

## Original Article

# The Effectiveness of Combined Eye Movement Desensitization and Reprocessing and Dialectical Behavior Therapy on Mentalization Components and Suicidal Ideation in Individuals with Borderline Personality Disorder

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### Abstract

The current research evaluated the effectiveness of a combined Eye Movement Desensitization and Reprocessing (EMDR) and Dialectical Behavior Therapy (DBT) intervention on mentalization components and suicidal ideation in persons with a borderline personality disorder (BPD). The research design was a quasi-experimental with pre-test, post-test and follow-up, and a control group. The target population included patients diagnosed with BPD and referred to psychotherapy centers within Mashhad city during the years 2024–2025. The sample size comprised of 50 participants who were chosen through convenience sampling and assigned to an experimental and control group (25 participants for each group). The experimental group was provided with 20 sessions of the integrated EMDR and DBT intervention. The research tools were Mentalization Questionnaire and the Beck Scale of Suicide Ideation. The analysis of the data was carried out with the help of repeated measures analysis of variance (ANOVA) with the SPSS software, version 26. The findings indicated a significant difference in the mean scores of motivation to mentalize, self-related mentalization, other-related mentalization and suicidal ideation across the pre-test, post-test, and follow-up phases. Additionally, the interaction effect of time and group membership was significant for motivation to mentalize ( $F=12.69$ ), self-related mentalization ( $F=15.00$ ), other-related mentalization ( $F=19.94$ ) and suicidal ideation ( $F=90.10$ )  $p < .001$ . The results showed that the combined EMDR+DBT treatment creates a synergistic effect by targeting mentalization deficits and traumatic roots, enhancing mentalization skills while deeply modifying the cognitive and emotional structures underlying suicidal ideation.

### Keywords

Borderline  
personality disorder  
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### Introduction

Borderline personality disorder (BPD) is one of the most commonly diagnosed personality disorders in a clinical and psychiatric setting (Leichsenring et al., 2024). It is a disorder that is marked by widespread emotional instability, impaired interpersonal relationships, identity disruption, impulsivity, and self-harm (Rahmani et al., 2023). BPD people generally have low self-esteem (Jia et al., 2022), low resilience, poor epistemic trust (Knapen et al., 2025), and the lack of meaning in their lives (Marco et al., 2020). They are also at an increased risk of poor mental health, such as perceived stress, depression, substance misuse, and suicidal behaviors (Rahmani et al., 2023; Salmani et al., 2024). Mortality research states that

the suicide rates among BPD patients are up to 10 percent, which is significantly higher than the rate of suicide in the general population (Reichl & Kaess., 2021). It is estimated that BPD is about 1.6 percent among the general population, but 10-20 % among outpatient and inpatient psychiatric samples (Bozzatello et al., 2021). Even though BPD and Post-Traumatic Stress Disorder are categorized separately, they often happen together. Research suggests that between 30 and 70 percent of people with Borderline Personality Disorder will also meet the criteria for PTSD at some point in their lives (Slotema et al., 2020). In recent years, mentalization has garnered significant attention due to its critical role in understanding and regulating the impact of past traumas (Ballespí et al., 2019). In borderline personality disorder, maladaptive behaviors including aggression, self-harm,

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and suicidal ideation may stem from impaired mentalization (Fonagy et al., 2016). Deficits in mentalization can lead to cognitive distortions, social difficulties, emotional instability, and increased vulnerability to psychological disorders; for instance, suicidal thoughts can represent maladaptive responses to emotion regulation deficits (Hefazi Tarqabeh & Najafi, 2024).

Pathological investigations have consistently highlighted a strong link between suicidal ideation and BPD. Suicide represents one of the leading causes of death among individuals aged 15 to 29 worldwide (World Health Organization, 2020). Suicidal ideation, in both verbal and non-verbal forms, is a psychiatric emergency. Individuals with suicidal ideation face a significantly increased risk of suicide attempts compared to those without such ideation (Hefazi Torghabeh & Fekriyan Arani, 2025; Ameri & Najafi, 2024). Jiang et al. (2022) found a direct relationship between BPD symptom severity and suicidal ideation severity. Notably, the study also revealed a strong correlation between emotional dysregulation and suicidality highlighting emotion regulation as a moderating factor in this interaction (Jiang et al., 2022; Mikaeili et al., 2023).

