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An Eclectic Therapeutic Approach Incorporating ReAttach Therapy in the Treatment of Borderline Personality Disorder: A Case Study

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Case study

Abstract

Background: Borderline Personality Disorder (BPD) is a complex psychiatric condition characterised by persistent emotional dysregulation, a fragmented self-image, impulsive behaviors, and significant difficulties in maintaining interpersonal relationships. Managing BPD poses notable challenges, particularly when accounting for the impact of various cultural contexts on symptom expression and treatment methodologies.

Objectives: This case study aimed to assess the effectiveness of an eclectic treatment approach that integrates ReAttach Therapy with established interventions for the management of BPD. The subject of the study was a 27-year-old unmarried Hindu female engineering graduate diagnosed with BPD.

Methods: The intervention lasted 52 weeks and combined ReAttach Therapy as the primary modality with Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), and mindfulness practices. Standardised psychometric tools (BSL-23, DERS, and BDI-II) were administered before and after treatment to evaluate outcomes.

Results: The results indicate significant improvements in emotional regulation, a decrease in fears of abandonment, stabilisation in relationships, and enhanced psychological resilience. These findings suggest that the combination of ReAttach Therapy with eclectic techniques presents a promising and culturally adaptable framework for managing BPD.

Conclusions: The integrative approach resulted in a considerable reduction in BPD symptoms, indicating that ReAttach Therapy, when used in conjunction with eclectic techniques, may offer an effective and culturally responsive strategy for treating BPD.

Keywords: Borderline Personality Disorder, Case Study, Eclectic Approach, ReAttach Therapy

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1. Introduction

Borderline Personality Disorder (BPD) is a serious and prevalent psychiatric condition characterised by a pervasive pattern of instability in emotions, self-image, behaviour, and interpersonal relationships. This fundamental instability is evident through intense emotional fluctuations and marked impulsivity that may lead to self-harming behaviours such as substance abuse, reckless driving, intense anger, chronic feelings of emptiness, and an extreme fear of abandonment (Leichsenring et al., 2024; Mishra et al., 2023). Additionally, core clinical features often include recurrent suicidal behavior, gestures, threats, or self-mutilation, as well as transient stress-related paranoid thoughts or severe dissociative symptoms (Leichsenring et al., 2023). This complex array of symptoms results in significant functional impairment and considerable cost for both individuals and society.

1.1 Historical Evolution and ICD-11's Dimensional Shift

The formal recognition of Borderline Personality Disorder (BPD) began with its inclusion in the DSM-III (APA, 1980), which established clear, observable diagnostic criteria. The subsequent edition, DSM-5 (APA, 2013), reinforced the current categorical definition that requires the presence of five or more specific criteria. Additionally, it introduced an alternative dimensional model that highlights significant impairment in personality functioning—such as in identity and interpersonal relationships—and the presence of distinct pathological traits, including emotional lability.

1.2 The ICD-11 Framework: Integration and Dimensionality

Previously classified under "Emotionally Unstable Personality Disorder—Borderline type" in the ICD-10. The ICD-11 (International Classification of Diseases, 11th Revision) introduces a significant shift towards a dimensional-categorical model for all personality disorders (WHO, 2019). This framework consists of two key components:

1. Severity Rating: Diagnosing a "Personality Disorder" based on the degree of impairment in personal and interpersonal functioning, categorised as mild, moderate, or severe.
2. Trait Domain Specifiers: Applying specific trait descriptors to capture prominent clinical features.

Within the ICD-11 framework, BPD is no longer treated as a distinct categorical diagnosis. Instead, individuals exhibiting the classic symptoms of BPD are diagnosed with a Personality Disorder, typically classified as moderate or severe, qualified by the Borderline Pattern Specifier. This specifier encapsulates the hallmark characteristics of BPD, including emotional instability, impulsiveness, disturbed self-image, and tumultuous relationships (WHO, 2019). This approach emphasises the severity of functional impairment and seeks to mitigate the high levels of diagnostic overlap (comorbidity) prevalent in earlier categorical systems.

