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# Integration of Gestalt Therapy with Evidence-Based Interventions for Borderline Personality Disorder - Theoretical Framework and Clinical Model

Enrico Moretto * , Roberta Stanzione , Chiara Scognamiglio , Valeria Cioffi , Lucia Luciana Mosca , Francesco Marino , Ottavio Ragozzino , Enrica Tortora , Raffaele Sperandeo

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# Integration of Gestalt Therapy with Evidence-Based Interventions for Borderline Personality Disorder

## Theoretical Framework and Clinical Model

**Enrico Moretto [1,*], Roberta Stanzione [1], Chiara Scognamiglio [1], Valeria Cioffi [1], Lucia Luciana Mosca [1], Francesco Marino [1], Ottavio Ragozzino [1], Enrica Tortora [1] and Raffaele Sperandeo [2]**

[1] SiPGI–Postgraduate School of Integrated Gestalt Psychotherapy, Torre Annunziata, Italy

[2] Department of Neuroscience and Department of Neurosciences Reproductive and Odontostomatologica Sciences, University of Naples "Federico II", Italy

* Correspondence: enrico.more@gmail.com

**Abstract**

Gestalt therapy traditionally opposes categorical diagnostic labelling due to its fundamental inconsistency with phenomenological and process-oriented ontology. However, this epistemological rigour can limit integration with structured evidence-based interventions for complex personality organisations such as Borderline Personality Disorder (BPD). This paper proposes a hybrid theoretical model that integrates the clinical epistemology of Gestalt therapy with Linehan's biosocial theory of Dialectical Behaviour Therapy (DBT) and schema-focused interventions, while preserving the core principles of Gestalt. We present a model of theoretical integration that draws on Gestalt contact theory, the four modules of DBT (mindfulness, distress tolerance, emotional regulation, interpersonal effectiveness) and the experiential techniques of Schema Therapy. The integration focuses on the dialectic of acceptance and change, which mirrors Gestalt's paradoxical theory of change. The proposed framework preserves the non-protocol dimension of Gestalt therapy while incorporating the pragmatic utility of DBT and Schema Therapy. Key innovations include: (1) conceptualising the "draft self" as the object and subject of therapeutic work, (2) integrating mindfulness and grounding as embodied processes within live Gestalt experiments, (3) activation techniques to explore the identity fragmentation endemic to DBP. This integration offers a coherent, embodied, and process-oriented framework for understanding and treating DBP that validates patients' lived experience, mobilises evidence-based interventions, and opens up meaningful intertheoretical dialogue.

**Keywords:** gestalt therapy; borderline personality disorder; DBT; schema therapy; therapeutic integration; phenomenology

## 1. Introduction

The clinical Gestalt approach to borderline personality organisation favours phenomenological exploration over diagnostic categorisation [1]. Isadore From's concept of the "draft self" – a fragile and provisional construct that borderline individuals maintain in order to preserve identity coherence amid internal fragmentation – provides a framework for therapeutic engagement [2]. This "draft" represents not a fixed structure of the self but a precarious gesture towards coherence in the face of overwhelming uncertainty.

Recent empirical research has provided a nuanced understanding of the complex aetiology of BPD. A large-scale study of 602 participants that examined dissociative experiences and temperamental-characterological traits showed that dissociative symptoms had greater predictive weight (89% significance) for the diagnosis of BPD than characterological traits alone [3]. This finding

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reinforces clinical observations that many individuals with BPD report histories of trauma, particularly sexual abuse [4].

However, trauma alone is insufficient to explain the development of DBP. Only individuals whose temperamental and characterological traits fall at certain extremes—such as high harm avoidance and low self-direction and cooperativeness—appear particularly vulnerable to translating traumatic stress into dissociative symptomatic patterns and identity disruption [5]. This complex interaction supports a model in which DBP emerges from non-linear and recursive processes involving constitutional vulnerabilities, traumatic environmental experiences, and dissociative coping mechanisms.

Network theories of psychopathology have argued that such disorders are not the product of single causal pathways but dynamic constellations of symptoms that reinforce each other over time [6]. Gestalt therapy responds to this complexity by cultivating awareness of how dissociation [7], identity diffusion and relational turbulence manifest themselves in the immediacy of contact.

