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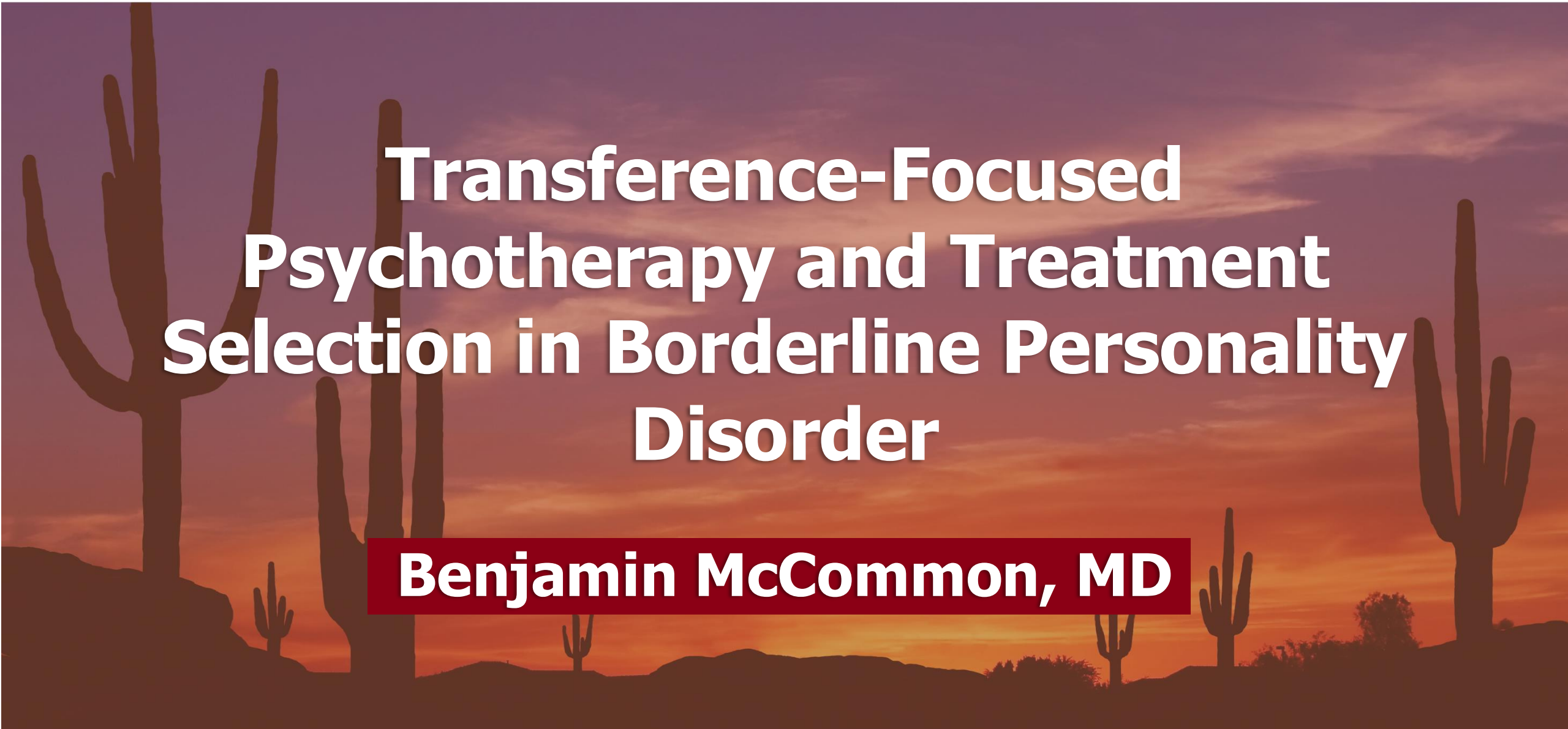

Transference-Focused Psychotherapy and Treatment Selection in Borderline Personality Disorder

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Southwest Summit on Transference-Focused Psychotherapy

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9:50 a.m. to 10:20 a.m.