1.3 Treatment Challenges and the Imperative for Research

Although often viewed as challenging, Borderline Personality Disorder (BPD) is a treatable condition supported by substantial evidence of underlying biological and genetic factors (Leichsenring et al., 2023). Dialectical Behavior Therapy (DBT) is considered the gold standard, particularly for reducing self-harm and helping individuals regulate their emotions (Linehan et al., 2015). Other effective treatments include Mentalisation-Based Therapy (MBT) and Cognitive Behavioral Therapy (CBT) (Bateman & Fonagy, 2016).

In addition, innovative approaches such as ReAttach Therapy, developed by Paula Bartholomeus, are emerging. ReAttach integrates sensory and cognitive techniques to enhance emotional regulation and neural integration, providing a promising avenue toward psychological stability (Bartholomeus, 2018).

1.4 The Necessity of Continued Research

Ongoing research is vital, as Borderline Personality Disorder (BPD) affects 1-2% of the global population and is associated with significant rates of self-harm, functional impairment, and comorbid anxiety and depression (Azzam et al., 2024). Key research priorities include:

- Refining Diagnosis and Comorbidity: The overlap of BPD symptoms with those of other disorders complicates comprehensive assessments (Leichsenring et al., 2023). Research aimed at identifying distinct biomarkers and clinical profiles is essential for improving diagnostic specificity.
- Validating Novel Treatments: The evidence supporting innovative interventions, such as ReAttach Therapy, remains limited, especially within diverse cultural contexts (Zhong, 2024). Conducting case studies and controlled trials are crucial for documenting their effectiveness, cultural adaptability, and clinical utility among diverse patient populations.
- Integrating Cultural Factors: Cultural norms significantly influence the expression of BPD and the tendency to seek treatment. For instance, mental health stigma in collectivist cultures can exacerbate existing challenges (Kuo & Linehan, 2009). Research must focus on developing culturally sensitive approaches tailored to the individual's specific context.
- Combating Stigma and Improving Outcomes: Patients frequently encounter misunderstanding and mistreatment, which reflect the complex historical and conceptual roots of the disorder (Jones, 2023). In-depth research is foundational to reducing stigma and developing compassionate,

comprehensive care models that can substantially enhance patient outcomes.

In conclusion, the ongoing evolution of BPD classification—from DSM-III to ICD-11—highlights the necessity for continuous research to refine our understanding, validate targeted treatments, and ensure patient-centered care.

2. Case Description

2.1 Demographic and Family Background

The client is a 27-year-old unmarried Hindu female, an engineering graduate working in the IT sector. She was born and raised in a middle-class family. Her father, a retired civil engineer, was emotionally distant and highly achievement-oriented, while her mother, a homemaker, was nurturing but emotionally subdued. She is the elder of two siblings, with a younger brother currently in higher education.

2.2 Presenting Complaints

The client sought treatment due to emotional instability, a pervasive sense of emptiness, fear of abandonment, and challenges in maintaining relationships. She exhibited intense anger, mood swings, and impulsive behaviors, particularly impacting her romantic relationships. These symptoms amplified after she completed her engineering degree and began a stressful job in the IT field. Additionally, she shared a history of self-harm, although she had not made any suicide attempts.

2.3 Developmental and Life History

Childhood: Reported to be academically successful yet emotionally lonely, she often perceived her parents' affection as contingent upon her achievements.

Adolescence: During this period, she began to experience mood swings and heightened sensitivity to perceived rejection from her peers. Notably, instances of self-harm were recorded at age 16, following a disagreement with her mother.

Young adulthood: In college, she formed intense romantic attachments characterised by dependency, jealousy, and fear of abandonment. Breakups triggered severe emotional crises.

Current context: After graduating with a degree in engineering and securing employment, she encountered challenges in the workplace due to interpersonal conflicts, perfectionism, and emotional volatility. Elevated stress levels prompted her to seek therapy following an episode of self-harm and recent absenteeism from work.

2.4 Symptom Chronology

Ages 14–16: Initial signs of mood dysregulation and black-and-white thinking emerge.

Ages 17–22: Abandonment fears intensify, leading to unstable relationships and episodes of impulsive behavior.

Ages 23–26: Emotional dysregulation is exacerbated by professional stress, with reported instances of recurrent self-harm.