## 2. From Diagnostic Label to Process Field

Borderline Personality Disorder is characterised by pervasive emotional instability, identity diffusion, impulsivity and patterns of interpersonal chaos. Kernberg's influential model conceptualises these phenomena as arising from three fundamental intrapsychic processes: identity diffusion, reliance on primitive defences (splitting and projective identification) and fluctuations in reality testing [8].

In Gestalt therapy, these patterns are reformulated as dynamic and observable disruptions of contact and self-regulation: projection, confluence, retroflection, and deflection. Diagnosis becomes a process rather than a label, monitoring real-time indicators that include:

- Dysregulated contact boundaries (over-merging or withdrawal)
- Somatic signals of splitting: muscle rigidity, frozen gaze, shallow breathing
- Behaviours that interfere with therapy: chronic tardiness, sudden anger, seduction or avoidance, seen as emerging field phenomena rather than resistance

### *2.1. The Draft Self as a Therapeutic Focus*

To preserve the draft of the Self, we can feel the therapeutic presence in contact with others with this type of attitude towards the patient.

1. Clear boundaries: Therapists maintain their embodied individuality during relational storms ("I am here and I am not consumed by your accusations").
2. Curious engagement: Genuine interest in how the patient enacts the draft fosters trust and co-presence.
3. Embodied exploration: Inviting patients to trace bodily sensations as they enact the draft deepens contact with emerging individuality
4. Affirmative moment-to-moment dialogue: This micro-process respects the function of the draft, allowing subtle changes that suggest emerging integration

The draft of the self thus becomes both the object and subject of therapeutic work: object as what the patient presents, subject as living, emerging and transformable within the field of contact.

## 3. Integration: Gestalt Therapy, DBT and Schema Therapy

### *3.1. Integration of Dialectical Behaviour Therapy (DBT)*

Dialectical Behaviour Therapy (DBT), developed by Linehan, is one of the most influential contemporary treatments for BPD, demonstrating significant reductions in suicidal behaviour, hospitalisations and BPD symptoms [9,10]. Its conceptual core lies in biosocial theory, which posits that chronic emotional dysregulation stems from the interaction between biological vulnerabilities

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(increased limbic reactivity) and invalidating environments that punish, trivialise, or ignore emotional expression.

Linehan has operationalised this model in a structured treatment with four primary modules, each adaptable within a Gestalt framework:

Mindfulness: Learning to observe thoughts and emotions without judgement, bringing attention back to the present moment

Gestalt adaptation: Include guided body scans of 2-3 minutes in sessions to anchor attention and raise awareness of physiological arousal

Tolerance to suffering: Cultivate the ability to survive emotional crises without self-harm or impulsivity

Gestalt adaptation: Experiment with changes in temperature or position, body activations, changes in breathing, continuum of awareness and progressive relaxation practised in session.

Emotional regulation: Increase understanding and modulation of emotional responses

Gestalt adaptation: Map somatic triggers and emotional vulnerabilities with phenomenological reformulations; create experiments to observe different emotions using different media (artworks, books, music, etc.)

Interpersonal effectiveness: Develop assertive communication and the ability to set boundaries

Gestalt adaptation: Use chair work or group work to recognise the integration between polarities: assertive vs destructive aggression, empty vs full, fear vs excitement.

Integration of Schema Therapy

Schema Therapy, developed by Jeffrey Young [11], is a therapeutic approach that combines evidence-based cognitive-behavioural techniques with elements of interpersonal, experiential and psychodynamic therapies, specifically designed for the treatment of personality disorders and other complex issues. The principles of this approach concern:

Early Maladaptive Schemas

Early maladaptive schemas are emotional, cognitive, and behavioural patterns that arise at an early age when some of the basic emotional needs are chronically unmet by parental figures. These patterns form during childhood and/or adolescence and manifest themselves in adulthood as attitudes, thoughts or emotions that are dysfunctional in relation to the situation experienced in the present.

