The Evolving Landscape of BPD Treatments: What GET (Group Experience Therapy) can add up to standardized treatment for BPD

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Abstract

The clinical management of the borderline personality disorder (BPD), and of emotional dysregulation disorders in general, raises problems both during the diagnostic and the treatment processes. Despite these challenges, clinical experience and the data from the literature make evident that the remission of the symptoms and the recovery from such disorders is now possible, under the condition of being treated with continuity. Various effective therapeutic approaches are available, such as the Dialectical Behavioral Therapy (DBT), the Mentalization-based Therapy (MBT), the Transference Focused Therapy (TFP). Of late, although the current body of research remains limited, preliminary evidence suggests that the multilevel experiential approach, Group Experience Therapy (GET) has shown promise in managing emotional dysregulation, reducing suicidal and self-harming behaviors, and enhancing patients' quality of life. This paper serves as a brief introduction to the model's rationale.

Keywords: Borderline Personality Disorder, Borderline Personality, Emotional dysregulation, Group psychotherapy, Objectual relationships, Recovery.

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Introduction

Borderline personality disorder (BPD) is a debilitating mental disorder characterized by severe instability in affect, identity, interpersonal relationships, and emotional dysregulation.

The age onset of BPD varies but symptoms are usually manifested in early adulthood. In the adult general population, rates for BPD range between 0.7 and 2.7%, whereas the prevalence rates are higher in 6% primary care (6%), psychiatric outpatients (11-12%), and psychiatric inpatients (22%) (Leichsenring *et al.*, 2024).

The literature has shown a prevalence of BPD among women. Tomko and colleagues (2014) have noticed slightly higher rates of BPD for women compared to men (3% vs. 2.4%) in a US community sample. In the same direction, Zimmerman and Becker (2023) found considerably higher rates of BPD in women compared to men (72% vs. 28%) in a psychiatric outpatient setting. Beside the female prevalence, there are gender differences in comorbidity: women more frequently show mood, anxiety and eating disorders, and PTSD, while men with BPD exhibit more frequently substance abuse and antisocial personality disorder.

BPD is a severe condition deserving careful clinical attention. Indeed, it is estimated that more than 75% of people who suffer from BPD are likely to enact self-harming behaviors voluntarily (Oldham, 2006). Between 60% and 70% can be defined as proper suicide attempts, considering the specific intention to end their own life; this is evident by looking at the statistics, which show that 10-15% of patients directly die by suicide (Black *et al.*, 2004; Leichsenring *et al.*, 2011). Recent longitudinal data show that a total of 5.9% of borderline patients vs. 1.4% of control subjects died by suicide. Additionally, 14.0% of borderline patients and 5.5% of control subjects died by non-suicide causes (Temes *et al.*, 2019). It is also added how within borderline patients, number of prior hospitalizations significantly predicted completed suicide (Temes *et al.*, 2019).

Despite this worrying data, detecting people at high risk of attempting suicide and enhancing suicide prevention strategies in clinical practice remains a challenge so far (Franklin *et al.*, 2017). The attendance of a psychiatric treatment is a relative protective factor: several patients with BPD are prone to suicide attempts even while

undergoing a psychotherapy program, independently of the theoretical approach, thus making even more complex the management of the disorder (Brown and Chapman, 2007).

Notwithstanding such remarks, BPD has a better prognosis than it was thought in the past. Clinical experience and the data from the literature make evident that the remission of the symptoms and the recovery from borderline personality disorder is now possible, under the condition of being treated with continuity (Setkowski *et al.*, 2023; Crotty *et al.*, 2023; Storebø *et al.*, 2020; Ellison *et al.*, 2020; Oud *et al.*, 2018; Juanmartí *et al.*, 2017).

In a review by Ng and colleagues (2016), the authors found that the levels of symptom's remission and recovery differ due to individual differences and the studies' methodology. According to the authors, to recover means achieving a condition characterized by the ability to manage symptoms, and to comprehend their function within one's life, by also individualizing personal goals and applying specific strategies towards them. The achievement of a better quality of life always requires maintaining long-term adaptive models (Nesnidal *et al.*, 2020).

In line with the Practice Guidelines for the Treatment of Patients with BPD (APA, 2024; Substance Abuse and Mental Health Services Administration, 2012), recovery should be understood not only in overcoming symptoms and stopping critical behaviors, but also in:

1. better capacity of reaction to adverse events;
2. developing a positive idea of one's own social and personal identity;
3. feeling like you belong to a social network;
4. looking at the future with trust;
5. finding meanings and goals in one's own life;
6. beginning a path of self-awareness and restructuring of their identity.

The definition of the term "Borderline"

In 1938, Stern described for the first time the concept of "Borderline" as a mental issue characterized by deep psychological suffering, extreme hyper-sensibility, feelings of inferiority, anxiety, mechanisms of projective identification, reality-testing disturbances. (Stern,1938)

From the beginning, Stern considered these patients particularly challenging to comprehend and treat.

In 1975, Kernberg stated these patients must be considered to occupy a borderline area between neurosis and psychosis. The characteristics of Borderline Personality Organization (BPO) were: identity diffusion (no integrated concept of self and significant others), use of primitive defenses (such as splitting, denial, projective identification etc.) and variable reality testing (Kernberg,1975; Caligor 2007).

In 1980, in the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III), a new section titled "Axis II" was elaborated, dedicated to personality disorders, including the Borderline disorder. In the latest edition of DSM-5TR (2022), Borderline Personality Disorder (BPD) is described as a pervasive pattern of instability in interpersonal relationships, self-image, and emotion, as well as marked impulsivity beginning by early adulthood and present in a variety of contexts. It can be diagnosed if at least 5 of the symptoms reported in the diagnostic manual are present in the patient.

Furthermore, due to many problems associated with the categorical models (Monaghan *et al.*, 2023) – as the high levels of comorbidity and low level of reliability – in the DSM-5TR it is proposed an alternative dimensional model. However, some essential features for the diagnosis of personality disorders are maintained in both models (for both DSM-5 and 5TR, for example, having an impaired functioning must be a requirement and the diagnostic criteria stay the same).

