients often return for treatment and have higher mental health service utilization than other psychiatric disorders (Zanarini, 2009). Consequently, they receive lower treatment and rehabilitation opportunities. Current funding for research on BPD is only around $6 million annually. BPD patients make up 10% of psychiatric outpatient and 20% of inpatient programs, indicating a low demand for mandated services and treatment (Lieb et al., 2004).

Recent literature on borderline personality disorder continues to have a preoccupation with investigating certain diagnostic symptoms, such as emotional dysregulation (Tragesser et al., 2007), unstable and intense interpersonal relationships (Berdahl, 2010), self-harm and suicide ideation (Brown et al., 2002; Hunt, 2007; Miller et al., 2010; Alston & Robinson, 1992), and violent behavior (Lâtalová & Prasko, 2010), with little emphasis on how therapists may perceive these diagnostic symptoms during treatment.

Clinical psychologists play a crucial role in treating Borderline Personality Disorder (BPD) patients, who often experience emotional dysregulation, impulsivity, and interpersonal challenges. They must combine structured therapeutic approaches with professional boundaries to effectively treat these patients.

Dialectical Behavior Therapy (DBT), a cognitive-behavioral framework developed by Marsha Linehan, is a popular method for BPD treatment, combining mindfulness and distress tolerance with emotion regulation and interpersonal effectiveness. DBT has been shown to decrease self-harm actions, emotional volatility, and impulsive behavior, making it a top therapeutic approach for BPD (Linehan, 1993). The primary strength of DBT is mindfulness training, which helps patients detect their thoughts and emotions better, promoting better treatment compliance and sustained emotional well-being (Salgó et al., 2021).

Cognitive Behavioral Therapy (CBT) is another popular psychological therapeutic method for BPD treatment, helping patients restructure problematic thinking patterns and undesired behaviors. However, CBT's effectiveness falls behind DBT when treating severe emotional dysregulation and self-harm behaviors. Combining DBT with CBT offers complete advantages for BPD patients by treating thought distortions and emotional instability (Salgó et al., 2021).

BPD patients exhibit intense relationship instability towards therapists and unstable interpersonal interactions. Attachment instability is a core feature of BPD, leading patients to provide extreme positive or negative appraisals of their therapist within short periods (Euler et al., 2021). This can create obstacles for building stable therapeutic alliances between patient and therapist. Emotional exhaustion and

countertransference are common experiences for therapists working with BPD patients due to their intense emotional swings (Maslach & Leiter, 2016).

Emotional regulation challenges are a major issue in BPD, as emotional dysregulation produces strong mood shifts, impulsive actions, and challenges in managing distress (Robin et al., 2021). A heightened physiological stress response in BPD patients leads to difficulty regain control after emotional activation (Salgo et al., 2021). Mindfulness-based therapies like DBT provide effective solutions for emotional control through distress tolerance and emotion regulation methods. Combining mindfulness techniques within therapeutic sessions enables clients to decrease their emotional sensitivities and decisions based on impulse and destructive behaviors (Linehan, 1993).

Interpersonal difficulties in BPD include attachment instability, which prompts people to shift between extreme positive and negative views of others through splitting behavior (Euler et al., 2016). Chronologically changing emotions cause relationship conflicts and fear of abandonment, hindering stable relationships, including therapy sessions (Maslach & Leiter, 2016). BPD clients often develop strong emotional bonds with their therapists, but fluctuating perceptions can cause therapy ruptures and non-compliance, resulting in emotional distress for both parties. MBT and TFP offer structured methods to help clients and therapists build stable, realistic therapeutic bonds to handle these treatment challenges (Euler et al., 2021).

Along with diagnostic guidelines, empirical investigations have mainly explored the effectiveness of manualized treatments for patients with BPD, that is, Dialectical Behavior Therapy (DBT; Linehan, 1993). DBT integrates typical Cognitive Behavior Therapy skills with fundamental mindfulness skills to promote emotional regulation, distress tolerance, and interpersonal competence.

Fallon (2003) highlights the challenges faced by borderline personality disorder (BPD) clients, including extreme emotional instability, which can lead to challenging therapeutic encounters. Aviram, Brodsky, and Stanley (2006) asserted that therapists may feel negative emotions and avoid or actively dislike these patients. Community mental health professionals may feel insecure and demoralized, and may become overwhelmed by their clients' emotions. This can also affect their intimate and personal relationships. Caregivers and family members of BPD patients are more likely to experience depression, hostility, and anxiety (Scheirs & Bok, 2007). The therapeutic relationship between client and therapist is crucial for healing and modeling appropriate interpersonal skills. However, caregivers may feel challenged and triggered, leading to unconsciously modeled behaviors (Eskedal, 1998).