In recent years, DBT is the most studied and prescribed psychosocial therapy in BPD treatment and is typically viewed as a first-line treatment (Gillard et al., 2025). Empirical evidence demonstrates that DBT is a useful treatment in reducing emotional avoidance, anger dysregulation, mood instability, and suicidal thoughts in BPD patients (Shirvan et al., 2024). EMDR as a complement to DBT has also been picking up as another intervention to improve psychological functioning in this population, particularly minimizing the impact of the trauma processes (Hafkemeyer et al., 2023).

EMDR initially proposed by Shapiro (2018), is a behaviorally oriented intervention, which has gained a fair amount of scholarly attention, as it has been proven to alleviate emotional distress, reduce the processing of traumatic experiences, and enhance emotion regulation (Hase, 2021). Empirical studies indicate that a significant percentage of BPD patients have a history of trauma, particularly in childhood. Furthermore, randomized controlled trials have demonstrated that trauma-focused EMDR can reduce levels of depression, anxiety, and suicide in this population (Hofkeminger et al., 2023; Slotema et al., 2020; Snoek et al., 2025). Even though direct impact of EMDR on mentalization in BPD has not been specifically studied, initial evidence by Civilotti et al. (2019) indicates that EMDR improves reflective functioning and secure attachment in trauma-exposed youths. Therefore, it is reasonable to assume EMDR would have similar positive effects on mentalization capacities in individuals with BPD who have experienced early-life trauma (Civilotti et al., 2019).

The recent scientific literature suggests that at least one-third of patients with BPD have a history of traumatic experience (Slotema et al., 2020). Trauma and BPD co-occurrence is likely to be linked to severe emotional, cognitive, and interpersonal dysregulation, which further increases emotional instability, self-harming behavior,

and suicidal ideation (Sveen et al., 2025). Furthermore, Suicidal ideation is a strong predictor of suicide attempts in BPD (Jiang et al., 2022). Conventional treatments often overlook the underlying cognitive and emotional processing, making single-factor approaches insufficient for addressing complex dimensions like trauma (Snoek et al., 2025). While DBT is the first-line treatment for emotion regulation, it may be inadequate for deep trauma processing; however, EMDR offers shorter, sustained efficacy that improves attachment and mentalization (Civilotti et al., 2019). Based on attachment theory, early trauma disrupts attachment and mentalization, leading to emotion regulation deficits and suicidal ideation; thus, combined treatment targeting these skills can address the cognitive-emotional roots. In this model, EMDR targets deep traumatic roots structurally, while DBT provides stability and daily skills. Given the lack of research in Iran on this combination, this study aims to fill this gap by investigating the effectiveness of combined EMDR+DBT on mentalization and suicidal ideation in BPD patients within the Iranian cultural context.

## Method

### Participants

This quasi-experimental study employed a pre-test, post-test design with a three-month follow-up and a control group. The population included patients aged 20–40 years diagnosed with BPD who sought treatment at clinical centers in Mashhad city in during the years 2024–2025. Considering an effect size of .3, a statistical power of .95, and an alpha level of .05, the required sample size was calculated as 40 participants (20 participants for each group) using G\*Power, with 25 participants recruited per group to account for potential attrition. Fifty participants were selected based on the Borderline Personality Questionnaire (minimum score of 10) and the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD), conducted by a psychiatrist and the researcher. Inclusion criteria were: age 20–40 years with a clinical history of at least 6 months and no more than 5 years, at least a high school diploma, residency in Mashhad city, informed consent to participate, and the presence of borderline personality traits. Exclusion criteria included comorbid psychiatric disorders (e.g., mood disorders, psychotic disorders, or substance use disorders), concurrent psychological or pharmacological treatments, and significant medical conditions.

