Overwhelmed Students/Overwhelmed Staff and Faculty: Personality Disorders in University Students

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Abstract

Some of the most challenging students for university personnel are those who present with personality disorders. I will highlight how to identify those students who might have personality disorders and will address some of the common challenges. Often these students evoke powerful emotions, interpersonal conflict, dysfunctional alliances, boundary problems, impasses, and they are at high risk for attrition. Methods for addressing these challenges and treatment options will be discussed. Gaps in university mental health services for this population will also be addressed.

Personality disorders (PDs) are "prevalent, disabling, costly," and cause significant suffering for self and others (Conway et al., 2017, p.1000). As a result, early identification and intervention are essential for effective management and treatment. Research has demonstrated that the prevalence of PDs in university students is as high or possibly higher than the general population. Whereas the general population has a lifetime prevalence of approximately 15% (American Psychiatric Association, 2013), university populations have demonstrated prevalence rates ranging from 16% to 32% (Blanco et al., 2008; Eisenberg et al., 2013; Meaney et al., 2016; Sinha & Watson, 2001). In fact, Blanco et al.'s study found that personality disorder was the second most prevalent disorder (17.5%), after substance use (20.37%) among university students. Yet, research has demonstrated that PDs are often under- recognized and under-diagnosed in university populations (Conway et al., 2017; Kaess et al., 2014; Laurenssen et al., 2013). Lack of knowledge about the onset of the disorder, concern about the potential for stigmatization, apprehensiveness about how the recipient may respond to the diagnosis, and the reluctance to diagnose personality pathology in youth are factors that may contribute to the failure to identify or diagnose personality disorders in university students (Conway et al., 2017; LeQuesne & Hersh, 2004; Hersh, 2015; Paris, 2007).

Support for the importance of identifying those students with PDs is provided by the empirical and clinical literature that has repeatedly shown that this population is difficult to manage and slow to change. Students with PDs are at increased risk for self-harm or completed suicide (Allebeck et al, 1996: Goodman et al., 2012); premature drop out, treatment ruptures, or impasses (Marziali, 1992); have longstanding social dysfunction (Rutter, 1987); have a poorer response to psychosocial or pharmacological treatment compared to those without personality disorders (Busch & Sandberg, 2014; Hersh, 2015; Hoglend et al., 1993); have high rates of co-morbidity (Levy et al., 2014); and elicit negative countertransference (Gazzillo et al., 2015).

There are some signs and symptoms that can screen for personality disorders in university students. In general, those students with PDs often manifest significant malfunction in three core areas: interpersonal functioning, coping mechanisms/defenses, and affect regulation (Diamond et al., 2022; Fleischer, 1998; Pincus & Wiggins, 1990).

While they are usually not dysfunctional in all aspects of their lives, important aspects of their social functioning, and their ability to cope with stress and regulate their emotions are usually compromised, resulting in significant distress for self and others. The result is that their capacity to love, work, and/or enjoy life may be restricted.

There are some common markers for identifying personality dysfunction in the university population. In sum, the student's inner turmoil is often manifested in many aspects of their academic life and interpersonal arena. Poor, inconsistent academic performance, and performance below the student's capabilities are associated with personality pathology (Kaess et al., 2014). Chronic lateness, absence, attrition, disruptive classroom behaviours, and ongoing interpersonal conflicts are common (Cleary et al., 2012). They may exhibit extreme reactions to negative evaluations and may demonstrate dysfunctional relational patterns with faculty, manifested, for example, in excessive politeness or hostility, passive-aggressive behaviours, oppositionality, or withdrawal (Kernberg et al.,1989). Outside the university, relationships may be unstable and longstanding conflict with their family of origin is common. Repeated hospital emergency room visits, suicidality, and disparagement of other helping professionals or faculty are typical signs of personality pathology (Goodman et al., 2012). Students with PDs often have difficulty managing stress and tend to use maladaptive coping methods including substance use, self-cutting, sexual acting out, disordered eating, withdrawal into fantasy, excessive internet use, and/or pornography addictions.