It is important to highlight how there is still a controversy on the conceptualization of BPD as a specific disorder or as a level of functioning identifying a general impairment of personality (Tyrer *et al.*, 2019; Bach *et al.*, 2020; Mulder *et al.*, 2020). Moreover, in a recent review, Leichsenring and colleagues (2024) highlighted that – even though the construct of BPD is more coherent and trustable than we may believe – difficulties still persist in the diagnostic process due to very high level of symptomatology variability, frequent comorbidities with other psychopathological diagnosis, and differentiation from other diagnoses. In fact, frequently, patients with BPD are misdiagnosed, disliked, and overmedicated. Such practices persist despite considerable knowledge of how patients can be effectively treated (Gunderson, 2018).

We would like to clarify that in our view, starting from Kernberg's

theory for BPO (that will be introduced in the next section), we prefer to use the term "borderline functioning" since we consider it to be a modality to function in the world for the personality: the term describes how the person thinks, feels, acts and behaves. The definition of borderline personality disorder (BPD) will be used, in this article, when we quote research that use this term.

The borderline personality functioning: the emotional dysregulation

In this section we will try to clarify our specific theoretical model on BPD, which integrates different perspectives derived from psychodynamic theories of attachment and object relations, neurobiology, and phenomenological observation of patients' behavior.

The possible causes of BPD

Several developmental models suggest that BPD features are determined by a combination of biological and environmental mechanisms, the latter of which includes social and attachment-related disturbances (Linehan, 1993; Zanarini, 1997; Hughes, 2012)

According to many studies, at the origin of the emotional dysregulation and of the BPD, there is an interaction of many factors including:

1. biological vulnerability of the limbic cortex (Perez-Rodriguez *et al.*, 2018; Allen, Fonagy, 2008; Lis *et al.*, 2007; Linehan, 1993).
2. invalidating developmental context, related to intolerance toward the expression of private emotional experiences (Crowell *et al.*, 2009; Allen, Fonagy, Bateman, 2008; Linehan, 1993).
3. adverse childhood experience (Bozzatello *et al.*, 2021; Porter *et al.*, 2020; Kuo *et al.*, 2015; Fonagy 1996).

About point 1, in terms of neural systems, many studies suggest a frontal-limbic imbalance in BPD, in which emotion dysregulation is mediated by the hyperactivity of limbic structures (i.e., amygdala, hippocampus, and anterior cingulate cortex) and the abnormal functioning of prefrontal structures. The hyperactivity of the amygdala and the

hippocampal areas during emotional processing in BPD patients seems to be accompanied by impairments in habituation of the amygdala to repeated negative stimuli. The consequences of these impairments are higher levels of anxiety traits, aggressivity, and affective lability (Hazlett *et al.* 2012; Koeningsberg *et al.*, 2014; Bilek *et al.*, 2019). It is noted that BPD patients show structural cerebral alterations: reduction of the sizes of amygdala, hippocampus, insula, anterior cingulate cortex, orbitofrontal cortex, and dorsal prefrontal cortex; enlargement of the precuneus and posterior cingulate cortex (Ruocco *et al.*, 2012, Schulze *et al.*, 2016; Yang *et al.*, 2016; Perez- Rodriguez *et al.*, 2018).

Coming to the environmental influences, research (Fatimah *et al.*, 2020; Stepp *et al.*, 2016; Bailey *et al.*, 2015) revealed that the borderline personality can be associated with a family environment characterized by high emotional expressivity, conflicts, difficulty in dialogue, and limited reciprocal comprehension. Accordingly, borderline people often describe their family environment as unable to respond to their needs and comprehend their emotional states.

An environment that views emotions and their expressions as incomprehensible or not justifiable, if compared to the intensity of the events triggering the emotional activation, can be called invalidating. This kind of environment can be found not only in the family, but also at school, at work or, in general, in any kind of social relationship.

We can assume that this sort of environment is a combination of emotional, psychological, and relational experiences- past or present- that does not allow the proper development of object permanence and secure attachment. Consequently, borderline individuals have a higher probability of having a disorganized Self, and inconsistent self-esteem. Hence, this leads to a great difficulty in trusting others in relationships, becoming a source of anxiety.

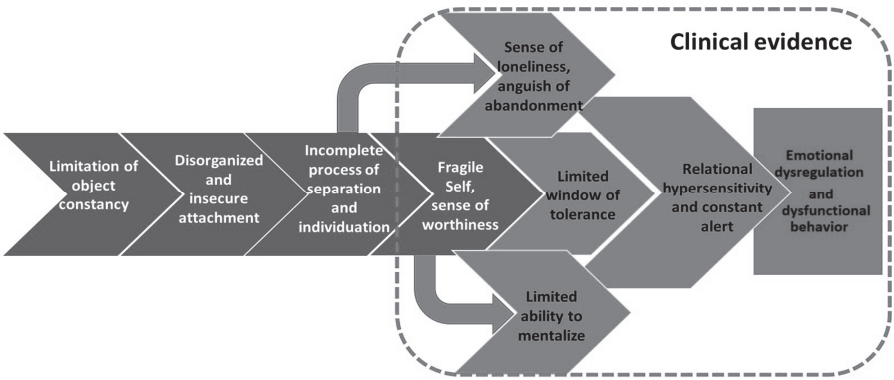
Another consequence of an invalidating surrounding, combined with emotional vulnerability, is the difficulty in recognizing and managing emotions, which are often felt with high intensity as we will explain later.

In summary – as shown in Figure n. 1 – the invalidating environment, the limitations of object permanence and insecure attachment are combined with an incomplete process of separation and individuation. As a matter of fact, borderline individuals are not able to handle

life events with the adequate adaptability and personological maturity. The consequences are fear of abandonment, instability in relationships and a feeling of constant alertness of the borderline person within relationships: as the beloved one is also the one who could abandon, the person oscillates between devaluation and idealization.

All these elements make certain events to become triggers that can cause emotional dysregulation, critical behaviors and relational difficulties.

Figure 1. *An hypothesis of the etiopathogenesis of emotional dysregulation*



The emotional dysregulation

The core of borderline functioning is emotional dysregulation. The concept of emotional dysregulation refers to the difficulty to recognize, regulate and accept your own emotions in an effective way. The borderline patient experiences a deep psychic sufferance caused by the active vulnerability: patients perceive themselves as "out of control" and consequently unable to find functional strategies of emotional regulations, leading them to impulsive thoughts and behaviors.