We have summarised them in a table:

**Table 1.** Early maladaptive schemas and domains.

| Domain | Scheme | Description |
|---|---|---|
| 1. Detachment and rejection | Emotional deprivation | The belief that fundamental emotional needs cannot be met by others. |
| | Abandonment/Instability | The expectation that relationships with others are unstable and may end. |
| | Distrust/Abuse | The expectation that others will hurt, humiliate or deceive us. |
| | Social isolation | A feeling of not belonging to any community. |
| | Inadequacy/Shame | The belief that one cannot be loved because one is imperfect, inferior, or bad. |
| 2. Reduced autonomy | Bankruptcy | The belief that one does not have sufficient skills to achieve results similar to others. |
| | Dependency/Incompetence | A feeling of being powerless and unable to function independently. |
| | Vulnerability to damage | The expectation that the world is full of dangers and that we do not have the resources to deal with them. |

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| | | |
|---|---|---|
| | Entanglement | Excessive emotional involvement in the lives of one or more loved ones, fusion of identity. |
| 3. Lack of rules | Claims/Grandiosity | Believing in one's own superiority, having special privileges or being above the rules. |
| | Insufficient self-control | Recurring difficulties with self-control, emotional management, and frustration tolerance. |
| 4. Excessive attention to the needs of others | Submission | Giving up one's desires, believing that the will of others takes priority in order to avoid negative consequences. |
| | Self-denial | The belief that one must constantly satisfy the needs of others at the expense of one's own. |
| | Approval search | Basing self-esteem on social acceptance and approval, on which personal value depends. |
| 5. Hypercontrol and emotional inhibition | Emotional inhibition | A reduction in emotional expression and genuine feelings in order to avoid rejection |
| | Strict standards | The belief that extremely high standards must be met in order to gain approval. |
| | Negativity/Pessimism | A view of life focused on the negative aspects, on what can go wrong. |
| | Punishment | The belief that people should be severely punished for their mistakes. |

## 2. Coping Strategies

There are three coping strategies that individuals can employ:
Surrender: behaving as if there were no alternative to the pattern
Hypercompensation: behaving as if the opposite of the pattern were true
Avoidance: avoiding both thinking about and experiencing situations that trigger the pattern

## 3. Mode

A mode is a combination of various activated Early Maladaptive Schemas mixed with coping strategies; the concept of mode describes the emotional-cognitive-behavioral state in which the person finds themselves at a given moment. Functional modes promote positive adaptation, while dysfunctional modes are characterized by strategies that can culminate in states of distress, avoidance, or self-sabotaging behaviors.

In Gestalt work with patients with borderline personality disorder, the integration of Schema Therapy concepts significantly enriches the phenomenological understanding of the patient's experience. Schema Therapy modalities find a natural correspondence with the Gestalt concept of figure/background, where different configurations of the Self emerge and recede in the phenomenological field depending on the contact activated.

Coping strategies—surrender, overcompensation, and avoidance—can be reinterpreted as creative ways for the organism to adapt, which, in the therapeutic here-and-now, manifest themselves through specific modes of contact or interruptions of contact itself. The Gestalt therapist, supporting moment-to-moment awareness, accompanies the patient in observing how these early patterns are actualized in the therapeutic relationship, not to analyze them cognitively but to experience them phenomenologically. This integration allows the anti-pathologizing approach of Gestalt to be maintained—recognizing patterns as creative adaptations of the patient in invalidating

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environments—while using the conceptualization of Schema Therapy to navigate the complexity of borderline configurations, promoting the emergence of more functional modes through the experience of authentic contact.

In the experience of the tolerable novelty of the therapeutic encounter, one can play with inventing new personal patterns, recognizing one's own, modifying them, and tracing their boundaries [12].