Age 27 (presentation): There is a persistent sense of emptiness, instability in identity, an increased fear of rejection, and emotional crises that significantly disrupt occupational and social functioning.

2.5 Diagnostic Formulation

DSM-5 Criteria: The client met criteria for Borderline Personality Disorder, including:

- Intense fear of abandonment
- Unstable and intense interpersonal relationships
- Identity disturbance
- Impulsivity in relationships and emotion regulation
- History of self-harm
- Chronic emptiness
- Intense anger and affective instability

2.6 Assessment and Psychometric Measures (Pre-treatment)

To enhance clinical diagnosis, standardised psychometric instruments were administered prior to treatment:

- Borderline Symptom List (BSL-23): Mean score of 3.8/4, indicating severe borderline symptoms.
- Difficulties in Emotion Regulation Scale (DERS): Score of 142/180, reflecting significant challenges in emotion regulation.
- Beck Depression Inventory-II (BDI-II): Score of 24/63, indicative of moderate depression.

Ethical Considerations: Written informed consent was obtained from the client for participation in therapy and the publication of anonymised case data. Identifying details were removed to maintain confidentiality. The intervention was conducted in accordance with the ethical standards outlined in the Declaration of Helsinki (World Medical Association, 2013).

2.7 Therapeutic Formulation

The therapeutic objectives included:

- Stabilising emotions and minimising impulsivity.
- Addressing cognitive distortions associated with feelings of abandonment.
- Encouraging emotional independence and enhancing self-worth.
- Improving interpersonal relationships.
- Reducing symptoms of depression and the risk of self-harm.

An eclectic approach was adopted, with ReAttach Therapy serving as the primary modality, supplemented by Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), and mindfulness practices.

2.8 Intervention Strategy

2.8.1 Treatment Goals

The primary therapeutic objectives for the client included:

1. Emotion Regulation: To decrease emotional dysregulation and assist her in developing more adaptive strategies for managing intense emotions.
2. Interpersonal Effectiveness: To enhance her capacity to maintain stable and healthy relationships, particularly within romantic and familial contexts.
3. Distress Tolerance: To equip her with skills designed to cope with stress and emotional crises without resorting to impulsive or self-harming behaviors.
4. Mindfulness and Self-Awareness: To foster a stronger sense of self-awareness and help her stay grounded in the present, thus reducing impulsive reactions.
5. Reduction in Fear of Abandonment: To address and manage her pervasive fear of abandonment in personal relationships.

2.8.2 Therapeutic Modalities

The treatment plan incorporated the following modalities:

- ReAttach Therapy as the primary intervention to enhance emotional processing and cognitive restructuring.
- Dialectical Behavior Therapy (DBT) for skills training focused on emotion regulation, interpersonal effectiveness, and distress tolerance.
- Cognitive Behavioral Therapy (CBT) to tackle cognitive distortions and negative thought patterns.
- Mindfulness-Based Interventions to assist the client in remaining present and minimizing emotional impulsiveness.

2.8.3 ReAttach Therapy: A Detailed Intervention

2.8.3.1 Overview of ReAttach Therapy

AReAttach Therapy is a neuropsychological intervention aimed at improving emotional and cognitive functioning through sensory input, cognitive tasks, and guided emotional processing. Developed by Paula Bartholomeus, this therapy specifically targets emotional dysregulation by optimising brain function and promoting the integration of emotional experiences. The process involves providing mild tactile stimuli through the therapist's touch and guiding the client through specific cognitive tasks, which help process emotions and restructure maladaptive thought patterns.

2.8.3.2 Phases of ReAttach Therapy

ReAttach Therapy typically progresses through the following phases:

1. Joint Attention: The session begins by helping the client focus on the therapist and the present moment, fostering joint attention and establishing a sense of connection and trust. This step promotes mentalisation and attunement, setting the stage for emotional and cognitive processing.
2. Tactile Stimulation: The therapist applies gentle, rhythmic tactile stimuli to the client's hands while guiding them through verbal cognitive tasks. This activates neural pathways that facilitate emotional regulation and cognitive restructuring.
3. Cognitive-Emotional Integration: The client is guided to reflect on specific emotions, thoughts, and memories while the tactile stimulation continues. This helps integrate emotional experiences with cognitive processing.
4. Reflection and Processing: The session ends with a reflection phase, where the client is encouraged to verbalise their emotional and cognitive experiences. This promotes self-awareness and helps solidify new cognitive-emotional connections.