Unfortunately, students with PDs often lack self-awareness or insight about their disorder and tend to fail to take responsibility for their contribution to their problems; they may come to the attention of mental health professionals due to the distress that they have caused others (Kernberg et al., 2009). In general, university students with PDs display enduring repetitive dysfunctional patterns of behaviour, and they may respond inappropriately to relatively innocuous stimuli (Marcus, 2017).

Students with PDs include a wide spectrum of individuals, with differing levels of impairment, co-morbidity, coping skills, insight, and treatment outcomes. Personality disorders are categorized on A, B, or C spectrums (American Psychiatric Association, 2013). Those students on the cluster A or B spectrum, who exhibit externalizing behaviours (e.g., self-harm, hypersexuality or substance use) or odd behaviours (e.g., paranoia, odd speech, appearance, or beliefs) (American Psychiatric Association, 2013) may be more readily identified for mental health problems. However, university personnel need to be on the lookout for those students on the cluster C spectrum, who are usually quieter, more anxious or withdrawn, and their difficulties may be manifested in perfectionism, self-criticism, procrastination, dependency, insecurity, low self-esteem, or indecisiveness (Stone, 1993). These students may function better and create less turmoil compared with students on the cluster A or B spectrum; however, they suffer and are at risk for negative outcomes.

It must be emphasized that this list of markers for screening for personality pathology does not definitively make a diagnosis, and these signs and symptoms could be associated with other disorders. For example, students who have psychotic disorders often have significant social impairment. Learning disorders can negatively impact academic performance, social functioning, and self-esteem (Bellak, 1983). Aspects of post-traumatic stress disorder or dissociative identity disorder can resemble personality pathology (Berzoff & Darwin, 1995; Gottlieb, 1997). However, students with any of these disorders

may have comorbid personality disorders (Diamond et al., 2014). The point is that when screening for personality pathology it is important that other issues and diagnoses are considered, as part of a comprehensive assessment and treatment planning.

To manage PDs effectively, early identification is critical for two reasons. First, faculty, and staff need to identify this population so that they can ensure that they receive appropriate mental health services. And second, they need to be able to manage their behaviour to promote optimal academic achievement and personal growth.

Perhaps the biggest challenge that university personnel face when they encounter students with PDs is associated with managing their countertransference and the student's transference (Betan et al., 2005). These students evoke powerful negative emotions and maladaptive responses, and these reactions can serve as a both useful tool and/or impediment to helping these students. As a tool, the intensity of the response alerts the recipient to the possibility of personality dysfunction and can help them to better understand the student. As an impediment, these reactions can impair their relationship with the student, and negatively impact their teaching and contribute to negative outcomes.

Students with PDs often display inappropriate reactions to those people who are in positions of authority, such as university personnel. They may display intense negative global reactions (transferences)-especially when they feel criticized, disappointed, or frustrated (Kernberg et al., 1989). Idealization may be followed by devaluation and these swings may occur daily or over the course of the semester. The student's response to others repeats elements of their past relationship history; however, they often lack awareness that something from the past is being acted out in the present. And university personnel are often at a loss to make sense of these reactions that are sometimes manifested, for example, in unwarranted complaints against faculty or requests for unreasonable accommodations. Faculty and staff often get trapped into dysfunctional dynamics and may find that they behave or speak in uncharacteristic ways. Splitting among the team members, resulting in unhealthy alliances between faculty factions, or inappropriate professor-student alliances may result in team conflicts (Green, 2018). The chaos in the student's internal world may get unknowingly acted out among the faculty and staff.

Unusual, atypical emotional responses to students-albeit overly positive, or negative, alerts the faculty, staff, or therapist to the possible presence of personality pathology (Colli et al., 2014). For example, faculty may experience strong negative emotions, such as excessive anger, dread, fear, hate, or disgust toward the student, resulting in arguing, avoidance, or punitive behaviours. Or the student may trigger an excessively positive reaction, that can be manifested in over-identifying with them, liking them too much, siding with them against colleagues, or boundary-crossing. Often these students get "under their skin," and it may feel like they invade their internal world, as demonstrated when they enter their dreams (Brown, 2007; Marcus, 2022). Because these students have a history of dysfunctional relationships that get compulsively played out in the present, these same dynamics inevitably occur with university personnel. And because students often use splitting and projective identification among other lower-level defenses, they create turmoil among staff and students.