### Instrument

#### *Mentalization Questionnaire:*

Mentalization Questionnaire is a 28-item self-report that was created by Dimitrijevic et al. (2018) and is rated on a five-point Likert scale of 1 to 5. The instrument has three subscales, such as self-related mentalization, other-related mentalization, and motivation to mentalize. The overall score is thus the sum of the scores of the three subscales and has a range of between 28 and 140. The sample of the BPD group had a Cronbach alpha of .79 in self-related mentalization, .75 in other related mentalization

and .60 in motivation to mentalize (Dimitrijevic et al., 2018). Safarimousavi et al. (2020) standardized this instrument in Iran and found .73 to .86 Cronbach  $\alpha$  coefficients of the overall score and the three subscales. The convergent validity was determined by assessing the correlations between the total mentalization score and secure attachment style, mindfulness, and social cognition with correlation coefficients of .54, .43 and .27, respectively (Safarimousavi et al., 2020).

### Suicidal Ideation Scale:

The Suicidal Ideation Scale is a scale created by Beck and Steer (1991) to recognize and quantify the intensity of suicidal ideation and preparation of suicide. The scale has 19 items. The items will be rated on a three-point Likert scale of 0 to 2. The final score is obtained by adding up the item scores which gives a potential score of 0-38. Beck and Steer (1991) state that the internal consistency of the scale was between .87 and .97 (Beck & Steer., 1991). Confirmatory factor analysis was applied to determine the validity of the scale in a study by Eghdami and Fouladchang (2022). The model fit indices of Suicidal Ideation Scale were a Root Mean Square Error of Approximation (RMSEA) of .04 with a 90 per cent confidence interval between .001 and .05. Cronbachs alpha was also used to verify the reliability of the scale and it was found that the scale was .93 (Eghdami & Fouladchang, 2022).

### Structured Clinical Interview for DSM-5 Personality Disorders:

This interview is a standard and valid tool for assessing the diagnosis of personality disorders based on DSM-5 criteria. This instrument was developed by First et al. (2014) and is used in clinical research to identify the 10 main personality disorders. In their study, First et al. (2014) assessed its concurrent validity and reliability, reporting the concurrent validity of this tool as 0.80 and inter-rater reliability as .80 - .90.

### Procedure

Following approval of the study protocol by the Ethics Committee of Semnan University of Medical Sciences under ethics code IR.SEMUMS.REC.2024.28 and registration of the trial in the Iranian Registry of Clinical Trials (IRCT) under registration number IRCTID: IRCT20250116064396N1. Participants were recruited through a public call from individuals with a confirmed BPD diagnosis at psychological centers. They were screened using clinical interviews and the BPD questionnaire (minimum score of 10). Eligible participants who provided consent were randomly assigned to groups and completed pretests. The experimental group received 20 weekly one-hour sessions of integrated EMDR+DBT treatment, followed by posttests and a three-month follow-up. The intervention content was developed based on *Dialectical Behavior Therapy in Clinical Practice* by Linehan (2020), *Eye Movement Desensitization and Reprocessing* by Shapiro (2018), and the session structure proposed in the integrative model by Snoek et al. (2020). The content of the intervention sessions is presented in Table 1.

**Table 1.** Summary of the Therapeutic Protocol of Combined EMDR and DBT

Sessions	Session Description
Sessions 1–3	The session included establishing the therapeutic relationship, gathering client information, treatment planning, introduction to basic DBT concepts, training in relaxation and mindfulness skills, practicing present-moment awareness, identifying thoughts and emotions, learning the three states of mind, and practicing advanced mindfulness skills.
Sessions 4-6	The session focused on teaching basic and advanced distress tolerance skills, practicing distraction and self-soothing, safe place imagery, value clarification, and using self-encouraging coping thoughts
Sessions 7-10	The EMDR session included reviewing relaxation techniques, using metaphors, approaching challenging activities, committing to personal values, selecting and reprocessing painful memories by replacing negative beliefs with positive ones, assessing positive beliefs using the 7-point Validity of Cognition scale (1 = completely false, 7 = completely true), and recording Subjective Units of Distress (SUD) ratings from 1 (no distress/anxiety) to 10 (maximum distress)
Sessions 11-14	The desensitization phase involved focusing on distressing memories, bilateral brain stimulation through eye movements, identifying emotional and somatic responses, reinforcing positive cognition, assessing SUD and VOC, and conducting body scan exercises to detect tension and enhance positive emotional experiences
Sessions 15-17	The session focused on teaching basic and advanced emotion regulation skills, including identifying emotions, reducing physical vulnerability, balancing thoughts and feelings, mindful attention, confronting intense emotions, and recognizing self-harming behaviors
Sessions 18-20	The session focused on teaching and practicing basic and advanced interpersonal effectiveness skills, managing conflict and negotiation, and developing a daily plan to maintain emotional well-being post-treatment