The theoretical framework for diagnosing and treating Borderline Personality Disorder (BPD) is based on several complementary ideas that work together to address clinical problems. Attachment theory provides insight into the connections between patients with BPD, as early interactions with caregivers form lasting relationship models that accompany people throughout their lives. Patients with BPD show substantial mentalization impairment coupled with heightened emotional states because their preoccupied and fearful-avoidant attachment patterns develop from early attachment difficulties (Bulh-Nielsen et al., 2024). These patients

demonstrate 25% intensified stress reaction patterns in their bodies, presenting complex care challenges for clinicians who need to heal attachment traumas and manage complex transference patterns (Buchheim & Diamond, 2018).

Borderline Personality Disorder (BPD) is characterized by a pervasive pattern of instability in interpersonal relationships, self-image, and affects, along with marked impulsivity, beginning by early adulthood and present in various contexts. This pattern includes intense fear of abandonment, unstable and intense relationships, identity disturbance, impulsivity, recurrent suicidal behavior or self-harm, emotional instability, chronic feelings of emptiness, inappropriate anger, and transient stress-related paranoia or dissociation. Recent literature on BPD has focused on investigating certain diagnostic symptoms, such as emotional dysregulation, unstable and intense interpersonal relationships, self-harm and suicide ideation, and violent behavior (Diagnostic and Statistical Manual of Mental Disorders, 5th ed., Text Revision [DSM-5-TR]; American Psychiatric Association, 2022).

Biosocial Model of Emotional Regulation is an empirical investigation that integrates typical Cognitive Behavior Therapy skills with fundamental mindfulness skills to promote emotional regulation, distress tolerance, and interpersonal competence. Emotional instability, one of the hallmark symptoms of BPD, can produce challenging therapeutic encounters for both the client and the therapist. Community mental health professionals encounter this group as insecurely attached and demoralized in their ability to work effectively with them, making it problematic to build a healthy therapeutic relationship (Erkoreka et al., 2021).

The Alternative Model for Personality Disorders (AMPD) personality disorder classification offers treatment strategies that focus on single traits, where therapists can use impulse control strategies to treat disinhibition while building empathy to decrease antagonistic behavior (Crow & Levy, 2019). However, medical professionals who use categorical models find it challenging to turn AMPD's dimensional structure into clinical application, which might influence both treatment strategies and patient insurance benefits (Erkoreka et al., 2021).

Schema theory explains the development of Borderline Personality Disorder (BPD) from early maladaptive schemas formed in childhood (Badoud et al., 2018). BPD patients often carry two main schemas: abandonment/instability perspectives and defectiveness/shame beliefs. During therapy, clinicians must understand when patients experience schema activation, as they view therapeutic boundaries as moments of abandonment (Miljikovitch et al., 2018).

The Stress-Diathesis Model suggests that BPD results from genetic vulnerabilities and environmental psychological challenges. Neurobiological evidence shows that HPA axis dysregulation and frontal-amygdala disconnection reduce emotional control (Fogelman & Canli, 2022). Core depressive symptoms present biological challenges when trying psychosocial treatments alone, as patients often require additional pharmaceutical medication support (Khoury et al., 2020)

Burnout theory highlights the challenges faced by therapists during BPD treatment, including emotional exhaustion, depersonalization, and decreased personal accomplishment. BPD treatment patients experience compassion fatigue, boundary issues, and negative therapeutic attitudes, which affect treatment success (Figley, 2002). Therapist self-care is essential for

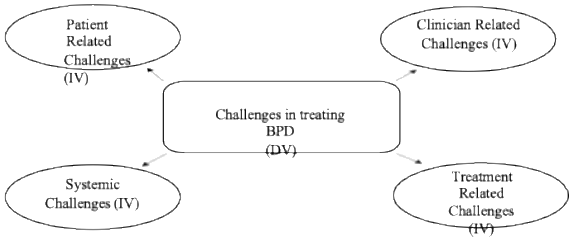
achieving treatment outcomes, as it represents a clinical competency above personal well-being(Edwards &O'Connell, 2020).

Mentalization theory reveals the primary cognitive-affective obstacles therapists face during BPD patient treatment (Fonagy & Bateman, 2019). Research indicates that therapists experiencing "mentalization failures" while interacting with emotionally intense patients experience a decrease in their mentalization capabilities by up to 40% during sessions (Allen & Fonagy, 2022). Both therapists and patients face epistemic trust issues as patients distrust social information, driving non-mentalizing reactions between the therapist and patient (Sharp et al., 2020).

