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# EXPLORING THE EFFECTIVENESS OF SCHEMA-FOCUSED THERAPY (SFT) IN MANAGING BORDERLINE PERSONALITY DISORDER IN PAKISTAN: THE ROLE OF SOCIO-CULTURAL FACTORS AND MENTAL HEALTH ACCESSIBILITY

*Original Research*

**Muhammad Rizwan Mushtaq[1]*, Zeeshan Manzoor[2], Benish Usman[3], Farah Gillani[4]*, Muhammad Bilal Kaleem[5]**
[1]Consultant Psychiatrist, Alshifa Brain Hospital & Drug Rehabilitation Center Muzaffargarh, Punjab, Pakistan.
[2]MS Clinical Psychology, School of Professional Psychology, Bahria University Lahore Campus, Pakistan.
[3]M.Phil. Psychology, Certified Master Practitioner NLP (ABNLP)/Certified Master Practitioner Time Line Therapist (TLTA) and Well-Being Counselor, Quaid -e-Azam University Islamabad, Pakistan
[4]MS Clinical Psychology, School of Professional Psychology, Bahria University, Islamabad, Pakistan.
[5]Senior Registrar, DUHS-KM Ruth Pfau Civil Hospital, Karachi, Pakistan.
**Corresponding Author:** Muhammad Rizwan Mushtaq, Consultant Psychiatrist, Alshifa Brain Hospital & Drug Rehabilitation Center Muzaffargarh, Punjab, Pakistan. dr.rizwanmushtaq@gmail.com
Farah Gillani, MS Clinical Psychology, School of Professional Psychology, Bahria University, Islamabad, Pakistan. syedafarah36@gmail.com

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## ABSTRACT

**Background:** Borderline Personality Disorder (BPD) is a complex psychiatric condition characterized by emotional instability, impulsivity, and interpersonal dysfunction, significantly impairing an individual's quality of life. While Schema-Focused Therapy (SFT) has demonstrated efficacy in Western populations, its applicability in culturally diverse settings remains underexplored. In Pakistan, socio-cultural barriers, including stigma, family influence, gender norms, and limited access to mental health care, pose significant challenges to treatment engagement. Understanding these factors is crucial for adapting SFT to the Pakistani context and improving therapeutic outcomes.

**Objective:** This study aimed to evaluate the effectiveness of SFT in treating BPD in Pakistan and to examine the influence of socio-cultural factors on treatment engagement, accessibility, and outcomes.

**Methods:** A mixed-methods design was employed, integrating quantitative and qualitative analyses. The study recruited 30 clinically diagnosed BPD patients using purposive sampling, ensuring representation from both urban and rural settings. Participants underwent 12–16 weekly SFT sessions, with therapy adapted to accommodate cultural considerations. Standardized psychometric assessments, including the Borderline Personality Disorder Severity Index (BPDSI), Global Assessment of Functioning (GAF), and Outcome Questionnaire-45 (OQ-45), were conducted at baseline and post-treatment. Additionally, semi-structured interviews and focus group discussions explored patients' experiences, cultural influences, and barriers to mental health care. Quantitative data were analyzed using paired-sample t-tests, while qualitative data underwent thematic analysis to identify recurring patterns.

**Results:** Post-treatment assessments revealed a statistically significant reduction in BPD symptoms. The mean BPDSI score decreased from 45.7 to 25.2 ($p < 0.001$), indicating improved emotional regulation and reduced impulsivity. Psychological functioning improved, as reflected by an increase in GAF scores from 40.5 to 65.3 ($p < 0.001$). Overall well-being showed marked enhancement, with OQ-45 scores decreasing from 72.4 to 48.1 ($p < 0.001$). Qualitative findings highlighted key socio-cultural influences on therapy, including family involvement, mental health stigma, gender expectations, and disparities in mental health accessibility. Rural participants reported greater barriers to therapy, including logistical challenges and cultural resistance, while urban participants exhibited better engagement.