### Results

In this study, one participant in the intervention group during the intervention period and two participants during the follow-up were lost to attrition. Analyses were conducted on the remaining participants in two groups. The mean age and standard deviation of participants in the combined (EMDR+DBT) group were  $28.80 \pm 6.55$ , whereas those of the control group were  $29.64 \pm 5.50$ .

Regarding educational background, 64% of participants in the intervention group had a university-level education, while the remaining participants had high school education. In the control group, 60% of participants had a university-level education, and the rest had high school education. Descriptive statistics for the mentalization components and the suicidal ideation variable for both the experimental and control groups are presented in Table 2.

**Table 2.** Descriptive statistics of mentalization components and suicidal ideation

Variables	Test	EMDR -DBT		control		
		M	SD	M	SD	
Mentalization	Motivation to Mentalize	Pre-test	21.95	2.25	19.43	3.97
		Post-test	25.50	2.14	20.08	2.93
		Follow-up	26.83	2.97	20.00	3.28
	Self-Related Mentalization	Pre-test	15.25	2.15	14.26	2.59
		Post-test	18.50	2.18	14.17	1.43
		Follow-up	20.08	3.41	14.13	1.79
	Other-Related Mentalization	Pre-test	16.37	2.51	15.82	2.14
		Post-test	21.95	1.68	16.04	1.71
		Follow-up	20.62	2.20	15.95	2.54
Suicidal Ideation	Pre-test	24.25	2.32	24.60	3.01	
	Post-test	13.87	2.02	23.86	2.30	
	Follow-up	12.58	2.22	25.04	2.82	

As shown in Table 2, in the post-test, the mentalization components of participants in the experimental group had higher means compared to the control group. In the experimental groups, the means increased from pre-test to post-test. Additionally, the suicidal ideation variable showed lower means in the experimental groups compared to the control group, and the means decreased from pre-test to post-test. However, no significant changes were observed from post-test to follow-up.

Repeated-measures analysis of variance (ANOVA) was conducted in the inferential analysis. The assumptions of

the test were carefully reviewed before the main study. Box plots were used as a means of identifying the existence of outliers and ensured that the data had no major deviations. Normality was evaluated through the Shapiro-Wilk test, the results showed that the values followed normal distribution ( $P > .05$ ). In addition, the test of equality of variances was adopted to provide the results of Levene's test, and the test is non-significant ( $P > .05$ ). Finally, the results of Mauchly's test of sphericity showed that the assumption of sphericity was met for both the mentalization components and suicidal ideation ( $P > .01$ ).

**Table 3.** examines the between-group and within-group differences in mentalization components and suicidal ideation

Variables	Source	SS	df	MS	F	p	( $\eta^2$ )	
Motivation to Mentalize	Within-Group	Test	190.80	2	95.40	21.38	< .001	.32
		Test $\times$ Group Membership	113.29	2	56.65	12.69	< .001	.22
		Error	401.53	90	4.46	-	-	-
	Between-Group	Group Membership	854.037	1	854.037	48.2	< .001	.51
		Error	800.232	45	17.783	-	-	-
Self-Related Mentalization	Within-Group	Test	135.37	2	67.51	13.47	< .001	.23
		Test $\times$ Group Membership	150.41	2	75.20	15.00	< .001	.25
		Error	451.01	90	4.46	-	-	-
	Between-Group	Group Membership	497.07	1	497.07	75.14	< .001	.62
		Error	297.662	45	6.61	-	-	-
Other-Related Mentalization	Within-Group	Test	214.74	2	107.373	23.11	< .001	.33
		Test $\times$ Group Membership	185.24	2	92.62	19.94	< .001	.30
		Error	418.00	90	4.64	-	-	-
	Between-Group	Group Membership	485.16	1	485.16	102.29	< .001	.69
		Error	213.42	45	4.74	-	-	-
Suicidal Ideation	Within-Group	Test	977.52	2	488.761	91.68	< .001	.67
		Test $\times$ Group Membership	960.61	2	480.30	90.10	< .001	.66
		Error	479.769	90	5.33	-	-	-
	Between-Group	Group Membership	2037.51	1	2037.51	266.355	< .001	.85
		Error	344.23	45	7.65	-	-	-