The moment of emotional dysregulation is called a "crisis". Emotionally vulnerable individuals have difficulties in the regulation of their own emotions, and their behavior is absorbed in dealing with their intense emotions.

Emotional vulnerability (Linehan ,1993) regards three facets such as:

- High sensitivity: individuals react immediately to stimuli that usually leaves others indifferently.
- High reactivity: individuals have intense reactions that sometimes can be extreme, to the point of hindering awareness of what is happening.
- Slow deceleration of emotions back to baseline: individuals might experience emotions that last for a long time, whose return to the base line takes more time than usual.

Emotional vulnerability could be also linked with the wideness of the person's window of tolerance (Siegel, 2013), a concept illustrating the capacity to fluctuate while remaining within a range of acceptable emotional arousal. Borderline patients' window of tolerance is limited, resulting in hyperarousal or hypoarousal in response to external triggers.

In fact, every crisis is unleashed by a trigger: an event that causes the fear of abandonment, meaning the fear of losing the beloved one or the attention of someone we care about.

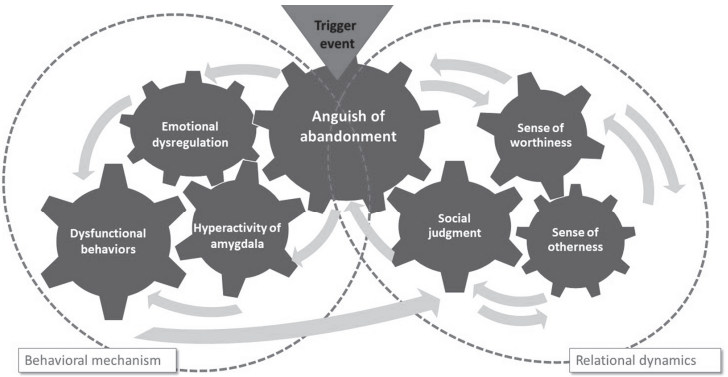
The trigger could be:

- External: an abandonment or rejection that actually happened,
- External + internal: an event that is felt and interpreted as an abandonment or rejection, even if maybe it is not,
- Internal: a thought or negative rumination that the person has in his/her own mind.

As shown in image n. 2, the trigger activates the fear of abandonment which, in turn, activates different levels: the neurobiological level and the emotional and/or relational level.

Hence, the trigger of the fear of abandonment activates rapidly the amygdala, which can lead to a precipitous reaction of fight or flight. The person feels overwhelmed by the intense emotions, and is unable to properly cope with the situation, that is, to behave in a way capable of lowering the levels of emotional activation. These behaviors lead to emotional and relational consequences, for example, feelings of unworthiness, of being different, and fear of social judgment. So, these feelings are the cause of fear and the effects of the crisis itself.

Figure 2. *Our conceptualization of the mechanism of emotional dysregulation*



Impulsivity and "dysfunctional behaviors"

Impulsivity is another borderline functioning aspect linked with emotional dysregulation: as already illustrated, the tendency to react without control is a response to emotional intolerability. Impulsive behaviors are often defined as dysfunctional, but from the individual subjective perspective they serve to reduce the emotional dysregulation and regulate the person's reaction to the emotion.

Selby and Joiner (2009) proposed the "emotional cascade" model in which the emotional dysregulation, the impulsivity and the dysregulated behaviors are explained. They explain vicious cycles of intense rumination and negative affect that may induce aversive emotional states. Rumination leads to judgment, in fact individuals with borderline functioning have pessimistic attitudes about their relational failures that confirms their self-image as inadequate and unworthy. Indeed, the dysregulated behaviors are functional to stop this cycle and regulate emotional activation.

According to the emotional cascade model, borderline individuals are frightened of emotional experiences (positive and negative) because they are worried about losing control and the possible catastrophic consequences. This fearful reaction gives rise to two processes: on the one hand, the non-acceptance of feelings and no emotion recognition, and, on the other hand, the tendency to avoid or stop

the subjective experience of emotions. In fact, avoidance is one of the strategies that allows the individual to not experience the situation that might potentially involve emotional pain or anguish. This leads to an incomplete experience of emotions and reduces the possibility of recognizing and regulating them.

As known, other strategies for regulating the intensity of emotions are the impulsive behaviors that we mentioned above (i.e., verbal and physical aggression, self-harming such as cutting or burning themselves, reckless driving, etc.). It should be noted that Self-harm can be divided into nonsuicidal self-injury (NSSI) and suicidal behavior (SB). They can be tangible symptoms for underlying problems of emotion regulation, impulse control, and interpersonal relations.

The therapeutic relationship with borderline patients and the treatment

Psychotherapy is the treatment of choice for BPD and several psychotherapy approaches were specifically developed for the BPD. In the relationship with BPD patients, clinicians are stimulated by multiple challenges (Bellino *et al.*, 2016) dealing with the core of the disorder: the affective and relational instability, behavioral impulsivity, and the fragile definition of identity. The elements that make therapy a complex endeavor regard all the dimensions of the intervention:

- the patient (suicidal risks, aggressive conducts, the complexity of the disorder, disorganized attachment styles);
- the therapist (required competencies and skills, intense countertransference, burnout risk);
- and the psychotherapy setting (patients' selection, building the therapeutic trust, the requirement of a structured contract, duration and conclusion of the therapy).

For these reasons, the ratio of premature dropout is often very high (Wnuk *et al.*, 2013; Arntz *et al.*, 2023; Iliakis *et al.*, 2021).

In fact, the difficulties and risks (considering for example the ones mentioned above) in relationships addressed by those suffering from BPD manifest also in the therapeutic relationship and represent a constant challenge, often difficult to handle. For example, the therapist could be extremely invested in the therapeutic relationship or dealing with extreme anguish or on the contrary trying to establish distance and rigid boundaries in the relationships, which raise the problems of conflict.

The literature suggests that the treatment of patients with BPD should begin with disclosure of the diagnosis and education about the expected course, genetics, and treatment of the disorder (Leichsenring, 2024). The consequence should be a reduction of the possible negative impact of the diagnostic label and could create a trusting relationship with the clinician.

The literature highlights how we have been taking big steps in the construction of more efficient treatments for BPD and that several approaches have been shown to be efficient, such as Dialectical Behavioral Therapy (DBT) (Hernandez-Bustamante *et al.*, 2024), Mentalization-based Therapy (MBT) (Vogt *et al.*, 2019), and Transference Focused Therapy (TFP) (Seyedi Asl *et al.*, 2024).