There are steps that faculty, staff, and mental health professionals can take to develop a more productive working alliance with students with PDs. Perhaps the key beginning step is education for university personnel about personality pathology (Ebrahim et al., 2016; Spektor et al., 2015). This knowledge enables university personnel to

understand the student and maintain greater objectivity. For example, university personnel can use their emotional response to the student for insight into the student's emotions. Students with personality dysfunction may unconsciously get others to feel what they feel by projecting their intolerable emotions into them (i.e., projective identification). Students who have difficulty processing their own emotions, such as anger, frustration, or depression may induce in others intense rage, frustration, or helplessness. The professional's response to the student mirrors aspects of the student's own experience. Understanding these mechanisms can contribute to greater empathy and emotional distance-resulting in less reactivity and a more optimal response. Managing negative countertransference effectively is associated with better therapeutic outcomes (Hayes et al., 2011).

When faculty or staff can take a step back and monitor their response, they are more likely to be able to actively listen, while empathizing, supporting, and affirming the student. Appropriate structure, boundary setting and limits, including delineating clear expectations and rules, and confrontation provide important containing and holding functions (Caligor et al., 2009). Punctuality, reliability, and structure help to develop the alliance. When ruptures or impasses inevitably occur, university personnel can demonstrate that disagreements can be worked through (Marziali & Monroe-Blum, 1994). While faculty members or staff are not expected to be psychotherapists, the ability to maintain their composure, during conflict or emotional storms, can help to emotionally regulate the student. University personnel can provide auxiliary ego functions that the student may be lacking. Students identify with mentors and ideally over time they can take on functions that formerly were provided by others (Shafer, 1968). In addition, new positive experiences with university personnel can help to challenge rigid dysfunctional relational templates and may contribute to healthier styles of relating.

Consultation with colleagues, supervision, and personal psychotherapy can be helpful for university personnel to help them cope with this challenging population. Often staff struggle alone with these difficult students, and they may feel relieved to find out that other staff have had similar reactions. Since PDs display repetitive maladaptive behaviours, similar themes emerge with different staff and faculty (Marcus, 2020). A coordinated and consistent response helps to contain the student. Faculty and staff responses to the identified student inform personality pathology screening (Betan et al., 2005). When other university personnel have similar responses, this corroborates that the reaction is more than just the individual's idiosyncratic response to the student's personality. Colleagues can support each other.

Faculty or staff may benefit from pursuing their own psychotherapy, as clients with PDs can trigger intense conflict in others about their own childhood, trauma, or current psychic conflicts. Psychotherapy can help university personnel better understand their reactions to the student and help them develop more adaptive ways to manage the student's behaviour. Personal psychotherapy can be especially helpful for university staff who provide mental health services to students (Åstrand & Sandell, 2019).

Referral to appropriate mental health resources for students who have possible PDs is a critical role for faculty, staff, and mental health personnel. University personnel are in an ideal position to identify those students requiring mental health services and can use their relationship with the students to facilitate their entry into treatment. Particularly during high stress periods such as exam periods, or when major assignments are due, students with PDs (and students in general) are more likely to have crises, sometimes

requiring emergency services, and/or their other symptoms are likely to escalate (Cabaniss, 2016; Linden & Stuart, 2020). Clients with PDs may be more amenable to getting professional help during crises and university personnel can use this opportunity to refer them to university counselling services and other appropriate resources (Blanco et al., 2008).

Contrary to popular opinion and myth, treatment for people with PDs is effective (Leichsenring & Rabung, 2008; Lilliengren et al., 2016). However, there is a consensus in the empirical and clinical literature that PDs require longer term more intensive treatments and/or specialized treatments (Koss & Shiang, 1994; Leichsenring et al., 2013: Turr & Andreatta, 2014). Traditionally, psychoanalytic therapy or psychoanalysis have been the treatment of choice for personality disordered individuals (Keefe et al., 2019; Levy et al., 2014; Lilliengren et al., 2016). However, recent research has indicated that some time limited forms of group treatment (e.g., dialectical behavioural therapy, or interpersonal group therapy) (Linehan et al., 2006; Marziali & Monroe-Blum, 1994) and individual therapy (e.g., cognitive behaviour therapy, cognitive analytic therapy, transference-focused therapy) (Chanen et al., 2008; Diamond et al., 2014; Rossouw & Fonagy, 2012; Westen, 2000) may provide an effective and parsimonious form of treatment for PDs. Whatever form of therapy is used, this is a challenging population to treat effectively.