E.g.: To do after grounding

*Imagine entering a space that you recognize intimately. It is an environment that you feel is yours, even if it does not always give you peace of mind. This place is very familiar to you... it once offered you shelter, but now it seems to limit your movements. Perhaps it is the habit of always having to appear invulnerable... or the tendency to put the needs of others before your own. Observe this environment with curiosity. What colors characterize it? What atmosphere do you perceive? Are there any elements that attract your attention? Presences? Paintings or photos on the walls?*

*Now, in front of you, a passageway appears. This passageway invites you outside this space... toward an unexplored dimension. Move toward it calmly... Before crossing it, feel that you can decide... Do you want to stay in this familiar environment, or do you want to experience, even briefly, what it means to cross it?*

*You don't need to have all the answers. It is enough to feel curiosity for something new. Cross the threshold.*

*Beyond it, you feel a refreshing breeze, brightness, spaciousness. Perhaps there is a little fear, but it is accompanied by a sense of openness. Keep in mind that you can always return to this dimension whenever you wish.*

*The choice is yours.*

## 4. Dialectical Interventions Between Acceptance and Change

*If a patient says to the therapist:*
*"The moon is made of cheese," and the therapist replies:*
*"The moon and cheese are both yellow,"*
*we are witnessing a hermeneutic and clinical revolution.*
*Giovanni Salonia*

The paradoxical theory of Gestalt change and working with polarities naturally align with the dialectic (dià-legein meaning "to speak through," but also "to gather" + tèchne, meaning "the art" of dialogue and bringing together) acceptance-change of DBT. Rather than denying the patient's experience, therapists reconnect with "AND" statements that are perceptually verifiable and non-judgmental, keeping relational fields alive.

Examples of the application of this work include:

**Integrating chairs as drafts of oneself:** One chair expresses the punitive parental schema while the other embodies the vulnerable child

**Dramaturgy:** Applied in Gestalt therapy by guiding patients to reimagine painful scenes and insert nurturing figures.

Research has shown how schema-focused imagery and DBT emotional regulation strategies effectively adapt to emotional regulation patterns, illustrating their compatibility with the embodied orientation of Gestalt [13].

## 5. Clinical Implementation

### *5.1. Session Structure and Process*

The integrated approach maintains the non-protocol essence of Gestalt by incorporating structured elements:

Pre-contact

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Establish awareness of the present moment and assess your current emotional state (look at the draft in the present moment with possible experiences of mindfulness, listening, storytelling, drawing, writing, etc.) to create a shared here and now.

Start of contact

Phenomenological tracking of emerging contact patterns, with particular attention to:

- Fluctuations in boundaries
- Somatic indicators of dissociation or splitting
- Interpersonal enactments within the therapeutic relationship

Full contact

Recognize the domains [14] of the therapeutic relationship with a patient with BPD and support the integration process.

**Table 2.** Domains of the therapeutic relationship with a patient with BPD.

| *Domains* | *Domain 1* | *Domain 2* | *Domain 3* | *Domain 4* | *Domain 5* |
|---|---|---|---|---|---|
| *Name* | A confident, clear, and non-manipulative ethical stance. | Capture the now-for-next in the patient's relational difficulties. | Explain the elements of shared reality. | Support self-regulation in the face of primitive defenses. | Containing borderline suffering through countertransference. |
| ***Therapist skills*** | 1. Containment capacity;<br>2. Ethical clarity;<br>3. No manipulation. | Capture the tension of being fully present with the other person, despite aggressive and demeaning language. | Create a bridge between the current reaction and painful relationship patterns. | Developing a therapeutic language that captures the desire for integration between affection for others and autonomy. | Listening to countertransference emotions and their therapeutic contextualization. |
| ***Therapeutic objectives*** | Support the patient's primary intention to rely on that therapist. | The patient experiences the ability to preserve the outline of himself with the other, despite the ambivalence that causes him to lose his sense of integrity. | Experience the coherence between past pain and current reaction. Feel the therapist's closeness in the attempt to integrate conflicting parts. | Experiencing both the ability to reach out to others and perceptual autonomy. | Validate the patient's desperate experience and cope with the split with less anxiety and reactivity. |

Post contact

Support assimilation and discarding processes by emphasizing directionality (next).

*5.2. Therapeutic Posture and Relationship*

The therapist maintains a dual awareness:

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holding space for the draft self while containing phenomena at the process level.