Therefore, considering what just discussed, we suggest not to work alone and independently. According to the literature (Hernandez-Bustamante *et al.*, 2024; Vogt *et al.*,2019) and based on our experience, the équipe is an essential and necessary resource to have in handling the complexity of the patient. As we will describe later, teamwork is considered an essential element for structuring a valid intervention, especially for GET, in that mutual comparison among professionals is an integral part of the method.

After having seen the main characteristics of BPD and the diagnostic-clinical challenges that characterize this condition, we now present the most influential treatment models.

Dialectical Behavioral Therapy (DBT)

DBT is a cognitive behavior therapy developed specifically for BPD by Marsha Linehan. According to this theoretical framework, emotional dysregulation is the upshot of the interaction between biological and environmental vulnerabilities. It is one of the primary targets of the treatment, since emotional dysregulation is understood as the source of all the other BPD's pathological manifestations.

The treatment focused on training and developing different skills in patients, including emotion regulation, mindfulness, stress tolerance, and interpersonal efficacy (Linehan, 1993; 2015).

DBT evolved from a combined motivational and capability deficit model of BPD. The idea was twofold: (1) borderline individuals lack

important interpersonal, self-regulation (including emotional regulation), and distress tolerance skills, and (2) personal and environmental factors inhibit the use of behavioral skills that the individual does have and often reinforce inappropriate borderline behaviors (Linehan, 1993).

The treatment consists of three different modes: psychosocial groups (for skills training), individual psychotherapy (addressing motivational issues and skill strengthening), and telephone contact with the individual therapist (addressing generalization).

It is characterized by a philosophy of dialectics, a biosocial theoretical perspective, a hierarchy of treatment targets specific to the mode, and a set of treatment strategy groups. Treatment targets are hierarchically arranged as follows:

1. Reducing high-risk suicidal behaviors (parasuicide and high-risk suicide ideation and plans).
2. Reducing therapy-interfering behaviors-all responses or behaviors of both the patient and the therapist that make therapy progress or continuation difficult (i.e., missing or coming late to sessions, phoning at unreasonable hours, refusing to collaborate or work in sessions, remaining interpersonally aloof or too clinging, invalidating the other, and not returning phone calls).
3. Reducing behavioral patterns serious enough to substantially interfere with any chance of a reasonable quality of life (serious substance abuse would qualify here).
4. Behavioral skill acquisition (skills in emotion regulation, interpersonal effectiveness, distress tolerance, and self- management, as well as a number of "core" [mindfulness] abilities to observe, describe, participate spontaneously, be nonjudgmental, focus awareness, and focus on effectiveness).
5. Reducing posttraumatic stress responses related to previous traumatic events.
6. Increasing self-respect.
7. Meeting other goals of the patient.

DBT efficacy has been proved as significant by many researchers. Here, we mentioned a recent review study conducted by Hernandez-Bustamante and colleagues that in 2024 have highlighted how both short-term DBT and standard DBT improved suicidality in BPD patients with small or moderate effect sizes, lasting up to 24 months after

the treatment period. Furthermore, the studies reviewed revealed that DBT has an efficacy on general psychopathology and depressive symptoms in patients with BPD.

Mentalization-based Therapy (MBT)

Let's now address Mentalization Based Treatment (MBT), a kind of therapy that promotes the development of mentalization. It has been tested in research trials and found to be an effective treatment for BPD (Vogt, 2019). Mentalization is a mental process that leads to perceiving and interpreting one's own and other people's behaviors as the result of internal and intentional mental states, that is, as the result of desires, beliefs, expectations, needs, goals, and feelings.

Having a good mentalization ability allows one to understand the affective manifestations of others, regulate emotions, control impulses, and self-monitor (Fonagy *et al.*, 1996). It is therefore a dimension of great interest for understanding the borderline personality organization, which is theorized to be characterized by a fragile mentalizing capacity. According to MBT, poor mentalizing skills are theorized to be the sources of emotional dysregulation.

MBT therapy can be done either with individual sessions or in groups. One of the first goals in MBT is to regulate emotional expression, because dysregulation, and the related impulsivity, negatively impact the internal representations. Another goal of MBT intervention is reinstating mentalizing when it is lost or to help to maintain it in any circumstance.

Primarily, the treatment uses some generic psychotherapy techniques such as empathy, support, and clarification, and then moves on to other interventions which place emphasis on the attachment relationship within controlled conditions, which includes a focus on the patient-therapist relationship through "mentalizing the transference".

The therapist's mentalizing therapeutic perspective is characterized by humility (a sense of "not knowing"), patience (in taking time for understanding others), a legitimizing stance towards others' perspectives, and proactivity in fostering descriptions ("what questions") rather than explanations ("why questions").

The attention of the therapeutic work is oriented in the present and

how this could influence the events of the past, not on the past itself. The therapist's duty is to direct the attention to the present and explore how the emotions from the past are activated in present situations. By recognizing the activated emotions, the therapist helps the patient to distinguish facts from their own subjective interpretations and the function of the behavioral answer.

Mentalization-based therapy was found to significantly reduce self-mutilating behaviors reporting a measure of parasuicidal behaviors, including two follow-ups (Bales *et al.*, 2012; Bateman & Fonagy, 1999; Kvarstein *et al.*, 2015; Rossouw & Fonagy, 2012).

The systematic review by Vogt (2019) indicates that MBT can achieve significant reductions in BPD symptom severity, severity of comorbid disorders, and use of psychotropic medication. It can also improve general psychiatric well-being, interpersonal functioning, and social adjustment. Borderline-specific features were also found to decrease over the course of treatment, including substantial reductions in parasuicidal behavior.

Transference Focused Psychotherapy (TFP)

Based on a sophisticated psychodynamic theoretical framework, Transference Focused psychotherapy (TFP) is treatment developed by Otto F. Kernberg and colleagues to treat severe personality disorders. The concept of *transference* refers to the feelings, attitudes, desires or fantasies expressed by the patient towards the therapist that appear to be based on the patient's past experiences about significant relationships, like the one with the caregivers. In fact, TFP is based on the centrality of the exploration of the patient's experience of self and others, through the observation of the patient's experience of the therapy and the therapist. The treatment also focuses on the patient's difficulties in work and relationships outside the treatment. Hence, the therapist's attention is focused on transference because it is believed that the observation of the patient's moment-to-moment experience of the therapist provides the most direct access to understanding the patient's internal world.