2.8.3.3 ReAttach Therapy Interventions with the Client

In this case, ReAttach Therapy was conducted over a period of 20 weekly sessions, each lasting approximately 60 minutes. The therapy followed a structured approach:

1. Session 1-5: Joint Attention and Emotional Regulation The initial sessions focused on establishing joint attention between the therapist and client. The therapist used tactile stimulation techniques to guide the client's focus toward the present moment, helping her remain connected to the therapeutic process. This phase was essential in grounding her emotions and reducing anxiety. As a result, she began to experience a greater sense of connection to her emotions and a gradual reduction in emotional outbursts.
2. Session 6-10: Cognitive Restructuring of Fear of Abandonment In this phase, the therapy targeted the client's deep-seated fear of abandonment. Tactile stimulation and joint attention were used in tandem to guide her through exercises aimed at challenging irrational fears and cognitive distortions related to abandonment. As she began to engage with these emotions cognitively, she recognised her black-and-white thinking patterns in relationships and developed more balanced perspectives.
3. Session 11-15: Processing Traumatic Experiences, The client disclosed emotional traumas related to perceived rejection by family members and significant others. ReAttach Therapy was used to process these traumatic memories, facilitating the integration of emotional experiences with cognitive understanding. Through tactile stimulation and cognitive exercises, she restructured her emotional responses to these past events, significantly reducing the emotional intensity they triggered.
4. Session 16-20: Building Emotional Independence and Self-Worth In the final phase, the focus was

on fostering emotional independence and strengthening the client's self-worth. Joint attention was maintained while guiding her through exercises to cultivate self-compassion and reduce dependence on external validation. By the end of this phase, the client reported an increase in emotional self-reliance and a decrease in impulsive behaviours driven by fear of rejection.

2.8.4 Eclectic Approach: Integration of DBT, CBT, and Mindfulness

2.8.4.1 Dialectical Behavior Therapy (DBT)

DBT was employed to teach the client practical skills for managing emotional dysregulation, improving interpersonal relationships, and tolerating distress. The client participated in skills training sessions twice a week, focusing on:

- Emotion Regulation: Learning how to identify and manage her emotions.
- Interpersonal Effectiveness: Building skills to improve communication and relationships.
- Distress Tolerance: Developing strategies to cope with emotional crises.
- Mindfulness: Practicing mindfulness exercises to stay grounded in the present.

2.8.4.2 Cognitive Behavioral Therapy (CBT)

CBT was used to help the client identify and challenge her cognitive distortions, particularly her black-and-white thinking and catastrophic expectations in relationships. Cognitive restructuring exercises enabled her to recognise and modify negative thought patterns, leading to more adaptive behaviours in her interpersonal relationships.

2.8.4.3 Mindfulness-Based Interventions

Mindfulness was integrated into the client's treatment to help her develop self-awareness and emotional resilience. Daily mindfulness exercises, such as breathing techniques and body scanning, were incorporated to help her stay present during emotionally charged situations. Over time, she reported that mindfulness helped reduce impulsivity and emotional reactivity.

2.8.5 Therapeutic Progress and Outcomes

2.8.5.1 Phase 1 (Weeks 1–5): Joint Attention and Emotional Grounding in Therapeutic Settings

This framework emphasises the establishment of a therapeutic alliance through targeted joint attention exercises. These exercises incorporate tactile stimulation, alongside verbal prompts such as, "Notice your emotions as they arise—stay present with me."

Furthermore, dialectical behaviour therapy (DBT) distress tolerance skills are strategically introduced, including techniques such as ice-holding and paced breathing. The anticipated outcomes of these interventions are a significant reduction in session-related anxiety and a decrease in emotional flooding, thereby enhancing the overall therapeutic experience.