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Diagnosis in Borderline Personality Disorder (BPD)

- Treatment selection in BPD begins with diagnosis
- BPD diagnosis: DSM-5 Section II provides a categorical diagnosis mostly unchanged from DSM-4
- 5 out of 9 criteria: 1) fears of abandonment, 2) unstable interpersonal relationships, 3) identity disturbance, 4) impulsivity, 5) suicidal or self-mutilating behavior, 6) affective instability, 7) emptiness, 8) anger, 9) paranoid ideation or dissociation
- Does not provide a specific measure of severity (not dimensional)
- Primary method of diagnosis used in BPD treatments other than Transference-Focused Psychotherapy (TFP)

Diagnosis in BPD

- DSM-5 Section III provides an Alternative Model of Personality Disorder (AMPD) for joint dimensional and categorical diagnosis of BPD
- Categorical diagnosis is retained with changes (Criterion B)
- 4 out of 7: 1) emotional lability; 2) anxiousness; 3) separation insecurity; 4) depressivity; 5) impulsivity; 6) risk-taking; 7) hostility

Diagnosis in BPD

- Dimensional diagnosis in the AMPD is captured in the Level of Personality Functioning (Criterion A)
- Elements of personality function
  - Self functioning
    - Identity
    - Self-direction
  - Interpersonal functioning
    - Empathy
    - Intimacy

Diagnosis in BPD

- TFP also uses a joint categorical and dimensional approach to diagnosis of BPD compatible with the AMPD
- Level of personality organization determined in TFP with the structural interview (parallels Level of Personality Functioning)
- Assesses multiple domains of personality functioning (RADIOS)
  - R Reality testing
  - A Aggression
  - D Defenses
  - I Identity
  - O Object relations
  - S Superego

Diagnosis in BPD

- Self functioning
  - Identity
    - Experience of oneself as unique, with clear boundaries between self and other (I, R)
    - Stability of self-esteem and accuracy of self-appraisal (I, R)
    - Capacity for, and ability to regulate, a range of emotional experience (I, D, A)
  - Self-direction
    - Pursuit of coherent and meaningful short-term and life goals (I, R)
    - Utilization of constructive and prosocial internal standards of behavior (I, S, A)
    - Ability to self-reflect productively (I)

Diagnosis in BPD

- Interpersonal functioning
  - Empathy
    - Comprehension and appreciation of others' experiences and motivations (O, R)
    - Tolerance of differing perspectives (O)
    - Understanding the effects of one's own behavior on others (O, I, R)
  - Intimacy
    - Depth and duration of connection with others (O)
    - Desire and capacity for closeness (O, I)
    - Mutuality of regard reflected in interpersonal behavior (O, I, A)

Comorbidity in BPD and treatment selection

- Comorbidity in BPD is the norm
- BPD is often given little or no attention compared to comorbid disorders
  - Most psychiatrists have comfort and training in prescribing medications for comorbid disorders
  - Most psychiatrists and other clinicians do not have comfort and training in making psychosocial interventions in BPD
  - This is especially a problem when treatment of BPD should be considered primary to comorbid disorders

Comorbidity in BPD and treatment selection

- BPD is generally secondary to comorbid disorders when there is impairment in involvement, active learning, or motivation
  - Bipolar I, acute manic episode
  - PTSD, severe (?)
  - Substance Use Disorders, before 3-6 months sobriety
  - Anorexia Nervosa
  - Antisocial Personality Disorder, especially if secondary gain predominates

Comorbidity in BPD and treatment selection

- BPD is generally primary to comorbid disorders when the comorbid disorder is unlikely to remit or likely to relapse unless BPD is adequately treated
  - Major Depressive Disorder
  - Bipolar I or II Disorder, except acute manic episode
  - Panic Disorder
  - PTSD, less severe (?)
  - Narcissistic Personality Disorder
  - Bulimia Nervosa, if physical health is stable