Often university students' first point of contact for mental health services is the university counselling centre. Unfortunately, most university counselling programs are not disorder specific. Research has indicated that most university mental health services are short-term (Gallagher, 2010; Jaworska et al., 2016), with the mean number of sessions being 5.5 (Rando & Barr, 2009). The common approaches mirror the mainstream popular contemporary treatments-which are often cognitive behavioural, mindfulness, solution-focused, and strength- based (Conley et al., 2013; Lees & Deitch, 2012). Universities offer a variety of different mental health services, including psychoeducational, peer support, triage, health promotion, movement-based, pet therapy, crisis intervention or supportive treatments (Linden & Stuart, 2020). While all these services are potentially useful, the difficulty is that the option of longer-term therapies, insight-oriented treatments, and treatments targeted toward a specific disorder are largely missing (Cabaniss & Holoshitz, 2019). The recent introduction of the stepped care model in Ontario universities is an important attempt to match students to the appropriate treatment (Nair & Otaki, 2021). However, to my knowledge, there are no university counselling programs in North America aimed specifically at students with PDs (Laurennsen et al., 2013).

If the PD is not identified or targeted, the student may not receive the appropriate referral and/or stay in treatment long enough to be referred to the more specialized treatments that tend to be most effective at addressing their longstanding, complex problems. If they do not receive appropriate treatment, there is increased risk of therapeutic impasses, premature termination, failed treatments, recidivism, frustrated clinicians, and hopeless students (Dunley et al., 2016). And even if the practitioner does the screening and makes the appropriate referral, given the paucity of long-term treatment and the growing demand for services, they may be placed on a lengthy waiting list, resulting in higher risk of attrition (Wampers et al., 2018). Also, there is a dearth of research on treatment programs and outcomes and prevention programs for university students with PDs (Laurennsen et al., 2013). University programs need to develop more flexible treatments and creative programs for their students with mental health disorders in general.

Despite the challenges faced in working with university students with PDs, the university setting offers an ideal opportunity to engage these students in treatment. Because the students are often relatively young, and are in a period of transition, their personality may be more malleable. Although some personality pathology, such as borderline personality may sometimes burn itself out or be ameliorated in middle or older age (Stone, 2016), personality defenses rigidify and dysfunctional behaviour tends to become more stereotyped with advancing age (Bangash, 2020; Gleason et al., 2014). The university life phase provides an ideal opportunity to help students move beyond a developmental impasse, challenge their dysfunctional patterns, fortify healthy coping methods, and to revive their growth potential.

References

Allebeck, P. Allgulander, G., & Fisher, L.D. (1998). Predictors of completed suicide in a cohort of 50, 465 young men: role of personality and deviant behaviour. *British Medical Journal*, 297, 176-178.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books9780890425596

Åstrand, K. & Sandell, R. (2019). Influence of personal therapy on learning and development of psychotherapeutic skills. *Psychoanalytic Psychotherapy*, 33, 34-48.

Bangash, A. (2020). Personality disorders in later life: Epidemiology, presentation and management. *The British Journal of Psychiatry*, 26(4), 208-218.

Bellak, L. (1983). Ego functions and their components. In Psychiatric aspects of attention deficit disorder in adults, Part 1. *Directions in Psychiatry* (pp.498-499). Heatherleigh Ltd.

Betan, E., Heim, A.K., Conklin, C.Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: an empirical investigation. *American Journal of Psychiatry*, 162(5). 890-8. https://doi.org/10.1176/appi.ajp.162.5.890.

Blanco, C., Okuda, M., Wright, C., Hasin, D.S. & Grant, D.S. (2008). Mental health of college students and their non-college-attending peers: Results from the National Epidemiologic Study on Alcohol and Related Conditions. *Archives of General Psychiatry*, 2008, 65, 1429–1437.