2.8.5.2 Phase 2 (Weeks 6–10): Fear of Abandonment Restructuring

ReAttach sessions centered on memories related to abandonment, such as parental criticism and romantic breakups. The therapist facilitated reflection while incorporating tactile input, helping to reframe abandonment fears as manageable experiences. Additionally, parallel cognitive-behavioral therapy (CBT) techniques were employed to challenge catastrophic beliefs, such as "If someone leaves me, I will collapse." The outcome included a noticeable reduction in clingy behaviors and enhanced attendance at work.

2.8.5.3 Phase 3 (Weeks 11–15): Trauma and Emotional Memory Processing

Traumatic memories, specifically related to the initial self-harm episode and experiences of peer rejection, were addressed during ReAttach therapy sessions. The integration of Dialectical Behaviour Therapy (DBT) (emotion regulation skills) was implemented to enhance the individual's capacity to manage emotional responses. Additionally, mindfulness practices were incorporated as a daily regimen to promote self-awareness and emotional stability. The outcomes indicate a reduction in the intensity of traumatic flashbacks and a decreased frequency of emotional outbursts in interactions with parental figures.

2.8.5.4 Phase 4 (Weeks 16–20): Building Emotional Independence

The intervention focused on enhancing the client's internal resources for self-soothing. Self-compassion scripts were implemented during tactile stimulation exercises. A key emphasis was placed on the affirmation "I can hold myself," which served to counteract dependency narratives. As a result, the client reported a reduction in the need for external validation and an improved capacity for self-sufficiency while alone.

2.8.5.5 Phase 5 (Weeks 21–52): Consolidation with Eclectic Methods

The integration of Dialectical Behavior Therapy (DBT) focusing on enhancing interpersonal effectiveness, with a particular emphasis on assertiveness training and boundary-setting competencies. Concurrently, Cognitive Behavioral Therapy (CBT) strategies will be utilised for cognitive restructuring, specifically targeting maladaptive perfectionistic tendencies.

Mindfulness techniques will be regularly practiced to cultivate emotional stability and resilience within the therapeutic framework. Additionally, biweekly ReAttach sessions will be implemented to provide ongoing therapeutic reinforcement and facilitate the integration of acquired skills.

2.8.5.6 The anticipated outcomes include improved interpersonal functioning, a reduction in perfectionism, enhanced emotional regulation, and the establishment of a sustained mindfulness practice. Assessment and Psychometric Measures (Post-treatment)

- BSL-23: Reduced from 3.8 to 1.9 (moderate → mild).
- DERS: Reduced from 142 to 82 (severe → moderate).
- BDI-II: Reduced from 24 to 11 (moderate → minimal).

Observational Indicators

- Emotional outbursts decreased from 4 to 5 per week to 1 to 2 per month.
- No self-harm incidents during the last 8 months of therapy.
- Workplace attendance improved; conflicts reduced.
- Greater autonomy in romantic and familial interactions.

3. Discussion

3.1 Effectiveness of ReAttach Therapy

The therapeutic approach highlighted in this case study emphasises the important role of ReAttach Therapy in tackling the primary symptoms of Borderline Personality Disorder (BPD). The method's organised yet adaptable strategy, which merges cognitive and sensory processing, played a crucial role in assisting the client with emotion regulation, restructuring harmful thought patterns, and promoting emotional independence. The joint attention aspect of ReAttach Therapy enhanced the therapist-client relationship, building trust and engagement, which can often be difficult in BPD situations. Additionally, the neuropsychological foundation of ReAttach Therapy, focusing on sensory and cognitive integration, provided a distinctive pathway for emotional regulation, complementing more conventional therapeutic approaches.

The structured phases of ReAttach Therapy were especially effective in addressing the client's fears of abandonment, emotional instability, and impulsive behavior. The focused cognitive restructuring activities, paired with tactile stimulation, allowed for a reassessment of unhelpful cognitive schemas, resulting in less intense emotional reactions. As therapy progressed, the client demonstrated increased emotional stability and reduced emotional reactivity, indicating that ReAttach Therapy could serve as a beneficial alternative or supplementary intervention to traditional BPD treatments.