In summary, the core of TFP is helping patients to understand the shifts in borderline experience of themselves and others, as the split

sense of identity shows in the treatment relationship itself. As is clear, the main reference here is the theory of objectual relationships. According to TFP, emotional dysregulation is rooted in split conflictual objectual relationships, which shape disturbed relationships in real life. In fact, the patient has difficulties in tolerating and integrating disparate images of the self and others, so the therapist helps in containing the emotions and observe the enacted representations; moreover, the therapist understands the reasons, the wishes, fears and anxieties that support the continued separation of these fragmented senses of self and other.

The therapist also helps the patient to observe shifts in the dominant self-experience, using therapeutic techniques that include 1) clarification of internal states, 2) confrontation of observed contradictions, and 3) interpretation that helps explain the divisions and links between different states.

The work of TFP is structured by an initial phase of defining a limit-setting, with respect to the patient's destructive behaviors, and a longer phase of exploration of the patient's mind and sense of identity.

Accordingly, after confirming the diagnosis, the therapist and patient work to identify factors in the patient's life that might interfere with the consistency and conduct of the treatment (such factors could be drug abuse or addiction, chronic misuse of medication, a severe eating disorder, and self-injury and suicidality).

TFP has demonstrated efficacy in treatment of BPD's symptoms across various randomized clinical trials (Seyedi *et al.*, 2024).

Group Experience Therapy (GET)

Let's now address Group Experience Therapy (GET), a treatment that integrates several core elements of the models outlined above. The handbook describing GET's features has been recently published (Visintini, 2024), and with it one can argue that this treatment definitely strives for being included in the list of specific treatments for emotional dysregulation disorders. GET is a psychotherapeutic method whose development began in 2009, when a group of clinicians from the Day Hospital for the diagnosis and treatment of personality disorders (IRCCS Ospedale San Raffaele-Turro, Milan, Italy) began to formulate a methodology of intervention focused on the main critical

problematics of emotional dysregulation disorders. GET stemmed from the awareness that it is impossible to work within the traditional boundaries of only one therapeutic tradition: rather, it is evident the necessity to go beyond the classical approaches to properly address the peculiar features characterizing such complex disorder. In other words, the main goal grounding the elaboration of GET was to implement specific techniques focused on the different psychopathological manifestations of the disorder, drawing from and integrating cognitive, phenomenological, psychodynamic approaches.

The phenomenological approach inspires all the phases of GET treatment and the approach of therapists: the focus is on the lived experience and subjectivity of each individual, immersing in the patient's experience, seeking to understand the meaning they have for experiences, feelings, emotions and behaviors. The psychodynamic theories, on the other hand, inspire our view of DBP as an object relations disorder and its link with the development of object consistency (as Kernberg explains and as outlined in a previous section); psychodynamic approach is also the basis for the techniques used in the second phase of treatment.

At the same time, we keep in mind that the result of personality disorder is emotional dysregulation (as Linehan explains), which has a neurobiological basis and is also conditioned by an unsupportive/invalidating environment. The emotional dysregulation and the related clinical aspects, in the early stages of therapy, can only be addressed by cognitive experiential techniques.

So, with a view to the evolution of the person within the treatment, GET is structured in a way that starts from an approach based on cognitive techniques, to an approach based on psychodynamic ones.

The acronym of GET is explained as follows:

- GROUPS= The therapy is based on different group activities, which are the core and the heart of the treatment.
- EXPERIENCE = The experiential dimension emphasizes the importance of promoting and using the knowledge through the experience in the present, with the goal of evolving.
  In fact, experience is the base of thought, emotions, and actions, and it is the medium for developing new modalities to cope with life challenges.

So, in group, everyone elaborates in first person, together with their peers, new and more functional modalities to deal with and face up to emotions, relationships, and events of their own life.

- THERAPY = Thanks to the support of the équipe of psychotherapists and psychologists, the different group experiences acquire their therapeutic and transformative function. The patients who end the therapeutic path are no longer in the criteria of the diagnosis and there is an evolution of the self, recovering a better quality of life.

  Considering what just mentioned above, our treatment is based on a specific vision of the borderline organization of personality and the focus of its sufferings:
  - the crisis generated from the process of emotional
  - dysregulation;
  - the social avoidance;
  - the difficult or missing connection with one's own emotional;
  - world as well as one's own body perception;
  - the difficulties and conflicts of the object relationships.

  Each of these aspects is targeted by the different types of experiential groups characterizing the treatment, that we will describe later.

Focus on the role of the group

GET's principal therapeutic tool is the group. The theoretical framework we refer to is psychodynamic and starts from Lewin (1951) and the "field theory" and arrives at the "matrix concept" (Foulkes, 1964).

Following the Lewin (1951) definitions of a state of interdependence of fate and of task, we can say that the patients in the group recognize each other, having the same destiny, and in the course of treatment they also take on the same task, that is, to participate in the group work, where each group activity is focused on a specific task (crisis, planning, etc.).

GET's group main feature is homogeneity (with regards to the individuals' disorder and, as far as possible, their ages). Indeed, since groups are created in a way where members have similar

characteristics, the transformative power of therapy is amplified due to patients sharing their experiences with peers with whom they share significant aspects of their lives. In group, everyone elaborates in first person, together with their peers, new and more functional modalities to deal with and face up to emotions, relationships, and events of their own life.

In fact, the key role of the change process in patients is played by the interplay between learning new knowledge and lived experiences in interaction with peers in their group, and not by skills taught by the therapist.

For example, participation in Crisis and Planning groups allows one to develop a shared awareness of triggering events, interpretations and functions of risk behaviors, resulting in a sense of commonality of one's core suffering. In addition, groups allow for the sharing of a group culture and the experiential construction of strategies to prevent crises.

In this scenario the group builds a new matrix of reference. Being immersed in this new network and matrix, different from the one that contributed to the disorder, can become a transformative and therapeutic experience. In fact, experience is the base of thought, emotions, and actions, and it is the medium for developing new modalities to cope with life challenges.