**Conclusion:** SFT proved to be an effective therapeutic intervention for BPD in Pakistan, demonstrating substantial symptom reduction and improved psychological well-being. However, socio-cultural barriers significantly influenced treatment engagement and outcomes. To enhance the effectiveness of SFT, culturally adaptive strategies such as family psychoeducation, stigma reduction initiatives, teletherapy expansion, and gender-sensitive therapeutic approaches should be integrated into mental health care frameworks in Pakistan.

**Keywords:** Borderline Personality Disorder, Cognitive Behavioral Therapy, Mental Health Services, Mental Health Stigma, Pakistan, Psychotherapy, Socio-Cultural Factors.

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## INTRODUCTION

Borderline Personality Disorder (BPD) is a complex and debilitating psychiatric condition characterized by pervasive instability in interpersonal relationships, self-image, emotions, and impulsive behaviors. Individuals with BPD often experience intense emotional responses, chronic feelings of emptiness, difficulty in maintaining stable relationships, and engagement in self-harming behaviors. The etiology of BPD is multifaceted, with a significant contribution from early-life adversities, including childhood trauma, disrupted parental bonding, and chronic emotional invalidation (1). While biological and genetic factors may play a role, environmental influences remain predominant in the development of the disorder. Comorbidities such as mood disorders, anxiety disorders, and substance use disorders further complicate its clinical presentation, making diagnosis and treatment imperative. However, despite the profound impact of BPD on an individual's psychosocial functioning, the disorder remains underdiagnosed and undertreated in many regions, including Pakistan, where mental health awareness is limited, and stigma surrounding psychiatric conditions is deeply entrenched (2).

Schema-Focused Therapy (SFT), developed as an extension of cognitive-behavioral therapy (CBT), presents a promising psychotherapeutic approach for individuals with BPD. This therapy targets early maladaptive schemas—deeply ingrained cognitive and emotional patterns that develop in response to unmet childhood needs. By integrating cognitive, behavioral, experiential, and psychodynamic techniques, SFT facilitates the identification and restructuring of these schemas, thereby improving emotional regulation and interpersonal functioning. Empirical evidence has demonstrated its efficacy in reducing self-harming behaviors, enhancing emotional stability, and improving overall psychological well-being. Compared to other therapeutic modalities such as Dialectical Behavior Therapy (DBT), SFT has been found to offer superior benefits in fostering relational functionality and addressing the core emotional vulnerabilities associated with BPD. However, despite its effectiveness, the availability and implementation of SFT in Pakistan remain minimal due to the scarcity of trained professionals, limited institutional support, and inadequate integration of specialized therapies within the mental health care system (3).

Cultural factors play a critical role in shaping the manifestation, interpretation, and treatment of mental health disorders, including BPD. In contrast to Western societies, where individualism and self-expression are encouraged, Pakistani culture is rooted in collectivist values that emphasize family honor, social conformity, and communal responsibility. These cultural dynamics influence how individuals with BPD perceive their symptoms and seek help. Rather than viewing emotional dysregulation and interpersonal instability as clinical concerns, these behaviors are often attributed to personal weaknesses or social dysfunction. Additionally, traditional and religious beliefs heavily influence mental health perceptions in Pakistan, leading many individuals to seek guidance from religious leaders or alternative healers instead of professional mental health practitioners. Women with BPD are particularly vulnerable to social stigma, often facing blame and ostracization for their emotional instability. In rural areas, where conservative values are more deeply ingrained, the stigma associated with mental illness is even more pronounced, further hindering access to appropriate psychiatric care (4).