Brown, L. J. (2007). On dreaming one's patient: Reflections on an aspect of countertransference dreams. *Psychoanalytic Quarterly*, 76, 835-861.

Berzoff, J., & Darwin, J. (1995). Treatment of character or treatment of trauma? In L. Cohen, J. Berzoff, & M. Elin, *Dissociative identity disorder: Theoretical and treatment controversies* (pp.447-466). Jason Aronson.

Busch, F. & Sandberg, L. (2014). *Psychotherapy and medication: The challenge of integration.* Routledge.

Cabaniss, D.L., Cherry, S., Douglas, C.J. & Schwartz, A.R. (2016). *Psychodynamic psychotherapy: A clinical manual.* Wiley Blackwell.

Cabaniss, D.L., & Holoshitz, Y. (2019). *Different patients, different therapies: Optimizing treatment using different therapeutics.* Norton.

Caligor, E., Diamond, D., Yeomans, F. E. & Kernberg, O. F. (2009). The interpretive process in the psychoanalytic psychotherapy of borderline personality pathology. *Journal of the American Psychoanalytic Association,* 57, 271-301.

Chanen, A.M,, Jackson, H.J., McCutcheon LK, et al. (2008). Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: Randomized controlled trial. *British Journal of Psychiatry,* 193 (6),477–484.

Cleary, M., Horsfall, J., Baines, J., & Happell, B. (2012). Mental health behaviours among undergraduate nursing students: Issues for consideration. *Nurse Education Today*, *32*(8), 951-955.

Colli, A., Tanzilli, A., Dimaggio, G., & Lingiardi, V. (2014). Patient personality and therapist response: An empirical investigation. *American Journal of Psychiatry,* 171, 102-108.

Conley, C.S., Durlak J.A., Dickson, D.A. (2013). An evaluative review of outcome research on universal mental health promotion and prevention programs for higher education students. *Journal of American College Health*, 61(5), 286–301.

Conway, C. C., Tackett, J.L., & Skodol, A.E. (2017). Are personality disorders assessed in young people? *American Journal of Psychiatry,* 174 (10), 1000-1001.

Diamond, D., Yeomans, F.E., Stern, B.L., & Kernberg, O. (2022). *Treating pathological narcissism with transference-focused psychotherapy*. Guilford Press.

Diamond, D., Clarkin, J. F., Levy, K. N., Meehan, K. B., Cain, N. M., Yeomans, F. E. & Kernberg, O. F. (2014). Change in attachment and reflective function in borderline patients with and without comorbid narcissistic personality disorder in transference focused psychotherapy. *Contemporary Psychoanalysis*, 50, 175-210.

Dunley, D., Papadopoulos A. (2019). Why is it so hard to get help? Barriers to help-seeking in postsecondary students struggling with mental health issues: A scoping review. International *Journal of Mental Health and Addiction*,17(3), 699–715. https://doi.org/10.1007/s11469-018-0029-z

Ebrahim, S., Robinson, S., Crooks, S., Harenwall, S., & Forsyth, A. (2016). Evaluation of awareness level knowledge and understanding framework personality disorder training with mental health staff: Impact on attitudes and clinical practice. *The Journal of Mental Health Training, Education, and Practice, 11*(3), 133-143.

Eisenberg, D., Hunt J., & Speer, N. (2013). Mental health in American colleges and universities: variation across student subgroups and across campuses. *Journal of Nervous and Mental Diseases*, 201, 60–67.

Fleischer, L.M. (1998). *Dimensions of personality functioning: Implications for clinical social work assessment*. [Unpublished Doctoral Dissertation, Smith College].

Gallagher, R. P. (2010) *National Survey of Counseling Center Directors 2009.* Project Report. The International Association of Counseling Services (IACS).

Gazzillo, F., Lingiardi, V., Del Corno, F., Genova, F., Bornstein, R. F., Gordon, R. M., & McWilliams, N. (2015). Clinicians' emotional responses and *Psychodynamic Diagnostic Manual* adult personality disorders: A clinically relevant empirical investigation. *Psychotherapy, 52*(2), 238–246.