In a more specific and clinical point of view, group therapy allows for different therapeutic factors:

1. installing and maintaining hope: comforting and comparing with other group members allows to witness the individual's change, observing, for example, people who have been in treatment the longest;
2. sharing information: what is said by a peer becomes an important resource because it implies reciprocal care and interest; for example, the psycho-educational notions, which may initially be provided by the facilitator, are almost immediately internalized and conveyed by the group itself;
3. experiencing the therapeutic factor of altruism: the patient does not feel only a burden to others but experiences a versatility of role that allows both him/her to receive and to give help;
4. learning socialization skills: for example, patients confronting each other by experientially learning how to manage possible conflicts or divergences of thought;

5. experiencing the therapeutic factor of imitative behavior: for example, through analysis of a crisis in which impulsive behavior was managed, a person may realize how certain strategies – found together during the group session – work for a groupmate and is more likely to implement them as well.

The teamwork

GET treatment is carried out by a team of professionals, under the responsibility of the équipe's coordinator.

Each group is held by a practitioner (i.e., psychologist, psychotherapist, or psychiatric rehabilitation technician) taking the role of "facilitator", i.e., he/she facilitates peers' interactions towards the group's goals and encourages their participation.

In addition to the group activities other professionals and roles are involved in the therapy process: the tutor (a psychotherapist) who conducts weekly individual sessions and is responsible for that patient's group work and follows him/her throughout the whole treatment; a psychiatrist or neuropsychiatrist (specialized in the treatment of this type of patients), who might be involved if medication is needed.

The team is not only a place of sharing topics about patients and therapy, but also a safe space to share the emotional burden that patients generate on the operators, a place of psychological processing and sharing for the operators themselves; this place is essential for the overwhelming and emotional engagement of the BPO patients and to reduce burnout risks. In fact, it is known that the patient with borderline personality organization brings emotional content and carries out behaviors that can generate fear, anguish, insecurity in the operators, and doubts about their work. Furthermore, these people often tend to establish relational dynamics – i.e., fusional or conflictual relationships, intense countertransference – that are difficult for the single operator to manage. It is therefore important that each operator shares these potential problems with the team.

All operators meet periodically to discuss cases, check their evolution and the progress of the treatment, and decide together the best way to address and resolve any potential problems; furthermore, teamwork allows the tutors to avoid being the only point of reference for the

patient and feeling excessively responsible for their patients' therapeutic progress.

Furthermore, ongoing training of GET practitioners, through supervision, enables them to possess skills necessary to manage the complex relationship with the borderline patient.

In summary, although many difficulties obviously persist in patient relations and treatment management, the GET's teamwork makes it possible to overcome them.

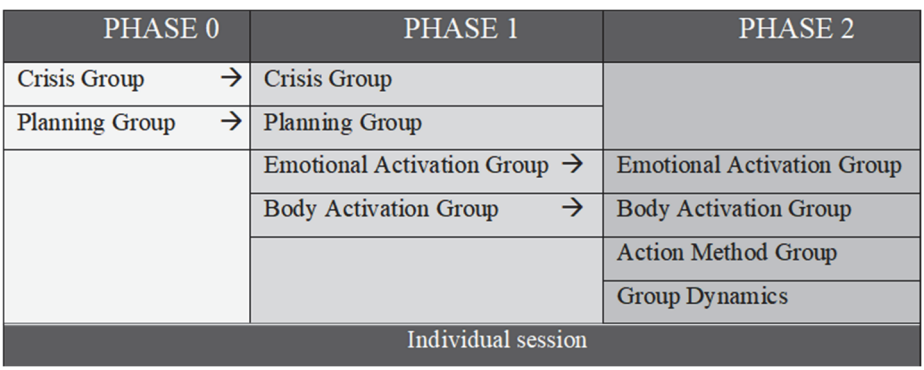
The structure of the GET treatment

The start of possible treatment is preceded by a psycho-diagnostic assessment phase, followed by the équipe discussion for intake, aimed at identifying the therapeutic intervention best suited to the needs and personological characteristics of each individual patient.

Overall, GET is a multilevel treatment whose activities are administered in a synchronic way: patients participate in a program where several activities – group and individual sessions – are planned each week.

As shown in image n. 3, the method is based on three consequential phases (consistent to the patient's evolution) and has an estimated duration of 2 years. Each phase envisages different kinds of groups: two group activities in phase 0 and four group activities in phase 1 and 2.

Figure 3. The GET method structure.



PHASE 0 – duration 3-6 months approximately

This is the initial phase where the patient encounters the idea of the group as a therapeutic instrument, it has a cognitive-phenomenological and psychoeducational approach.

During this phase, patients start to participate in activities, comprehend how to work in a group, and share their own symptoms with the group peers.

Phase 0 includes 2 groups activities:

• **Crisis Group**: starting to analyze and take into consideration the cognitive and emotional flows that give rise to crisis/emotional dysregulations and impulsivity. It is aimed at reducing the manifestations of impulsive behaviors.

• **Planning Group:** it's about coping with the potentially present and future dysregulating events. Analyzing, comprehending and limiting the avoidant behaviors are the goals of this group that focuses on the development of planning, and programming skills regarding daily activities and interpersonal interactions.

The patient might pass to Phase 1 when is assessed to be able to use the group as a therapeutic instrument, by being actively engaged in the treatment, and when he/she starts to show signs of change, by realizing that the mental state of oneself and others can differ, and it is possible to collaborate and manage social situations in groups.

PHASE 1 – duration 9-12 months approximately

The cognitive-phenomenological approach and the psychoeducational aspect, present primarily in Phase 0, are reduced progressively.

Phase 1 has two goals:

1. Proceeding the analysis, comprehension, and regulation of the emotional appraisal thanks to **Crisis** and **Planning Groups**.
2. Starting the process of emotional alphabetization and development of mentalization skills through the **Emotional Activation Group** and the **Body Activation Group**.
   - **Emotional Activation Group:** the aim is recognizing in

themselves and in others the expression of emotions. This can be attained through watching movies and focusing the attention on different aspects, such as facial expressions, behaviors, and language.

Through discussion among group members, it will be possible to outline a shared emotional language and vocabulary that allows different emotions to be distinguished and identified. As with other group activities, these are not "ex cathedra" lectures, but circular exchanges in which the facilitator encourages the construction of knowledge within the group context. Thus, there is no transmission of knowledge from an expert to patients, but rather the culture of the group begins to build a kind of emotional alphabet.