The results of repeated measures ANOVA for mentalization components and suicidal ideation are presented in Table 3. As shown, significant differences were observed between the experimental and control groups in mentalization components and suicidal ideation based on test stages, group membership, and the interaction effect of test stages and group membership ( $p < .05$ ). Post hoc Bonferroni tests for comparing means across test stages are presented in Table 4.

Table 4 indicates that in experimental group, the means of mentalization components increased from pre-test to post-test and from pre-test to follow-up, with significant differences ( $p < .05$ ). Similarly, for suicidal ideation, means decreased from pre-test to post-test and from pre-test to follow-up, with significant differences ( $p < .05$ ). However, no significant changes were observed from post-test to follow-up in either group ( $p > .05$ ).

**Table 4.** The results of the post hoc Bonferroni test for comparing means across test stages

Variables	Group	Comparing Group	Mean Difference	Std. Error	p
Motivation to Mentalize	Pre-test	Post-test	-2.09	.43	< .001
		Follow-up	-2.720	.51	< .001
	Post-test	Pre-test	2.09	.43	< .001
		Follow-up	-.623	.34	.23
	Follow-up	Pre-test	2.720	.51	< .001
		Post-test	.623	.34	.23
Self-Related Mentalization	Pre-test	Post-test	-1.58	.41	.001
		Follow-up	-2.35	.50	< .001
	Post-test	Pre-test	1.58	.41	.001
		Follow-up	-.77	.46	.30
	Follow-up	Pre-test	2.35	.50	< .001
		Post-test	.77	.46	.30
Other-Related Mentalization	Pre-test	Post-test	-2.90	.40	< .001
		Follow-up	-2.19	.52	< .001
	Post-test	Pre-test	2.90	.40	< .001
		Follow-up	.71	.39	.23
	Follow-up	Pre-test	2.19	.52	< .001
		Post-test	-.71	.39	.23
Suicidal Ideation	Pre-test	Post-test	5.57	.42	< .001
		Follow-up	5.61	.54	< .001
	Post-test	Pre-test	-5.57	.42	< .001
		Follow-up	.05	.44	1.00
	Follow-up	Pre-test	-5.16	.54	< .001
		Post-test	-.05	.44	1.00

## Discussion

The current research aimed to determine the effectiveness of integrative intervention involving (EMDR+DBT) in assessing the elements of mentalization and suicidal ideation in patients diagnosed with BPD. The findings indicate that this dual-modality intervention significantly improved mentalization abilities and reduced suicidal ideation. These results further confirmed the first hypothesis regarding its positive impact on motivation to mentalize. Results showed a significant improvement in participants' willingness to engage in mentalization processes, supporting the hypothesis. This motivation, which is the tendency to consciously understand one's own and others' mental states, is often compromised in BPD due to trauma, interpersonal failures, and emotional dysregulation (Bateman et al., 2024). EMDR helps to achieve this process therapeutically through bilateral stimulation of the brain and simultaneous combination of cognitive and affective information, thus decreasing avoidance of emotional experiences and encouraging conscious involvement in affective experiences (Shapiro, 2018). Simultaneously, DBT provides a secure therapeutic environment that enhances self-efficacy, teaches emotion regulation, and cultivates mindfulness, all of which strengthen the motivation to use mentalization skills (Linehan, 2020). In general, the synergistic integration of EMDR+DBT not only enhances mentalization capacity but also increases the motivation to practice it, promoting adaptive processing of internal and interpersonal experiences. These findings align with modern mentalization models that view motivation as a key aspect of therapeutic change in BPD.