Gleason, M.E.J., Weinstein, Y., Balsis, S., & Oltmanns, T.F**.** (2014), The enduring impact of maladaptive personality traits on relationship quality and health in later life. *Journal of Personality, 82*, 493–501.

Goodman, M., Roiff, T., Oakes, A., & Paris, J. (2012). Suicidal risk and management in borderline personality disorder. *Current Psychiatry Reports*, 14,79-85.

Gottlieb, R. M. (1997). Does the mind fall apart in multiple personality disorder? Some proposals based on a psychoanalytic case. *Journal of the American Psychoanalytic Association* 45,907-932.

Green, H. (2018) Team splitting and the 'borderline personality': A relational reframe. *Psychoanalytic Psychotherapy*, 32, 249-266.

Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. *Psychotherapy*, *48(*1), 88–97. https://doi.org/10.1037/a0022182

Hersh, R. G. (2015). Using transference-focused psychotherapy principles in the pharmacotherapy of patients with severe personality disorders. *Psychodynamic Psychiatry* 43,181-199.

Hoglend, P., Sorlie, T., Heyerdahl, O., Sorbye, O., & Sorlie, T. (1993). Brief dynamic psychotherapy: Patient suitability, treatment length, and outcome. *Journal of Psychotherapy Practice and Research*, 2, 296-306.

Jaworska, N., De Somma, E., Fonseka, B., Heck, E., MacQueen, G.M. (2016). Mental health services for students at postsecondary institutions: A national survey. *Canadian Journal of Psychiatry*, 61(12), 766–75.

Kaess, M., Brunner, R., & Chanen, A. (2014). Borderline personality disorder in adolescence. *Pediatrics*,134(4), 782-793.

Keefe, J. R., McMain, S. F., McCarthy, K. S., Zilcha-Mano, S., Dinger, U., Sahin, Z., Graham, K., & Barber, J. P. (2019). A meta-analysis of psychodynamic treatments for borderline and cluster C personality disorders. *Personality Disorders: Theory, Research, and Treatment*, *11*(3), 157–169.

Kernberg, O. F. (1976). Technical considerations in the treatment of borderline personality organization. *Journal of the American Psychoanalytic Association*, 24, 795-829.

Kernberg, O., Selzer, M.A., Koenigsberg, H.W., Carr, A.C. & Applebaum, H. (1989). *Psychodynamic psychotherapy of borderline patients*. Basic Books.

Koss, M.P., & Shiang, J. (1994). Research on brief psychotherapy. In A. E. Bergin and S.E. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed., pp.664-678). Wiley.

Laurenssen, E. M. P., Hutsebaut, J., Feenstra, D. J., Van Busschbach, J. J., & Luyten, P. (2013). Diagnosis of personality disorders in adolescents: A study among psychologists. *Child and Adolescent Psychiatry and Mental Health, 7,* Article 3. https://doi.org/10.1186/1753-2000-7-3

Lees, J. & Deitch, P. (2012). An analysis of counselling services in Ontario colleges: Initial report. Center for innovation in campus mental health. https://campusmentalhealth.ca/wp-content/uploads/2019/09/Stepped-Care-Guide-V13.pdf.

Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychiatry*, 60(7), 1223-32. http://doi.org/10.1176/appi.ajp.160.7.1223

Leichsenring, F. & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *Journal of the American Medical Association*, 300(13),1551-1565. http://doi.org/10.1001/jama.300.13.1551

Leichsenring, F., Abbass, A., Luyten, P., Hilsenroth, M. & Rabung, S. (2013). The emerging evidence for long-term psychodynamic therapy. *Psychodynamic Psychiatry*, 41(3), 361-384.

LeQuesne, E. R., & Hersh, R. G. (2004). Disclosure of a diagnosis of borderline personality disorder. *Journal of Psychiatric Practice*, 10, 170-176.

Levy, K. N., Ehrenthal, J. C., Yeomans, F. E. & Caligor, E. (2014). The efficacy of psychotherapy: Focus on psychodynamic psychotherapy as an example. *Psychodynamic Psychiatry*, 42, 377-421.