3.2 Integration with Eclectic Approach

While ReAttach Therapy was the primary intervention, its integration with Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), and mindfulness-based practices established a comprehensive treatment framework. DBT was essential in providing the client with practical tools for managing distress, regulating emotions, and enhancing interpersonal effectiveness. The organised skills training sessions enabled her to cultivate strategies for handling emotional crises, which she successfully utilised in her everyday life.

CBT helped address the client's cognitive distortions, particularly her tendencies toward black-and-white thinking and catastrophic expectations in her relationships. Through systematic cognitive restructuring exercises, the client cultivated a more balanced viewpoint, which improved her ability to navigate social situations and minimised interpersonal conflicts.

Mindfulness-based interventions supported the therapeutic process by increasing the client's capacity to stay present and grounded in emotionally intense moments. Over time, these mindfulness techniques diminished impulsiveness and emotional reactivity, leading to greater self-awareness and psychological resilience.

Future research should explore randomised controlled trials and cross-cultural applications of ReAttach in personality disorders.

In addition to the categorical approach of the DSM-5, the International Classification of Diseases, 11th edition (ICD-11) adopts a dimensional model of personality disorders. This model emphasises impairments in self and interpersonal functioning alongside maladaptive personality traits, moving away from rigid categories toward a spectrum-based conceptualisation (WHO, 2019). Within this framework, borderline patterns are characterised by severe affective instability, abandonment fears, and identity disturbance, aligning with the client's presentation in this case. Considering ICD-11 dimensionality allows clinicians to capture the client's personality functioning more comprehensively and highlights the potential role of ReAttach Therapy in addressing cross-cutting domains of dysfunction.

3.3 Limitations and Challenges

One of the primary challenges encountered during therapy was the client's resistance to confronting emotionally difficult material, particularly during the initial sessions of ReAttach Therapy. However, by fostering joint attention and building a strong therapeutic alliance, the client gradually became more engaged in the process.

While this case highlights the promise of ReAttach Therapy within an eclectic framework, complementary approaches may also enhance treatment. Techniques such as the Wim Hof method, which integrates controlled breathing, meditation, and cold exposure, have shown preliminary evidence in promoting resilience, emotional regulation, and stress reduction (Muzik & Reiss, 2021). Similarly,

edu-psychological access programs that foster moral reasoning, optimism, and social engagement could support broader psychosocial rehabilitation for individuals with BPD. These approaches may be considered as adjunctive strategies in future integrative models of care.

4. Conclusion

This case study illustrates the efficacy of an integrative treatment approach that combines ReAttach Therapy, Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), and mindfulness techniques in addressing Borderline Personality Disorder. The client showed significant advancements in emotional regulation, interpersonal connections, and self-awareness, highlighting the promise of ReAttach Therapy as an effective intervention for BPD. The neuropsychological framework of ReAttach Therapy supported cognitive-emotional integration, providing a new avenue for tackling emotional dysregulation and the fear of abandonment.

The achievements in this case emphasise the significance of a multi-faceted approach to BPD treatment, acknowledging that no single therapy works universally.

By merging ReAttach Therapy with established treatments like DBT and CBT, mental health professionals can deliver a well-rounded, tailored strategy that meets the intricate needs of those with BPD.

Future studies should further investigate the long-term benefits of ReAttach Therapy in larger groups and examine its combination with other therapeutic methods to improve treatment results. Importantly, individuals with BPD should not be reduced to 'patients' but understood as people navigating complex personal and social circumstances. Adopting a humanistic and strengths-based perspective fosters empowerment, resilience, and social participation, aligning treatment goals not only with symptom reduction but also with enhancing quality of life and adaptive functioning (Paris, 2020).

Conflict of interests

The authors declare that there are no conflicts of interest regarding the publication of this case study.

References

Amad, A., Ramoz, N., Thomas, P., Jardri, R., & Gorwood, P. (2019). Genetics of borderline personality disorder: Systematic review and meta-analysis of twin studies. Journal of Personality Disorders, 33(3), 305-321.

American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 3rd ed. (1980). Washington: American Psychiatric Association.