Cultural and regional context significantly influences the diagnosis and treatment of BPD. In Pakistan, mental health conditions, including personality disorders, remain highly stigmatized, leading to delayed diagnosis and reluctance to seek treatment. Specific demographic factors also play a role in shaping therapeutic experiences, with gender norms influencing how symptoms are perceived and treated (Hedemann et al., 2023).

This research is motivated by the need to explore the challenges clinicians face while treating Borderline Personality Disorder (BPD) in Pakistan, especially in the context of limited understanding and the challenges associated with diagnosing and managing this complex mental health condition within the country. The lack of research focused specifically on the Pakistani context means that clinicians might encounter challenges that have not been fully explored in existing studies (Mowadat et. al., 2018). By addressing these issues, the study aims to contribute to the development of strategies that are better suited to the cultural context, ultimately improving mental health care for individuals living with BPD in Pakistan.

This study aims to explore the emotional and professional challenges faced by therapists working with Borderline Personality Disorder (BPD) patients, the key responsibilities of clinical psychologists, ethical dilemmas, time and resource limitations, therapy dropout rates, self-management, institutional challenges, effectiveness of different therapeutic modalities, impact of comorbidity with other mental health disorders, and navigating validation and boundary-setting in therapy for BPD patients. It also explores how psychologists manage themselves when treating BPD patients with intense transference and countertransference reactions, and how to adapt to institutional challenges.



Method

The study uses a qualitative phenomenological research design to examine the challenges faced by clinical professionals treating Borderline Personality Disorder (BPD) patients. It focuses on the emotional and professional difficulties, ethical dilemmas, time and resource limitations, therapy dropout rates, self-management, institutional challenges, effectiveness of therapeutic modalities, impact of comorbidity with other mental health disorders, and navigating validation and boundary-setting in therapy for BPD patients. The research also examines how psychologists manage themselves when treating BPD patients with intense reactions and adapt to institutional challenges.

The study selected five psychologists aged 28-33, both male and female, from both public and private clinical settings in Lahore, Pakistan, using non-probability sampling and multiple sampling techniques. The final sample included both male and female psychologists, with exclusion criteria including those with less than three years of experience, younger than 28 or older than 33 years, or unwilling or unavailable for online video interviews. None of the participants withdrawn from the study.

Table 1

Participants	Gender	Age	Experience	Locality
Participant 1	Female	29 years old	3 years	Lahore
Participant 2	Female	28 years old	7 years	Lahore
Participant 3	Male	33 years old	5 years	Lahore
Participant 4	Female	32 years old	3 years	Lahore
Participant 5	Male	28 years old	3 years	Lahore

Demographics Characteristics of Sample (Psychologists)

The study examines the emotional and professional challenges faced by therapists working with Borderline Personality Disorder (BPD) patients, including ethical dilemmas, time constraints, and resource limitations. Factors contributing to therapy dropout rates include intense reactions, institutional challenges, and the effectiveness of different therapeutic modalities. The study also explores the impact of comorbidity with other mental health disorders on treatment outcomes and the complexities of balancing validation and boundary-setting in therapy for BPD patients. The interviews were conducted in English or Urdu, respecting cultural and linguistic diversity.

Ethical approval was taken from ethical review board, Department of Psychology, Air University along with head of Institute (Air Marshal Abdul Moeed Khan). Throughout the research procedure, ethical integrity was upheld to protect each participant's rights, dignity, and welfare. Participants included in study were made fully aware of the study's objectives, and their freedom to discontinue participation at any moment without facing repercussions.

Procedure

This research study involved five clinical psychologists from Lahore, Pakistan, who were trained in treating Borderline Personality Disorder (BPD). The study was conducted via a virtual network, with informed consent obtained from each participant. The data collection technique used was semi-structured interviews, which were recorded using digital devices. The interviews were structured to ensure in-depth insights and maintain accuracy. The study was conducted in an unbiased and non-judgmental manner, with an interview guide created to structure the interviews effectively. This standardized structure reduced interviewer bias and enhanced the quality and reliability of the collected data.

Results

Borderline Personality Disorder (BPD) significantly impacts both clients and therapists, with common themes including emotional impact, managing cognitive distortion, and building emotional resilience. Therapists face challenges in addressing these issues, such as resource scarcity and unclear rules. Ethical dilemmas include facilitating collaborative support systems, addressing ethical boundaries, and maintaining a balanced approach. Clear communication and relationship clarity are crucial for supporting healing and protecting the therapist.