Lilliengren, P., Johansson, R., Lindqvist, K., Mechler, J., & Andersson, G. (2016). Efficacy of experiential dynamic therapy for psychiatric conditions: A meta-analysis of randomized controlled trials. *Psychotherapy, 53*(1), 90-104. https://doi.org/10.1037/pst0000024

Linden, B., & Stuart, H. (2020). Post-secondary stress and mental well-being: A scoping review of the academic literature. *Canadian Journal of Community Mental Health, 39*(1), 1–32. https://doi.org/10.7870/cjcmh-2020-002

Linehan, M.M., Comtois, K.A., Murray, A.M,, Brown, M.Z,, Gallop, R.J., Heard, H.L., Korslund K.E., Tutek, D.A., Reynolds, S.K., & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63(7), 757-766

Marcus, E. R. (2017). *Psychosis and near psychosis: Ego function, symbol, structure, treatment.* Routledge.

Marcus, E. R. (2020) Rigid character: A modern ego psychology view. *Canadian Journal of Psychoanalysis,* 28, 208-225.

Marcus, E. (2022). The adaptation function of dreams and the waking work: A modern ego psychology view. *Psychoanalytic Inquiry*, 42, 194-203.

Marziali, E. (1992). Borderline personality: Diagnosis, etiology, and treatment. *Smith College Studies in Social Work*, 62(3), 205-227.

Marziali, E. & Monroe-Blum, H. (1994). *Interpersonal group psychotherapy for borderline personality disorder.* Basic Books.

Meaney, R., Hasking, P., & Reupert, A. (2016). Prevalence of borderline personality disorder in university samples: Systematic review, meta-analysis and meta-regression. *PloS One, 11*(5), https://doi.org/10.1371/journal.pone.0155439

Nair, B. & Otaki, F. (2021). Promoting university students' mental health: A systematic literature review introducing the 4M-Model of Individual-Level Interventions. *Frontiers in Public Health.* 9, 1-10. https://doi.org/10.3389/fpubh.2021.699030.

Paris, J. (2007). Why psychiatrists are reluctant to diagnose borderline personality disorder. *Psychiatry,* 4(1), 35-39.

Pincus, A. & Wiggins, J.S. (1990). Interpersonal conceptions of personality disorders. *Journal of Personality Disorders,* 4(4), 342-352.

Rando, R., & Barr, V. (2009). The Association for University and College Counseling Center Directors annual survey.

Rossouw, T.I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: A randomized control trial. *Journal of American Academy of Child and Adolescent Psychiatry*, 51(12),1304-1313. https://doi.org/10.1016/j.jaac.2012.09.018

Rutter, M. (1987). Temperament, personality, and personality disorder. *British Journal of Psychiatry*, 150, 443-458.

Schafer, R. (1968). *Aspects of internalization*. International Universities Press.

Sinha, B., & Watson, D. (2001). Personality disorder in university students: A multitrait-multimethod matrix study. *Journal of Personality Disorders*, *15*(3), 235–244.

Spektor, V., Luu, L., & Gordon, R. M. (2015). The relationship between theoretical orientation and accuracy of countertransference expectations. *Journal of the American Psychoanalytic Association*, *63*(4), NP28–NP32.

Stone, M. (1993). Long term outcome in personality disorders. *British Journal of Psychiatry*, 162, 299-313.

Stone, M. (2016). Long-term course of borderline personality disorder. *Psychodynamic Psychiatry*, 44(3), 449-474. https://doi.org/10.1521/pdps.2016.44.3.449.

Turri, M., & Andreatta, L. (2014). Does psychoanalytic psychotherapy offset use of mental health services and related costs in severe borderline personality disorder? – A case study. *Psychoanalytic Psychotherapy*, 28, 139-158.

Wampers, M., Pola, C., Verhaest, Y., Vandeneede, B., Demyttenaere, K., Vermote, R. & Lowyck, B. (2018). Predictors of dropout from a psychodynamic hospitalization-based treatment for personality disorders. *Psychoanalytic Psychology*, 35, 217-223.

Westen, D. (2000). The efficacy of dialectical behavior therapy for borderline personality disorder. *Clinical Psychology: Science and Practice, 7*(1), 92-94. https://doi.org/10.1093/clipsy.7.1.92.