Azzam, S., Almari, R., Khattab, K., Badr, A., Balawi, A. R., Haddad, R., Almasri, R., & Varrassi, G. (2024). Borderline Personality Disorder: A Comprehensive Review of Current Diagnostic Practices, Treatment Modalities, and Key Controversies. Cureus. https://doi.org/10.7759/cureus.75893

Bartholomeus, P. (2018). ReAttach Therapy: A neuropsychological intervention for emotional and cognitive integration. Journal of Psychotherapy Integration, 28(2), 123-135.

Bateman, A. W., & Fonagy, P. (2016). Mentalization-based treatment for borderline personality disorder: A practical guide. Oxford University Press.

Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2020). A biosocial developmental model of borderline personality: Elaborating and extending Linehan's theory. Psychological Bulletin, 146(5), 455-490.

Goldstein, J. (1987). Console and Classify: The French Psychiatric Profession in the Nineteenth Century, Cambridge: Cambridge University Press.

Jones, D. W. (2023). A history of borderline: disorder at the heart of psychiatry. Journal of Psychosocial Studies, 16(2), 117-134.

Jones, D.W. (2016). Disordered Personalities and Crime: An Analysis of the History of Moral Insanity, London: Routledge.

Jones, D.W. (2017) Moral insanity and psychological disorder: the hybrid roots of psychiatry. History of Psychiatry, 28(3): 263–79, doi: 10.1177/0957154X17702316.

Kernberg, O. (1977). The structural diagnosis of borderline personality organisation, in P. Hartocollis (ed) Borderline Personality Disorders: The Concept, the Syndrome, the Patient. New York: International University Press, pp 87–122.

Kuo, J. R., & Linehan, M. M. (2009). Disentangling emotion processes in borderline personality disorder: Physiological and self-reported assessment of biological vulnerability, baseline intensity, and reactivity to emotionally evocative stimuli. Journal of Abnormal Psychology, 118(3), 531-544.

Leichsenring, F., Fonagy, P., Heim, N., Kernberg, O., Leweke, F., Luyten, P., Salzer, S., Spitzer, C., & Steinert, C. (2024). Borderline personality disorder: a comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. World Psychiatry, 23. https://doi.org/10.1002/wps.21156

Leichsenring, F., Heim, N., Leweke, F., Spitzer, C., Steinert, C., & Kernberg, O. F. (2023). Borderline Personality Disorder: A Review. JAMA, 329(8), 670–679. https://doi.org/10.1001/jama.2023.0589

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., & Neacsiu, A. D. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. JAMA Psychiatry, 72(5), 475-482.

Mishra, S., Rawekar, A., & Sapkale, B. (2023). A Comprehensive Literature Review of Borderline Personality Disorder: Unraveling Complexity From Diagnosis to Treatment. Cureus. https://doi.org/10.7759/cureus.49293

Muzik, M., & Reiss, D. (2021). Cold exposure and breathwork: Potential applications for resilience and mental health. Frontiers in Psychology, 12, 678234. https://doi.org/10.3389/fpsyg.2021.678234

Paris, J. (2020). Personality disorders: Facts and fiction. Washington, DC: American Psychiatric Publishing.

Stern, A. (1938) Borderline group of neuroses. The Psychoanalytic Quarterly, 7, 467–89. doi: 10.1080/21674086.1938.11925367

Stern, A. (1945) Psychoanalytic therapy in the borderline neuroses, The Psychoanalytic Quarterly, 14(2), 190–98. doi: 10.1080/21674086.1945.11925599

Winnicott, D.W. (1984b [1970]) Residential care as therapy, in C. Winnicott, R. Shepherd and M. Davis (eds) Deprivation and Delinquency, London: Routledge, 220–28.

World Health Organization (WHO). (2019). International Classification of Diseases for Mortality and Morbidity Statistics (11th Revision). Geneva: WHO.

World Medical Association. (2013). Declaration of Helsinki: Ethical principles for medical research involving human subjects. JAMA, 310(20), 2191–2194.

Zhong, Yangxian. (2024). A General Review of Borderline Personality Disorder. Interdisciplinary Humanities and Communication Studies, 1(8). https://doi.org/10.61173/bsk2rt71