Table 2

Clusters	Themes	Codes
1. Psychological Impact	Emotional Impact	Emotional, Sensitive, Emotional reactions, Emotional baggage, Emotional pace, Emotional burden, Can't move on, Heavy toll, Fixation, Overthinking, Distress.
	Managing Cognitive Distortion and Building Emotional Resilience in Clients	
2. Ethical Dilemma	Facilitating Collaborative Support System in Family Relations	Relationship imbalances, Family support, Home Environment, Relapse, Poor compliance, Cultural representation, Gesture, Clear boundaries, Professional relationship, Ethical practices, Humanity first, Support, Limitation set.
	Resource Scarcity and Systemic Gaps	
3. Boundary Setting	Addressing Ethical Boundaries	Ethical practices, limitations and Boundaries Ethics, Avoiding counter-transference, Supervised training, Being punctual, Therapeutic boundaries, Drop the session, Fixation, Create strong Boundary, Session time devised by schedule.
	Maintaining Balanced Approach	

Clusters, Themes and Corresponding Codes Identified Through Thematic Analysis

Discussion

This research aimed to explore the emotional, professional, systemic, and therapeutic challenges faced by clinical psychologists in treating individuals diagnosed with Borderline Personality Disorder (BPD). The study focused on clinicians practicing in Lahore, Pakistan, who had at least three years of experience working with BPD clients. The study found that emotional burnout, fear of client self-harm, and professional self-doubt were the most challenging aspects of treating BPD clients. Therapists reported experiencing emotional exhaustion, physiological symptoms like "sweating" or "tightness in the chest" when dealing with intense cases aligning with Linehan's (2000) study.

The key responsibilities of a clinical psychologist in ensuring effective therapeutic intervention include emotional regulation, boundary setting, and psychoeducation. Therapists must maintain professional distance while offering warmth and validation, and must be highly self-aware and emotionally regulated themselves. Ethical dilemmas faced by psychologists include navigating blurred boundaries, confidentiality breaches, and intense transference, which can lead to therapist depletion (Fonagy & Bateman, 2019).

Time constraints and resource limitations affect a clinician's ability to provide optimal care for BPD patients, with high caseloads, limited supervision, and absence of standardized tools as major barriers. Poor institutional support for BPD treatment in Pakistani settings leads to misdiagnosis and poor outcomes, reinforcing clinician burnout and frustration. Therapy dropout rates among individuals with BPD from the clinician's perspective are often due to unstable attachment patterns, emotional volatility, and distrust. Structured methods like DBT and MBT are essential, but clinicians must also receive training to manage early ruptures in the alliance, these findings are consistent with Hedemann et al. (2023).

Psychologists manage themselves when treating BPD patients who exhibit intense transference and countertransference reactions by discussing the importance of self-care, supervision, and mindfulness. Mindfulness techniques help clinicians stay grounded during emotional volatility, supporting Edwards and O'Connell's (2020) that therapist self-care is a clinical competency. However, many participants lacked formal supervision or peer consultation, leaving them to manage emotional load independently, increasing the risk for secondary trauma.

Unseen institutional challenges prevent clinicians from implementing evidence-based therapies, such as outdated education, lack of ongoing training, and rigid hospital structures. Clinicians adapt by using eclectic approaches and personal experience to guide treatment, but this may lead to inconsistent

care and inefficacy, further stigmatizing BPD clients as "resistant" or "difficult." The study explores the effectiveness of different therapeutic modalities, such as DBT, CBT, and schema therapy, in treating Borderline Personality Disorder (BPD). Participants found DBT to be the most structured and effective, particularly for emotional regulation. CBT was often used for cognitive restructuring, while Schema Therapy helped address early maladaptive beliefs. However, limited access to formal training restricts their optimal use, leading to improvised application that can affect treatment quality.

Comorbidities with other mental health disorders, such as depression, PTSD, and schizophrenia, complicate diagnosis and therapy in BPD patients. This highlights the need for comprehensive assessment protocols and interdisciplinary treatment approaches to address the full spectrum of patient issues. Balancing validation and boundary-setting in therapy for individuals with BPD is crucial, and this balance is emotionally taxing and requires skillful execution.