Treatment selection in BPD

- Specialist treatments for BPD (more resource-intensive, greater training requirements)
  - Dialectical Behavioral Therapy (DBT)
  - Schema Focused Therapy
  - Mentalization Based Therapy (MBT)
  - Transference-Focused Psychotherapy (TFP)
- Generalist treatments for BPD (less resource-intensive, fewer training requirements)
  - Good Psychiatric Management (studied vs. DBT)
  - Structured Clinical Management (studied vs. MBT)
  - Supportive Psychotherapy (studied vs. TFP)

Treatment selection in BPD

- DBT is the most studied treatment, but no treatment is clearly superior to another (in general or for specific subgroups)
- Ideally patients would have the option to do a generalist treatment first
- Specialist treatment would be reserved for patients with an unsatisfactory response to generalist treatment
- Generalist treatment would also be a fall-back option after specialist treatment
- Generalist treatment might be especially appropriate as a final treatment for chronic severe, unremitting patients

Treatment selection in BPD

- Treatment selection is limited by a dearth of treatment specialists
- One study in 2019 showed only hundreds of certified specialists (at most) in any modality in any country
- Lifetime prevalence of BPD ranges from 2.4% to 5.9% in the United States (7 million to 18 million people)
- DBT is the most commonly available modality
- DBT will often be the treatment selected by default because only DBT is available
- Most common will be generalists providing treatment-as-usual

Dialectical Behavioral Therapy

- Skills training in group and individual sessions
  - Dialectic between acceptance (self-validation) and change
  - Improved management of emotional dysregulation
  - Better communication in environments perceived as invalidating
- Phone coaching
  - Available prior to self-harming behavior
  - Agreement to take suicide off the table
  - ER as back-up
  - Phone coaching often not incorporated in treatments available in the community
- Goal of building a better life encouraged

Good Psychiatric Management

- Psychodynamically-informed supportive psychotherapy
  - Psychodynamics and behavioral approaches built-in
  - Doesn’t require additional training in either
  - Using model of interpersonal hypersensitivity
  - Eclectic, adding in whatever works
- Case management
- Limited psychopharmacology
- Probably should be called Good Clinical Management because the role of medications is limited (can be practiced by psychologists, social workers, mental health counselors)

Good Psychiatric Management

- Case management: life outside of therapy
- Psychoeducation: genetics, prognosis, treatment options
- Work and love as overarching goals (work before love)
- Symptom reduction near-term goal, okay to have goal of determining goals
- Multi-modal: medications, 12-step, family work
- Variable frequency and duration
- Connecting emotions and behavior to interpersonal stressors using the model of interpersonal hypersensitivity

GPM: Interpersonal Hypersensitivity

- The patient's thoughts, feelings, and behaviors are consistently approached using the model of hypersensitivity to interpersonal stressors, which results in a cycle of self states
  - Connectedness
  - Feeling threatened
  - Aloneness
  - Despair

GPM: Interpersonal Hypersensitivity

- Connectedness
  - Fostered by idealization
  - Fragile because of rejection sensitivity
- Feeling threatened
  - Occurs with perceptions of separation, criticism, hostility
  - Leads to devaluation, anxiety, anger, self-injury, help seeking
  - Requires support from others to return to “connectedness”
- Aloneness
  - Results if others withdraw support
  - Leads to dissociation, paranoia, impulsivity, help rejection

GPM: Interpersonal Hypersensitivity

- Despair
  - Characterized by anhedonia, suicidal thoughts and behaviors
  - Possibly requires ER or rescue by others
  - Holding environment allows fragile return to “connectedness”
- Simplified model allows the clinician to collaborate with the patient
  - Examining together typical self states in BPD
  - Attention to alternative ways of thinking and behaviors
  - Goal of promoting support from others
  - Goal of avoiding withdrawal from others
  - Planning for when the ER may be needed, limited phone availability for crises