To improve one's therapeutic posture, the therapist's embodied presence is the first essential element, referring to the clinician's ability to maintain their emotional and physical grounding (countertransference) during the intense relational dynamics that characterize working with emotionally dysregulated patients [15]. This stable presence provides a safe container for the patient's experience. The second component is phenomenological curiosity, which directs therapeutic attention toward the how of the patient's symptomatic manifestations, rather than toward premature causal interpretations of the why. This shift in focus allows for a more immediate and concrete understanding of the patient's lived experience. Finally, collaborative formulation is a mode of co-constructing meaning that integrates neurobiological understanding with subjective experience. When patients ask questions such as "Why am I so reactive?", the therapist can respond with formulations that acknowledge both individual biological sensitivity and environmental influences on dysregulation, while simultaneously redirecting attention to the phenomenological analysis of the present moment: "You are biologically sensitive and your environment has not helped to regulate this - let's explore how it manifests itself right here in our interaction." This integration of presence, phenomenological curiosity, and collaboration allows the therapeutic process to be anchored in the immediacy of shared experience, facilitating co-constructed regulation processes.

## 6. Discussion

### *6.1. Theoretical Consistency*

The integration of the biosocial theory of DBT, mindfulness, and dialectical work between polarities significantly enriches the theoretical framework of Gestalt. The biosocial lens of DBT, which places emotional dysregulation at the intersection of innate sensitivity and invalidating environments, finds phenomenological complementarity in Gestalt's emphasis on moment-to-moment awareness of lived experience.

This integrative process [16] accompanies observation and reorganization that is tolerable for the patient and creates a minimalist relationship of contact with the therapist, maintaining an optimal distance for both that prevents retraumatization. This creates a conscious and dynamic outline of the "consequences of love" that can lead to regulating emotional processes without completely identifying with them, but observing them when they can modify the outline without destroying it.

From this perspective, the Self is no longer merely fragmented but becomes a form of functioning in the environment and, consequently, in the relationship between patient and therapist, in line with the Gestalt principle of Self theory, according to which the Self is not a static entity but a dynamic process that emerges from the creative contact between organism and environment and is articulated through three interconnected functions that operate at different times: Es function - Represents the receptive dimension of experience, characterized by a passive quality that concerns "what happens to us" beyond our conscious will; Ego Function - Allows us to modulate the degree of openness or closure in contact, deciding whether to accept, reject, or limit what emerges from experience. Personality Function - Constitutes the internal representation of the self, deriving from the integration of experiences lived throughout existence. It is the identity substrate that allows us to recognize ourselves over time and to give continuity and meaning to our experiences.

From this point of view, borderline patients are the "ideal" patients for Gestalt therapists due to their anti-neurotic nature. Rather than pathologizing symptoms, they are recognized as creative adaptations of the organism to difficult situations. Integration with DBT tools does not aim to eliminate "negative" emotions, but to develop a more fluid and conscious relationship with the entire emotional spectrum.

As Greenberg points out, "changing emotions with emotions" [17], the therapeutic process is not based on suppression or control, but on transformation through access to more adaptive and authentic emotional resources. This principle resonates deeply with the Gestalt approach of supporting organismic spontaneity and the intrinsic wisdom of the self-regulation process [18].

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## 7. Conclusions

This integrated approach is not limited to simply modulating emotional reactions, but aspires to a deeper and ontologically significant transformation: the metamorphosis of the unbridgeable void that characterizes the borderline experience into what Gestalt defines as a "fertile void" [19].

While the pathological void of BPD is experienced as devastating absence, identity fragmentation, and existential horror vacui, the fertile void represents a potential space for creativity, a field open to emerging possibilities [20], and a generative terrain for self-realization [21]. Through the integration of biosocial validation, restructuring of maladaptive schemas, and embodied presence in the here-and-now, the patient can gradually experience this emptiness no longer as an abyss to be compulsively filled, but as a space for conscious breathing, a creative pause between stimulus and response, a fertile silence from which new gestalts of meaning can emerge.

This transmutation of emptiness—from an experience of annihilation to a therapeutic resource—is perhaps the most distinctive contribution of this integrated model, offering patients with BPD not only symptomatic stabilization but access to an existential dimension of fullness paradoxically rooted in the conscious acceptance of their own inner space [22].

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