The availability of mental health services in Pakistan is alarmingly inadequate. With an estimated 0.2 psychiatrists per 100,000 people, the country faces a severe shortage of mental health professionals. Rural areas are particularly affected, lacking not only specialized psychiatric services but also basic mental health facilities. Even in urban centers, evidence-based therapies such as CBT and DBT are not widely practiced due to limited professional training opportunities and insufficient institutional support. The high cost of therapy further exacerbates accessibility issues, making specialized treatments such as SFT unattainable for the majority of individuals diagnosed with BPD. While efforts have been made to integrate mental health care within primary healthcare settings and develop community-based programs, these initiatives remain in their infancy and are insufficient to meet the complex needs of BPD patients. The limited availability of trained clinicians further restricts the widespread application of SFT, necessitating alternative approaches to enhance its accessibility and cultural adaptability within the Pakistani context (5).

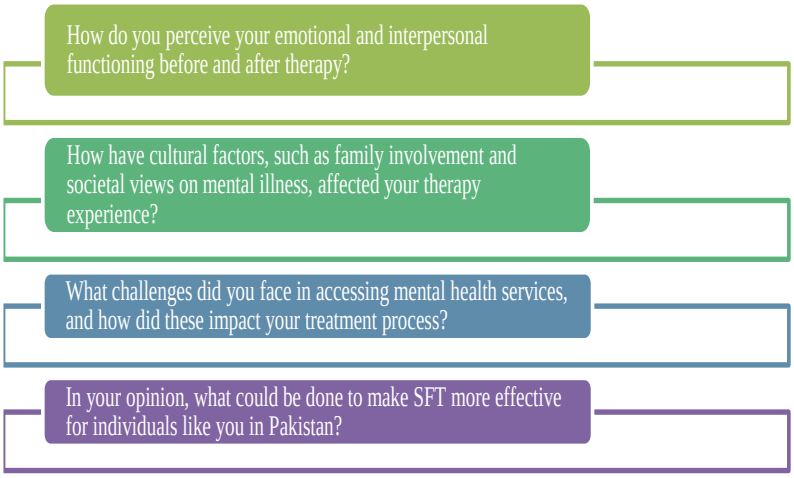
The effectiveness of SFT in Pakistan is not solely dependent on its therapeutic framework but also on its ability to align with the socio-cultural realities of the population. The collectivist nature of Pakistani society presents both opportunities and challenges for therapy. On one hand, family involvement can facilitate emotional support and contribute to better treatment outcomes. On the other hand, rigid familial structures and societal taboos may inhibit open discussions about emotional distress, thereby limiting the effectiveness of therapy. Additionally, gender norms and cultural expectations influence how individuals engage in therapy. Men, for instance, are often discouraged from expressing vulnerability, while women with mental health conditions face social ostracization. A culturally sensitive

approach to SFT, incorporating elements of community engagement, familial psychoeducation, and context-specific modifications, could enhance its applicability and acceptance in Pakistan. Addressing cultural barriers, expanding mental health literacy, and increasing professional training opportunities are crucial steps toward improving the implementation of SFT for BPD (6).

This study aims to evaluate the effectiveness of Schema-Focused Therapy in treating BPD in Pakistan while exploring the influence of socio-cultural factors and mental health accessibility on treatment outcomes. Additionally, it seeks to identify potential cultural adaptations that could optimize SFT's impact within the Pakistani context. By examining the role of informal support systems such as family, religious leaders, and community networks, this research will provide insights into the integration of SFT within Pakistan's mental health framework, ultimately contributing to the development of more inclusive and effective treatment strategies.

## METHODS

A mixed-methods research design, integrating both quantitative and qualitative methodologies, was employed to comprehensively assess the effectiveness of Schema-Focused Therapy (SFT) in treating Borderline Personality Disorder (BPD) in Pakistan. The study aimed to evaluate therapeutic outcomes while considering the influence of socio-cultural factors and psychosocial barriers to mental health accessibility. A quasi-experimental design was utilized for the quantitative component to measure symptom severity and psychological functioning before and after therapy. In contrast, qualitative approaches explored the lived experiences of participants, providing deeper insight into the contextual factors influencing treatment efficacy (7).