- **Body Activation Group:** during this group, the patients realize the centrality of their body in the comprehension of the emotions and in their regulation, mindfulness techniques are used.

In this Phase, the tutor starts a weekly session with the patients, and will support them during Phase 2, until the end of the treatment.

PHASE 2 – duration 9-12 months approximately

The patient is ready to pass in phase 2 when he/she acquires the capacity to regulate intense emotions and impulsivity, starts to acquire the ability to mentalize, and there is a reduction of self-harming behaviors. At this point of the treatment, the patient is also capable of not using invalidating judgment and rumination as the only obsessive modalities to think about themselves and the world around them, that usually made them feel invalidated, in pain, and inefficient. The consequences of the changes just described are positive: the emotional sufferance remains present but is less intense, constant and devastating; the presence of the first signs of a "psychological mind", defined by Appelbaum as «the ability of a person to see the relations between thoughts, emotions and actions, with the goal of comprehending the meanings and causes of their own experiences and behaviors» (1973, p. 36), and by Farber as «a disposition to reflect on the meaning and motivation of behaviors, thoughts and emotions of themselves and

others» (1985, p. 170). If a person starts therapy feeling like they have no control over their emotions or their mind, Phase 1 is where they begin to "keep the mind in mind".

Phase 2 continues the process of change, focusing more on relationships and is based on a psychodynamic and expressive approach. It is designed for improving evolutionary processes that started developing in earlier phases, such as: mentalization, improving relationship skills, and building a more mature and integrated sense of self.

This phase focuses on two main areas:

1. **Dynamics of the emotions**: with the tools learned in Phase 1, the person goes deeper into understanding and analyzing their emotions, especially through the **Emotional and Body Activation groups** according to the increased ability of the participants to reach a greater knowledge, awareness of their emotions, sensations and feelings.
2. **Relational dynamics**: through the **Group Dynamics** and **Action Methods group**, the person starts developing a different way of dealing with relationship issues, trying out new and more functional ways to interact with others.

The goal here is to support the process of reactivation of separation and individuation and to lay the foundation for building emotional consistency and a stable, integrated personality.

Support for families and relatives

Finally, we point out that the GET treatment also includes support for families and people who live with or are close to a person suffering from BPD — whether they are family members, partners, roommates, etc. This kind of support is crucial considering the increasingly younger age of patients and the fact that in most cases they still live in families or otherwise have close ties to them and considering the importance of the environmental factor in the evolution of the disorder.

The GET method provides support through groups and each group is made up of about 5–6 family "units", so around 10–12 people in total. It's a closed group (so no new people join once it starts) and it lasts for around one year, with one session per month. Each session lasts 90 minutes and is generally split into the following parts:

- **Sharing, discussion, support**: family members talk about how they're doing and what is happening in their relationship with their loved ones. The focus is on intra-family dynamics rather than on the patients themselves.
- **Focused analysis on specific topics, from the family experience's point of view**: another part of the session is about reviewing some "homework" or exercises that the group gets each time. These are meant to help people become more aware of what's really going on in their family relationships — the emotions, patterns, and behaviors that show up in their daily life.
- **Psychoeducation**: it's a part dedicated to educational content about psychological concepts and emotional/relationship dynamics.

Some data about method efficacy

To date, the available studies highlight that GET shows significant outcomes in the reduction of emotional dysregulation, self-harming behaviors, and suicidal behaviors (Gaj *et al.*, 2016; Visintini *et al.*, 2020). In addition, the comparison with DBT has shown a substantial equivalence in the reduction of target variables after one year of treatment (Carretta *et al.*, 2015; Roder *et al.*, 2017; Visintini *et al.*, 2020). A study conducted by Visintini and colleagues (2020), that compared GET and DBT, reached comparable outcomes on target variables. In fact, it was reported that suicidality, self-harm, emotional and behavioral dysregulation decreased in both groups after one year of treatment. Strategies to regulate intense emotions and mindfulness skills improved better in GET for the patients who completed the entire treatment, compared to drop-outs.

In a recent study, conducted by Fortaner-Uyà and colleagues (2025), it was demonstrated that DBT and GET psychotherapy programs were comparable in terms of improvement of BPD symptoms: 6 months of both treatments were associated with a significant reduction of emotional dysregulation and aggression dimensions, confirming that the two different interventions did not represent a source of heterogeneity.

The GET model is currently used in outpatient and community settings. In both, it has shown a good adaptability and flexibility to be

implemented in different health care settings. Even if more accurate research and studies are required, the available efficacy outcomes are encouraging.

Brief comparison among some aspects of the different approaches

Each of the model described has specific techniques and modes of interventions, and share many similar aspects: they all show efficacy on recovery of borderline sufferance; they are all manualized, structured, and have a theoretical coherence; they are relatively long treatments (they last more than one year), they have a clear focus, and they primarily target patients' affective experience and the therapeutic relationship.

In order to obtain a very profound and lasting modification of behavior and mental processes, we claim -based on our clinical experience- that it is essential a therapy group. Accordingly, specific psychotherapy for BPD, such as DBT and MBT, are group therapy and this kind of setting has provided great therapeutic potential (Hernandez-Bustamante *et al.*, 2024; Vogt *et al.*, 2019).

At the same time, even though many of the therapeutic approaches described in this article are based on group settings, the group in GET therapy is conceptualized in a different way as described in the comparison with DBT. In fact, in GET treatment we observe that when people are in an experiential group, they are not only attentive to comprehend and conceptualize the contents, but – at the same time – they experience and observe the processes brought by the relationships with the other members. In short, they experience what Lewin (1951) defined as a state of interdependence of fate and of task.

Our patients – during Phase 0 – learn to accept the group dimensions as safe and trustworthy. This allows the changes. It is important to highlight that the main goal of GET is not only to overcome symptomatology, but also to gain back the personal evolution of the individual (school, work, and relationships). In fact, this is linked to our vision of the borderline sufferance that we try to synthesize.

Comparing DBT and GET, other similarities are: the importance of emotional management, the main focus of the body through the development of the ability of mindfulness, the work on the reduction of at risk behaviors and the development of relational capacities.