The second hypothesis tested the effect of the combined EMDR+DBT protocol on the ability to self-related mentalization. Although limited direct studies exist on this specific effect, theoretical assumptions and empirical evidence allow for a consistent interpretation of these findings. Self-related mentalization requires the ability to discern, label, and integratively understand internal affective states (Hefazi Tarqabeh & Najafi, 2024), which is significantly impaired in patients with borderline personality disorder, especially in the context of exposure to trauma and insecure attachment (Bateman et al., 2024). Trauma-based modalities, including EMDR, can trigger self-mentalization by lowering affective arousal and promoting consolidation of traumatic memories. Civetti et al. (2019) showed that EMDR improved reflective functioning and secure attachment in traumatized youth. At the same time, the focus of DBT on emotion regulation and distress tolerance provides an indirect but useful scaffold for self-related mentalization (Linehan, 2020; Mikaeili et al., 2025). Therefore, integrating +leverages the synergy between affect regulation and trauma processing to foster deeper, lasting improvements in self-related mentalization for individuals with BPD. These findings support EMDR+DBT as an effective approach for enhancing mentalization capacity, reducing emotional vulnerability, and improving psychosocial functioning.

The third hypothesis examined the effect of the combined EMDR+DBT intervention on other-related mentalization in BPD patients. Results showed a statistically significant improvement, confirming the hypothesis. This ability is crucial but often impaired in this group due to insecure relationships and traumatic experiences. Such patients are

susceptible to mentalization failures and distorted perceptions of the behaviors and intentions of other people in emotionally charged circumstances (Bateman et al., 2024). In theory, EMDR reduces the affective load of traumatic memories and re-tunes the attachment-related schemas, thus altering the maladaptive interpersonal patterns and creating more realistic perceptions of the mental state of others (Shapiro, 2018; Civiletti et al., 2019). At the same time, the emphasis of DBT on interpersonal effectiveness, emotion regulation, and mindfulness helps clients to control their affective responses and avoid primitive, emotion-based interpretations (Linehan, 2018). In this way, the alliance of trauma processing and interpersonal skills training, which is a combination of EMDR+DBT, is an effective reinforcement of the ability to mentalize others in this cohort, which is consistent with mentalization-based models that consider the restoration of interpersonal functioning to be a primary therapeutic goal. The last hypothesis, which examined the impact of combined EMDR+DBT treatment on reducing suicidal ideation severity, was supported by empirical evidence. While DBT reduces self-harming behaviors by teaching emotion regulation and distress tolerance skills (Linehan, 2020), it does not directly address underlying traumatic substrates. Conversely, EMDR targets these maladaptively stored traumatic memories based on adaptive information processing theory, reprocessing them to reduce emotional load and alleviate feelings of powerlessness and despair (Shapiro, 2018). The intervention utilizes imaginal flooding, cognitive restructuring, bilateral eye movements, and focused attention on traumatic material to reduce the intensity of reactions to traumatic events (Houdys et al., 2022). Integrating EMDR into the supportive DBT system creates a synergy where DBT skills provide emotional tolerance and safety, preparing patients to face traumatic memories, while EMDR processes these memories, resulting in a more lasting decrease in suicidal ideation (Snoek et al., 2020). Furthermore, the trauma processing of EMDR can reduce symptoms of depression, anxiety, and BPD, such as affective instability, abandonment fears, and acute stress reactions, while also improving secure attachment and reflective functioning (Hafkemeyer et al., 2023; Civiletti et al., 2019). This integrative model, which combines both skill-building and trauma-focused processes, proves to be more effective compared to DBT in reducing the severity of suicidal ideation.

## Conclusion

The results of the present research suggest that the joint implementation of EMDR+DBT is an effective way to increase self- and other-oriented mentalization, increase motivation to mentalization, and reduce the intensity of suicidal thoughts in the patients with BPD. This integrative approach combines DBT skills with EMDR trauma processing to enhance patients' ability to reflect on their experiences and reduce emotional vulnerability. Consequently, EMDR+DBT is an effective comprehensive therapy for improving psychosocial functioning and decreasing self-harm risks in individuals with BPD, particularly those with a history of trauma and severe interpersonal issues. This study has three main

limitations. First, the limited clinical sample restricts generalizability, suggesting future studies use larger, more diverse samples. Second, contextual variables like trauma intensity and gender were not fully controlled, so future research should account for these factors. Third, the integrated nature of EMDR+DBT made it impossible to determine the specific role of each component; therefore, future studies should employ dismantling designs to isolate the effects of each treatment component.

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