Participants were selected using purposive sampling, targeting individuals aged 18–45 years who had been clinically diagnosed with BPD based on DSM-5 criteria and were willing to undergo therapy. The sample included an equal representation from urban and rural populations to capture socio-cultural diversity. Eligibility criteria required that participants were not undergoing any other psychotherapy and had no history of severe comorbid psychiatric disorders, such as psychotic illnesses. A final cohort of 30 participants was enrolled in the study. Exclusion criteria included individuals receiving prior SFT interventions or those diagnosed with conditions that could confound treatment outcomes (8).

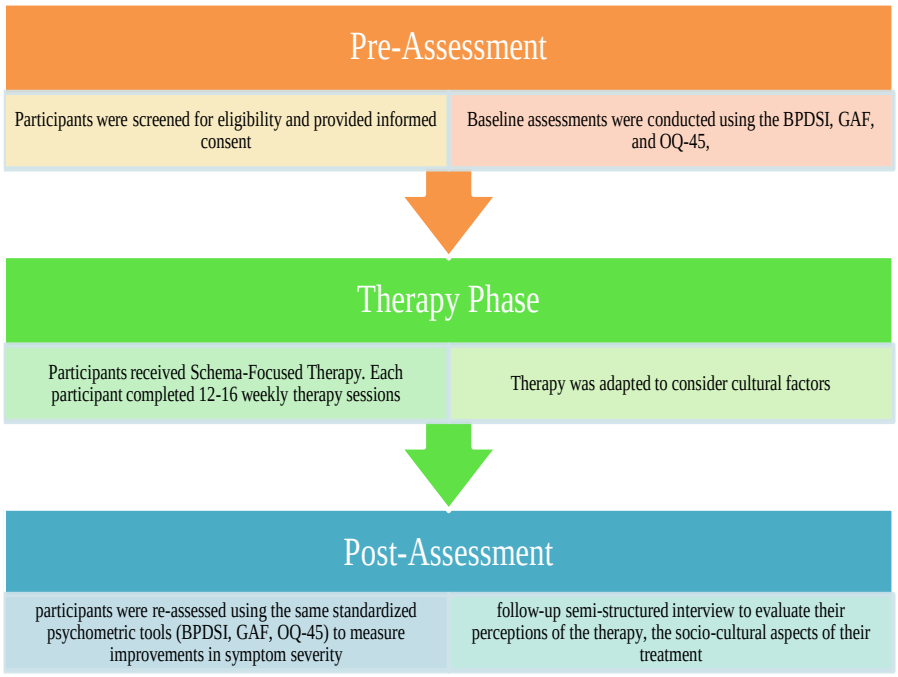
Quantitative data collection involved pre-treatment and post-treatment assessments using standardized psychometric tools to evaluate symptom severity and functional outcomes. The Borderline Personality Disorder Severity Index (BPDSI) was administered to measure core symptoms, including emotional dysregulation, identity disturbances, and interpersonal difficulties. The Global Assessment of Functioning (GAF) Scale was employed to assess overall psychological and social functioning. The Outcome Questionnaire-45 (OQ-45) was used to track general psychological well-being and symptom reduction over the course of therapy. These assessments were conducted at baseline and after completing 12–16 therapy sessions to determine the efficacy of the intervention.

Qualitative data were gathered through in-depth semi-structured interviews conducted before and after therapy. The interview guide included key questions exploring emotional and interpersonal changes, the influence of cultural factors on treatment experience, barriers to accessing mental health services, and recommendations for improving SFT's applicability in Pakistan. Focus group discussions were also conducted post-treatment to capture shared experiences and perceptions regarding therapy, with particular emphasis on cultural adaptations and challenges faced during the treatment process.