The study provides valuable insight into the multilayered challenges faced by clinicians working with BPD patients in Pakistan. It highlights a consistent theme of emotional burden, ethical complexity, and systemic under preparedness. Therapists showed resilience, commitment, and creativity in coping with their demanding roles. However, without institutional reform, professional development opportunities, and culturally relevant treatment protocols, optimal care for BPD clients remains a distant goal.

Limitations of the study include the lack of quantitative data, time limitations, snowball sampling, thematic analysis, limited sample size, geographical location, and demographic uniformity among the interviewed clinicians. To overcome these limitations, future studies should attempt to include quantitative or mixed-method designs, employ longitudinal designs, and use standardized measures to validate qualitative results. Longitudinal studies have the ability to provide richer, dynamic information about the therapeutic process, which is of great value when dealing with complex and chronic client conditions like BPD. Future research should explore solutions to improve therapist training, supervision, and emotional support within Pakistan's unique sociocultural and healthcare context. Future studies should use more inclusive and strategic sampling techniques to minimize snowball sampling bias. This will include clinicians from diverse backgrounds and experience levels, allowing researchers to tap into a broader clinical narrative. Interpretative Phenomenological Analysis (IPA) can provide richer interpretations, especially in emotionally taxing situations. To increase external validity, recruit more clinicians, extend the geographical scope of studies to include clinicians from rural and urban areas, and engage participants from a broader age group and professional experience levels. This will make the studies more representative and inclusive of the wider clinical population.

References

Alston, M. H., & Robinson, B. H. (1992). Nurses' attitudes toward suicide. Omega, 25(3), 205. Retrieved from http://search.proquest.com.ezproxy.sofia.edu:2048/docview/209686906?accountid=25304 American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). Washington, DC: Author.

Arrindell, W.A., & Ettema, J. H. M. (2003)

Symptom Checklist SCL-90. Handleiding bij een multidimensionele psychopathologie-indicator. Lisse: Swets Test.

Badoud, D., Prada, P., Nicastro, R., Germond, C., Luyten, P., Perroud, N., & Debbané, M. (2018). Attachment and reflective Functioning in Women With Borderline Personality Disorder.. *Journal of personality disorders*, 32 1, 17-30. https://doi.org/10.1521/pedi_2017_31_283

Bateman, A., & Fonagy, P. (2016). Mentalization-based treatment for personality disorders. *World Psychiatry, 15*(1), 13–15. https://pmc.ncbi.nlm.nih.gov/articles/PMC2816926/

Bernheim, D., Gander, M., Keller, F., Becker, M., Lischke, A., Mentel, R., Freyberger, H., & Buchheim, A. (2019). The role of attachment characteristics in dialectical behavior therapy for patients with borderline personality disorder. *Clinical psychology & psychotherapy*, 26 3, 339-349. https://doi.org/10.1002/cpp.2355

Bourke, M. E., & Grenyer, B. F. S. (2010). Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis. Psychotherapy Research, 20(6), 680–691. https://doi.org/10.1080/10503307.2010.504242

Buchheim, A., & Diamond, D. (2018). Attachment and Borderline Personality Disorder. *The Psychiatric clinics of North America*, 41 4, 651-668. https://doi.org/10.1016/j.psc.2018.07.010

Buhl-Nielsen, B., Steele, H., & Steele, M. (2024). Attachment and body representations in adolescents with personality disorder. *Journal of clinical psychology*. https://doi.org/10.1002/jclp.23705

Chalker, S. A., Carmel, A., Atkins, D. C., Landes, S. J., & Comtois, K. A. (2015). Therapy- interfering behavior and suicide-related behavior among suicidal clients: A comparison of dialectical behavior therapy versus community treatment by experts. Suicide and Life- Threatening Behavior, 45(5), 556–570. https://doi.org/10.1111/sltb.12152

Crow, T., & Levy, K. (2019). Adult attachment anxiety moderates the relation between self- reported childhood maltreatment and borderline personality disorder features.. *Personality and mental health*. https://doi.org/10.1002/pmh.1468

Edwards, J., & O'Connell, M. (2020). Self-care as clinical competency: The role of therapist self-awareness in preventing burnout among clinicians treating personality disorders. Journal of Clinical Psychology, 76(5), 892-908. http://dx.doi.org/10.1002/capr.1283

Erkoreka, L., Zamalloa, I., Rodriguez, S., Muñoz, P., Mendizabal, I., Zamalloa, M., Arrue, A., Zumárraga, M., & Gonzalez-Torres, M. (2021). Attachment anxiety as a mediator of the relationship between childhood trauma and personality dysfunction in borderline personality disorder.