Treatment Selection in BPD

- Diagnosis
  - Not required for a patient to accept the diagnosis of BPD in any modality
  - Patients might identify more with specific personality factors (rejection sensitivity, mood reactivity, self esteem fragility)
- Contact of prior treaters
  - Not required in GPM or DBT although might be encouraged
  - Required in TFP

Treatment Selection in BPD

- Treatment goals
  - Symptom reduction okay as a treatment goal in DBT
  - GPM is even more flexible because an initial goal can be to develop goals
  - TFP requires at least one specific life goal in work, intimate relationships, friendships, or leisure time activities
  - TFP requires engagement in meaningful productive activity
  - Half-time school or work, can initially be volunteering
  - Some patients will grudgingly accept meaningful productive activity as a requirement for TFP treatment even though they don't personally have it as a treatment goal (they will feel like they are submitting to an unreasonable demand)

Treatment Selection in BPD

- Treatment agreement in TFP
  - Overarching goal of the TFP treatment agreement is limiting destructive or treatment-interfering behaviors
  - More ambitious treatment oriented towards psychological change cannot occur if destructiveness is not limited
  - Without limits on destructiveness, treatments become supportive or crisis-oriented
  - Severity of illness determines rigor of treatment agreement
  - TFP assessment of aggression and superego deficits (antisocial traits) is the most important aid to determining severity of illness

Treatment Selection in BPD

- Primary elements of a treatment agreement in TFP
  - Treatment of comorbid medical and psychiatric disorders
    - Adjunctive treatments required
    - Might be acceptable in GPM or DBT to have an encouragement phase
  - Management of self-destructive behavior
    - Primary patient responsibility
    - Agreement to go the ER if unable to manage self-destructive urges
    - And follow recommendations of the ER and inpatient treatment teams
    - More strict requirements and less inter-session availability than GPM or DBT
  - Engagement in meaningful productive activity
    - Later in treatment in DBT to build a good life
    - Focus of attention in GPM, but not required
    - Required in TFP

Treatment Selection in BPD

- Family meeting
- Available in DBT
  - Family Connections is based on DBT principles adapted for family members
  - Free, online, 8 or 12 weeks
  - www.borderlinepersonalitydisorder.org (also available Family Guidelines)
- Encouraged in GPM
  - Emphasis on psychoeducation, family coaching
- Required in TFP under certain circumstances
  - Required if significant emotional or financial dependence
  - Required if significant antisocial features (to provide reality to treatment)
  - Emphasis on enlisting family support of treatment and reduction of splitting (avoidance of patients turning families against treatment)

Treatment Extending Beyond BPD

- Narcissistic Personality Disorder
  - No clinical trials yet
  - Expert opinion is to adapt treatments developed for BPD
  - DBT, GPM, TFP all have published adaptations
- Higher Level Personality Disorders
- Subthreshold Personality Disorder (DSM-5) aka Personality Difficulty (ICD-11) aka Personality Rigidity (TFP-Extended)
  - DBT in practice given for many problems, often without specific diagnosis
  - GPM advisable if a patient has 3 or more BPD traits
  - TFP-Extended is a manualized adaptation describing use of TFP techniques in more focal areas of difficulty

Ongoing Treatment in BPD

- Long-term psychodynamically-informed clinical management
- Most important aspects of any long-term treatment
  - Structured
  - Flexible
  - Focused on positive change to enhance morale
- Psychodynamic/psychoanalytic clinicians are ideally suited to provide a spectrum of care in BPD and other personality disorders and difficulties
  - Able to manage negative transference
- Can learn GPM relatively easily to guide basic initial care or to inform long-term care: Gunderson Institute, McLean/Harvard, 8 hours online, $35
- Able to use TFP principles to augment their use of psychoanalytic techniques
- Or even pursue full TFP training!

- Thank you!