The study procedure comprised three phases: pre-assessment, therapy intervention, and post-assessment. During the pre-assessment phase, participants were screened for eligibility, provided informed consent, and completed baseline psychometric assessments. Semi-structured interviews were conducted to explore pre-existing perceptions of BPD and therapy. In the therapy phase, participants received SFT, completing 12–16 weekly sessions, each lasting approximately 60–90 minutes. Cultural adaptations were incorporated to enhance therapy effectiveness, including the use of culturally relevant metaphors, analogies, and therapeutic strategies that acknowledged the

role of family structures and societal norms in shaping emotional expression. Women participants were specifically guided to identify maladaptive schemas related to abandonment, emotional deprivation, and mistrust, which are particularly relevant in the Pakistani socio-cultural context (9).

Following treatment completion, post-assessment measures were administered to evaluate symptom improvement and psychological functioning using the same psychometric tools as in the pre-assessment phase. Final semi-structured interviews and focus group discussions were conducted to explore participants' subjective experiences, perceptions of therapy benefits, and socio-cultural influences on treatment engagement. These qualitative data provided additional depth in understanding the effectiveness of SFT beyond standardized measures.




Data analysis involved both statistical and thematic approaches. Quantitative data were analyzed using **paired-sample t-tests** in **SPSS Version 25** to compare pre-treatment and post-treatment scores, determining the statistical significance of symptom reduction and psychological improvement. Qualitative data were subjected to **thematic analysis** using **NVivo Version 12**, where transcripts from interviews and focus groups were systematically coded to identify emerging themes related to therapy experiences, cultural influences, and barriers to mental health care. A combined **deductive-inductive approach** was employed to ensure that themes aligned with research objectives while allowing novel insights to emerge from participant narratives.

## RESULTS

**Table 1 Demographic Information (N=30)**

| Demographic Variable | Frequency (n) | Percentage (%) |
|---|---|---|
| **Gender** | | |
| Male | 12 | 40% |
| Female | 18 | 60% |
| **Age Range** | | |
| 18-25 years | 8 | 27% |
| 26-35 years | 15 | 50% |
| 36-45 years | 7 | 23% |
| **Urban/Rural** | | |
| Urban | 15 | 50% |
| Rural | 15 | 50% |
| **Marital Status** | | |
| Married | 13 | 43.33% |
| Single | 17 | 56.67% |

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The demographics of the study participants (N=30) were presented. From the respondents, 12 (40%) were males and 18 (60%) were females. The age category was also as follows: eight respondents (or 27%) are aged 18-25, 50% is in the age group of 26-35 years, and seven respondents (or 23%) are aged 36-45 years old. There were 50% of respondents who lived in an urban setting while 50% lived in a rural setting. In terms of marital status, 13 respondents (43.33%) were married, while 56.67% were single.

**Table 2 Pre- Treatment Psychometric Assessment**

| Measure | Mean Score (SD) | Range |
|---|---|---|
| BPDSI (Severity) | 45.7 (7.3) | 30–56 |
| GAF (Psychological Functioning) | 40.5 (6.2) | 32–50 |
| OQ-45 (Overall Well-being) | 72.4 (8.1) | 56–90 |

Depicts the pretreatment psychometric results of participants. BPDSI (Severity) had a mean score of 45.7 (SD = 7.3) on a range of 30 to 56, suggesting different ranges in severity of borderline personality. The GAF, for psychological functioning, reported a mean of 40.5 (SD = 6.2) with a range from 32 to 50, signifying moderate to severe impairment. The OQ-45, assessing overall well-being, reported a mean of 72.4 (SD = 8.1) with scores from 56 to 90-weight, thus showing changes in psychological distress among participants.