Clinical psychology & psychotherapy. https://doi.org/10.1002/cpp.2640

Euler, S., Nolte, T., Constantinou, M., Griem, J., Montague, P. R., & Fonagy, P. (2021). Interpersonal problems in borderline personality disorder: Associations with mentalizing, emotion regulation, and impulsiveness. *Journal of Personality Disorders, 35*(2), 177–193. https://discovery.ucl.ac.uk/10066820/

Figley C. R. (2002). Compassion fatigue: psychotherapists' chronic lack of self-care. Journal of clinical psychology, 58(11), 1433–1441. https://doi.org/10.1002/jclp.10090

Finamore, C., Rocca, F., Parker, J., Blazdell, J., & Dale, O. (2020). The impact of a co- produced personality disorder training on staff burnout, knowledge and attitudes. Mental Health Review Journal, 25(3), 269–280. https://doi.org/10.1108/MHRJ-01-2020-0009

Fonagy, P., & Bateman, A. (2008). The development of borderline personality disorder--a mentalizing model. Journal of personality disorders, 22(1), 4–21.

Fonagy, P., & Allison, E. (2018). Epistemic trust in the psychotherapy process. In K. C. Myers & C. W. Leighton (Eds.), The Wiley handbook of psychotherapy integration (pp. 345–360). Wiley. https://doi.org/10.1002/9781119382198.ch17

Hammond, S. (2019). Crisis fatigue in borderline personality disorder treatment: Conceptualization and management strategies. *Clinical Social Work Journal, 47*(3), 301-309. https://doi.org/10.1007/s10615-018-0685-1

Haverkampf, C. J. (2017). Communication-focused therapy for borderline personality disorder. Journal of Psychology and Psychotherapy, 7(6). https://doi.org/10.4172/2161-0487.1000326

Hedemann, T., Asif, M., Aslam, H., Maqsood, A. (2023). Clinicians', patients' and carers' perspectives on borderline personality disorder in Pakistan: A mixed methods study protocol. *ProQuest, 18*(6), e0286459. https://doi.org/10.1371/journal.pone.0286459

Juul, S., Lunn, S., Poulsen, S., Sørensen, P., Salimi, M., Jakobsen, J. C., Bateman, A., & Simonsen, S. (2019). Short-term versus long-term mentalization-based therapy for outpatients with subthreshold or diagnosed borderline personality disorder: a protocol for a randomized clinical trial. Trials, 20(1), 196. https://doi.org/10.1186/s13063-019-3306-7

Khoury, J., Zona, K., Bertha, E., Choi-Kain, L., Hennighausen, K., & Lyons-Ruth, K. (2020). Disorganized Attachment Interactions Among Young Adults With Borderline Personality Disorder, Other Diagnoses, and No Diagnosis.. *Journal of personality disorders*, 1-21. https://doi.org/10.1521/pedi_2019_33_408

Kornhaber, R., Haik, J., Sayers, J., Escott, P., & Cleary, M. (2017). People with borderline personality disorder and

burns: Some considerations for health professionals. *Issues in Mental Health Nursing*, *38*(9), 767-768. https://doi.org/10.1080/01612840.2017.1367592

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* Guilford Press. https://books.google.com.pk/books?id=UZim3OAPwe8C&printsec=frontcover&redir_esc=y#v=onepage&q&f=false

Linehan, M. M., Cochran, B. N., Mar, C. M., Levensky, E. R., & Comtois, K. A. (2000). Therapeutic burnout among borderline personality disordered clients and their therapists: Development and evaluation of two adaptations of the Maslach Burnout Inventory. Cognitive and Behavioral Practice, 7(3), 329-337. https://doi.org/10.1016/S1077-7229(00)80091-7

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. World Psychiatry, 15(2), 103–111. https://doi.org/10.1002/wps.20311

Miljkovitch, R., Deborde, A., Bernier, A., Corcos, M., Speranza, M., & Pham-Scottez, A. (2018). Borderline Personality Disorder in Adolescence as a Generalization of Disorganized Attachment. *Frontiers in Psychology*, 9. https://doi.org/10.3389/fpsyg.2018.01962

Perseius, K.-I., Kåver, A., Ekdahl, S., Åsberg, M., & Samuelsson, M. (2007). Stress and burnout in psychiatric professionals when starting to use dialectical behavioural therapy in the work with young self-harming women showing borderline personality symptoms. Journal of Psychiatric and Mental Health Nursing, 14(6), 635–643. https://doi.org/10.1111/j.1365-2850.2007.01144.x