Nevertheless, they are very different in the methodology and in the instruments used to achieve the treatment and the recovery. Hence, we can say that DBT is a "therapy in group" and GET is a "group therapy". In GET, the changes are facilitated and supported through the personal experience in the present.

Regarding the MBT treatment, as we described, the group also plays a key role in providing a context for social interaction and confrontation that facilitates growth and change. As it is conceived in GET, the MBT group offers the valuable opportunity to induce people to interact with each other and everything that happens in the group can be discussed in individual sessions, and vice versa.

Furthermore, some differences between the models explained concern the figure of the therapist: in DBT, MBT and especially in TFP, the therapist has a central role, meanwhile in GET the therapist's role is complementary to the role of the group.

DBT favors supportive interventions like giving advice and providing specific problem-solving skills. These types of interventions are only moderately recommended in MBT and it is discouraged in TFP. In GET, the main function of the facilitator or tutor is not to teach nor suggest specific tools to be applied, but to foster self-understanding through interactions with peers. In other words, the DBT therapist is steady, pragmatic and validating.

In MBT, the therapist is more participative than in GET, leading the discussion and offering constructive feedback. However, as in GET, the MBT therapist encourages everyone's participation and helps to keep the focus on their own experiences and interpersonal relationships.

Differently from GET, MBT can be applied even only in single interventions with the patient. During these sessions, the therapist is collaborative, explorative and restraining, using "non-knowledgeable" questions.

In TFP, the therapist uses confrontation, clarification and interpretation: he/she focuses on the analysis of transference, i.e., the relationship between patient and therapist. The therapist is considered as a mirror and observer of the transfer dynamics. Accordingly, the interpretation, in TFP, is fundamental, since it is a useful instrument in helping patients to connect different mental states previously dissociated, but by being still consciously aware in the therapeutic relationship.

In GET, the interpretation is not used since it is considered not acceptable for a patient with an underdeveloped Self, who could misinterpret the meaning of the interpretation. Hence, for GET, MBT, and DBT, this technique is considered as dangerous and harmful as it imposes the patient to elaborate an interpretation that might not completely correspond to his/her mental state.

Considering now the TFP and GET treatments, they both have the main goal to work on the split and the identity integration. It is essential to underline that GET treatment – unlike TFP – works first on the symptomatology with a cognitive and phenomenological approach, and then, during phase 2, on the identity with a more psychodynamic approach.

The four approaches described also differ in their philosophy of change and therapeutic goals. At the same time, there can also be parallels. The most evident benefits of the therapeutic treatments described regard behaviors of self-harming, suicidal ideations, and suicide attempts.

In order to better explain, in DBT, change is based on the dialectic between acceptance and change. Motivation is central. The patient is validated in his pain, but guided step by step to change dysfunctional behaviors through active learning of skills.

In MBT, change occurs by restoring and strengthening the ability to mentalize. The therapeutic relationship is used to reactivate interrupted mental processes. Hence, the goals are -in addition to developing and stabilizing the ability to mentalize – prevent acting-out and promote more stable and coherent relational functioning; strengthen the sense of self through interaction with the therapist and the group.

In TFP, the therapist works in the transference. The change is structural and profound and occurs through the integration of split representations of self and other, transforming a borderline structure into a more integrated one; making disturbed internal relational patterns that are activated in the transference aware; processing pathological object relations through intensive transference and countertransference analysis; promoting a more cohesive and stable sense of self.

Lastly, we want to emphasize how in GET, the integrated approach between different traditions and schools of thought allows us to consider therapeutic goals and recovery as a very complex system, involving behavior up to self-image and identity. Indeed, we use a module

that summarizes the different therapeutic goals at different stages of treatment. In Phase 0, the goals concern constancy and frequency in treatment, recognition of critical behavior, pharmacological compliance, the ability to see the other as a group, and compliance with the contract. In Phase 1, the following are added to those just described: the reduction of the use of regulatory behavior, the identification and acceptance of one's own critical areas, the tolerance of frustration, the development of an internal locus of control, the expansion of an emotional dictionary, the ability to be in the here and now and the ability to mentalize. In Phase 2, the therapeutic goals are: the absence of crises, identity stability, awareness of emotions and thoughts, persistence and constancy aimed at achieving defined goals, a substantial improvement in quality of life and the development of interpersonal skills. In summary, GET helps to support identity and the ability to reflect on oneself in relation to others, increase emotional tolerance and affect regulation, promote the expression and mentalization of interpersonal dynamics in the here and now, build a group mind, in which the individual can recognize himself as part of a relational whole.

Conclusions

The "borderline world" is very complex, and it represents a challenge on a diagnostic, therapeutic and relational level. In this article, we drew our vision of borderline functioning as the result of the virtuous interaction and integration of certain theoretical elements, presented within the paper.

According to our view, in borderline functioning, the cornerstones of the patient's suffering are: the crisis triggered by the process of emotional dysregulation, social avoidance, intolerability of contact with the emotional world and the body, the difficulties and conflict of object relations.

Throughout the article, we wanted to emphasize that behind the complexity there is a valid reason: a borderline person feels emotions as unbearable because the emotions are too intense and pervasive; so, they search for a way to survive the intolerability by different behaviors and strategies (e.g., self-harming) (Shaw, 2016).

Based on this theoretical approach and based on our clinical

experience, we have developed a new psychotherapeutic method: GET. The specificity of GET derives from integration of different theoretical and clinical influences through various group activities that constitute its uniqueness and originality. The group is the core and the heart of our treatment.

To better frame our proposal, we have briefly outlined the main treatments specific to borderline disorder: DBT, MBT and TFP. As we described, all the treatments are effective in the treatment of borderline personality disorder. Until now, research reported that the changes achieved with the treatment have demonstrated stability and duration in the long run for all of the treatments we mentioned (Carretta *et al.*, 2015; Juanmartí, & Lizeretti, 2017; Ellison *et al.*, 2020; Crotty *et al.*, 2023). This confirms the necessity of a specific psychotherapeutic treatment for BPD, if we want to achieve a recovery (Oud *et al.*, 2018).

Finally, we add that we do not believe that there is one treatment that is better than another, but that each individual patient, based on one's personality traits, resources and availability, can achieve better goals and a recovery with a specific treatment, which is why it is important to evaluate on a case-by-case, by a psychodiagnostics pathway (Kaiser *et al.*, 2023; Bucher *et al.*, 2019).

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