**Table 3 Post- Treatment Psychometric Assessment**

| Measure | Mean Score (SD) | Range |
|---|---|---|
| BPDSI (Severity) | 25.2 (6.1) | 14–35 |
| GAF (Psychological Functioning) | 65.3 (8.7) | 50–80 |
| OQ-45 (Overall Well-being) | 48.1 (7.3) | 35–60 |

Post-treatment psychometric assessment outcomes, indicating an improvement across all measures. BPDSI (Severity) had a mean of 25.2 (SD = 6.1), range = 14-35; indicative of a decrease in borderline personality disorder severity. GAF indicated a rise, with mean 65.3 (SD = 8.7) and range of 50 to 80, which is reflective of a better overall functioning. OQ-45 which measures well-being had a mean score of 48.1 (SD = 7.3), range = 35 to 60; this indicates a reduction in psychological distress and improvement in well-being after treatment.

**Table 4: Paired Sample t Test**

| Measure | Pre-Treatment Mean (SD) | Post-Treatment Mean (SD) | t-value | p-value |
|---|---|---|---|---|
| BPDSI (Severity) | 45.7 (7.3) | 25.2 (6.1) | 12.89 | <0.001 |
| GAF (Psychological Functioning) | 40.5 (6.2) | 65.3 (8.7) | -16.78 | <0.001 |
| OQ-45 (Overall Well-being) | 72.4 (8.1) | 48.1 (7.3) | 10.23 | <0.001 |

The paired sample t-test results comparing pre-treatment and post-treatment psychometric evaluations are presented. The BPDSI (Severity) absolute scores decreased significantly from a mean of 45.7 (SD = 7.3) pre-treatment to a mean of 25.2 (SD = 6.1) post-

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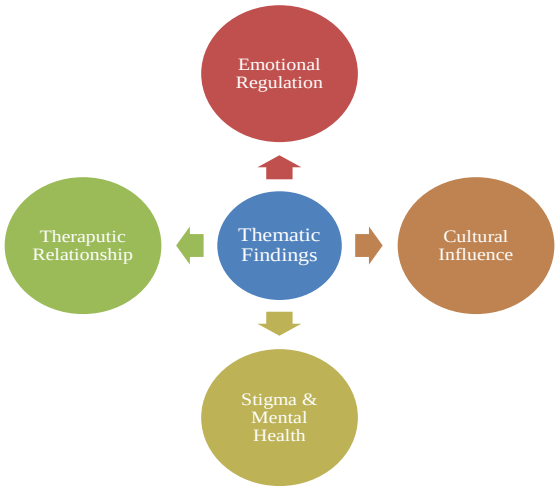
treatment, at t = 12.89, p < 0.001, indicating a significant improvement. Similarly, GAF psychological functioning improved significantly from a mean of 40.5 (SD = 6.2) to a mean of 65.3 (SD = 8.7) post-treatment, with t = -16.78, and p < 0.001. Likewise, with OQ-45 scores improving considerably from a pre-treatment mean of 72.4 (SD = 8.1) to a post-treatment mean of 48.1 (SD = 7.3), t = 10.23; p < 0.001, indicating a statistical improvement in overall well-being. This shows that the treatment had an important statistically convincing positive effect on symptom severity, psychological functioning and overall well-being.

**Qualitative Results**

The thematic analysis of the semi-structured interviews and focus group discussions suggested some of the major dimensions through which SFT participants experienced their involvement. The major themes were identified through both deductive and inductive coding approaches and are summarized as follows (figure 3):




**Thematic Result**

1. Emotional regulation and improvement of self-awareness appeared to be a great area of improvement amongst the participants, as they claimed to be able to handle intense emotions and to restrain themselves better. They attributed these changes to the identification and restructuring of their early maladaptive schemas.

2. Rural and urban participants alike emphasized the role of family in their therapeutic process. Urban participants had an informal environment to broach emotional issues; by contrast, the stigma of social protectionism and expectations from family members made it difficult for rural participants to express their emotional issues. Thus, family involvement was considered essential for the sustainability of therapeutic change.

3. Being distinct from other barriers facing the participants was the issue of stigma surrounding mental health treatment in society. Most voiced their fear of their friends or, in some cases, members of their extended family or community passing judgment on them. Other barriers cited were logistical barriers: few qualified therapists and expensive treatment costs.

4. Many participants considered the therapeutic relationship between therapist and patient to be very important to the success of treatment. Participants were able to look deeply into their schemas and emotional wounds as a result of the trust and empathy they built with their individual therapist.

## DISCUSSION

The findings of this study demonstrated that Schema-Focused Therapy (SFT) was an effective therapeutic intervention for the management of Borderline Personality Disorder (BPD) in Pakistan. Results indicated a significant reduction in symptom severity, improved psychological functioning, and enhanced emotional resilience. Statistically significant changes were observed in the Borderline Personality Disorder Severity Index (BPDSI), where scores decreased from 45.7 at baseline to 25.2 post-treatment, indicating substantial improvement in emotional regulation, impulsivity, and interpersonal stability. Similarly, Global Assessment of Functioning (GAF) scores improved from 40.5 to 65.3, reflecting better adaptability to social environments and an enhanced ability to manage daily life challenges. The Outcome Questionnaire-45 (OQ-45) also showed considerable improvements in overall psychological well-being. These findings were consistent with global literature, reinforcing SFT's efficacy in addressing the core symptoms of BPD by targeting early maladaptive schemas and fostering cognitive restructuring. While these results validated SFT as a valuable therapeutic approach in Pakistan, variability in treatment outcomes was noted, with some participants, particularly those from rural backgrounds, demonstrating slower progress due to socio-cultural constraints and limited mental health accessibility. These observations underscored the necessity of considering external influences alongside the therapy itself to maximize effectiveness in diverse populations(10,11).

The influence of cultural dynamics on the therapeutic process emerged as a critical factor in treatment engagement and outcomes. Societal norms, family involvement, and mental health stigma significantly impacted participation levels, with urban participants

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demonstrating greater openness to discussing emotional distress compared to individuals in rural regions. In conservative rural settings, adherence to traditional familial values and societal expectations often restricted emotional expression, thereby limiting therapeutic engagement. The stigma surrounding mental health further deterred several individuals from seeking treatment, as psychiatric disorders were frequently perceived as a source of shame and personal weakness(12). Women, in particular, faced heightened scrutiny, with mental health concerns often attributed to personal inadequacies rather than recognized as clinical conditions. In some instances, engagement in therapy was interpreted as defiance of cultural norms, especially when it involved confronting family dysfunction or discussing personal trauma. The collectivist nature of Pakistani society necessitated the incorporation of culturally sensitive strategies, such as family psychoeducation and community awareness initiatives, to reduce stigma and enhance therapeutic acceptance. A structured approach to normalizing mental health discussions within familial and communal settings could significantly contribute to improved treatment adherence and long-term psychological well-being (13,14).

Gender dynamics played a crucial role in shaping the therapeutic experience, with distinct patterns of emotional expression and treatment engagement observed between male and female participants. Women exhibited greater difficulty in articulating emotional distress due to socially enforced expectations of emotional suppression, which often hindered self-expression during therapy. Conversely, men demonstrated lower therapy participation rates, largely influenced by cultural norms that discouraged emotional vulnerability. These gender-specific challenges underscored the importance of incorporating tailored coping strategies within SFT to address the unique barriers faced by both men and women in conservative societies. Gender-sensitive adaptations, such as therapy modules that encourage emotional articulation among men and structured safe spaces for women to explore psychological distress without societal repercussions, could enhance treatment efficacy. The findings reinforced the necessity of contextualizing therapeutic interventions to accommodate culturally ingrained gender roles, ensuring that both male and female patients could engage with therapy in a manner that aligns with their sociocultural framework while promoting psychological growth (15,16).

Access to mental health services was a major determinant of treatment outcomes, with logistical and financial barriers significantly affecting therapy participation. The study highlighted that a lack of trained SFT practitioners, high treatment costs, and geographical constraints limited consistent access to therapy sessions. Transportation challenges and financial difficulties were common, particularly among participants from lower socioeconomic backgrounds, leading to irregular attendance and, in some cases, premature discontinuation of treatment. Pakistan's mental health infrastructure remains underdeveloped, with one of the lowest psychiatrist-to-patient ratios globally and a concentration of services in urban centers. Limited exposure to psychological frameworks among participants further compounded engagement difficulties, as many individuals lacked prior familiarity with therapy concepts, necessitating additional effort in psychoeducation. Strategies to improve accessibility, including the simplification of therapy language, the use of culturally relevant metaphors, and the incorporation of visual aids, could significantly enhance engagement, particularly among low-literacy populations. Expanding mental health outreach programs, integrating therapy into primary healthcare settings, and providing financial support mechanisms could further facilitate access to SFT, ensuring that individuals from diverse backgrounds can benefit from structured psychological interventions (17,18,19).

This study provided valuable insights into the application of SFT for BPD within a culturally complex environment, yet several limitations must be acknowledged. The relatively small sample size constrained the generalizability of findings, necessitating further large-scale studies to validate outcomes across a broader population. Additionally, the study primarily focused on short-term treatment effects, limiting conclusions regarding the long-term sustainability of symptom improvements. Future research should explore longitudinal treatment outcomes and relapse rates to provide a comprehensive understanding of SFT's long-term efficacy. The reliance on self-reported measures for qualitative data introduced the possibility of response biases, as participants' narratives may have been influenced by social desirability or recall limitations. Incorporating objective behavioral assessments alongside self-reporting could enhance the reliability of findings. Despite these constraints, the study made significant contributions to understanding the interplay between psychotherapy, cultural factors, and mental health accessibility in Pakistan, reinforcing the need for culturally adapted therapeutic interventions. Moving forward, efforts to integrate culturally responsive frameworks within mental health services, address accessibility barriers, and promote mental health awareness at a community level will be pivotal in advancing the effectiveness and reach of SFT for individuals with BPD (20,21,23).

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## CONCLUSION

The findings of this study reinforce the effectiveness of Schema-Focused Therapy (SFT) in managing Borderline Personality Disorder (BPD) in Pakistan, demonstrating substantial improvements in emotional regulation, psychological functioning, and overall well-being. However, the impact of socio-cultural factors on therapy engagement and outcomes cannot be overlooked. Family influence, societal stigma, gender roles, and limited mental health accessibility pose significant challenges that must be addressed to optimize treatment effectiveness. Integrating culturally adapted interventions, such as family psychoeducation, tele-therapy solutions, and gender-sensitive therapeutic approaches, could enhance engagement and ensure that therapy is more inclusive and accessible. Simplifying therapeutic communication and tailoring treatment strategies to align with the cultural framework of Pakistani society would further support individuals with BPD in benefiting from structured psychological interventions. Addressing these factors will contribute to bridging gaps in mental health services and strengthening the overall effectiveness of SFT in Pakistan's mental health landscape.

### AUTHOR CONTRIBUTIONS

| Author | Contribution |
|---|---|
| Muhammad Rizwan Mushtaq* | Substantial Contribution to study design, analysis, acquisition of Data<br>Manuscript Writing<br>Has given Final Approval of the version to be published |
| Zeeshan Manzoor | Substantial Contribution to study design, acquisition and interpretation of Data<br>Critical Review and Manuscript Writing<br>Has given Final Approval of the version to be published |
| Benish Usman | Substantial Contribution to acquisition and interpretation of Data<br>Has given Final Approval of the version to be published |
| Farah Gillani[4]* | Contributed to Data Collection and Analysis<br>Has given Final Approval of the version to be published |
| Muhammad Bilal Kaleem | Contributed to Data Collection and Analysis<br>Has given Final Approval of the version to be published |

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