

## **Psychoanalytic/Psychodynamic Approaches to Personality Disorder**

### **Introduction**

Historically, psychoanalytic thinking played a major role in identifying and defining personality disorders (PDs), in particular, by recognizing PDs as a collection of diagnoses that require a specific clinical approach. From Adolph Stern's (1938) influential description of his work with borderline patients, and the concept of the schizoid personality developed by Ronald Fairbairn (1940/1952) and others (e.g., Guntrip, 1968), personality pathology has acquired—and retained—a core position in psychoanalytic thinking. Psychoanalysis has traditionally been focused on personality features associated with psychopathology, rather than symptoms that arise from and perpetuate psychological problems (Clarkin, Fonagy, & Gabbard, 2010). Now, at a time when psychodynamic treatment is just one part of a large, diverse field of psychological interventions, PDs remains an area of pathology in which psychodynamic thinking is influential and psychodynamic interventions have shown effectiveness (Cristea et al., 2017; Leichsenring & Rabung, 2008).

We will begin this chapter with a brief overview of the psychodynamic approach to PDs. Next, we will describe some of the major contemporary psychodynamic approaches to PDs, their respective models, and the evidence for their effectiveness. Finally, we will describe more recent developments in our thinking in relation to PD, and how connecting this with theoretical developments in the area of a general psychopathology or “p” factor (Caspi et al., 2014) has led us to reconsider our views in relation to the conceptualization of personality disorders and their treatment.

The particular challenges presented by therapeutic work with individuals with PD have required psychoanalysts to reconsider their work in creative ways – for example, the limitations of a drive-focused, intrapsychic model in the context of working with severely disturbed patients contributing to a shift towards a more interpersonal, object-relational and developmental approach. This position of being forced to think differently—in terms of both theory and technique—that inspired Stern’s (1938) paper on what at the time was termed the “borderline group of neuroses,” its original meaning being here on the borderline between neurosis and psychosis. The challenges of comorbidity, complexity, and chronicity associated with PD continue to represent a significant challenge to how clinicians work, and have driven ongoing discussions about the structure of psychopathology (Skodol et al., 2011).

Psychodynamic thinking has made some vital contributions to the ways in which we now understand PD. However, the psychodynamic approach has also had its limitations; indeed, it might be argued that one of the reasons PD has stimulated so much intellectual interest in the psychoanalytic literature lies in the challenges that clinicians have faced when working with people with a diagnosis of PD.

### **Different Psychoanalytic Traditions and Approaches to Personality Disorder**

#### **The Kleinian–Bionian Model**

One of the models of PD that is perhaps most commonly held by psychoanalysts derives from the work of Melanie Klein and Wilfred Bion. In essence, this model posits that personality pathology is driven by the dominance of the *paranoid–schizoid position*, which causes the individual to split objects into good (idealized, loving) and bad (persecutory, frightening, hateful). The model also posits that psychological health depends on the individual being able to retain (with relative stability) the *depressive position*, which is characterized by a more balanced and developmentally mature capacity to recognize and tolerate the presence of both

bad and good together in one object, and to identify and correct one's own tendency to split representations of self and others in an unrealistic and distorting way.

In the classic Kleinian model, the tendency toward the paranoid–schizoid position is considered to be primarily constitutional in origin, reflecting the individual's overwhelming destructive impulses—described as “envy” by Klein (1957)—being turned upon the object, who provides love and sustenance. Bion elaborated this theory further by suggesting that environmental processes might exacerbate this constitutional tendency. For Bion, the primary environmental factor at work was the caregiver's limited capacity for *reverie*, a concept used by Bion (1967) to describe a caregiver's ability to tolerate and contain their child's primitive and often difficult thoughts and feelings, and reflect them back to the child in a contained and manageable form.

In relation to the symptoms and characteristics of PDs, this model proposes that persecutory anxiety—that is, the sense of an overwhelming threat from a bad object—results in a sense of fragmentation and even annihilation of the self. These symptoms are characteristic of severe PD, and are particularly pertinent in the context of recent work suggesting that borderline PD (BPD), which is perhaps most archetypically associated with these symptoms, may capture the core of personality pathology or be representative of all PDs (Sharp et al., 2015). In this model, chronic depression, such as manifests in depressive PD but also in most if not all PDs, is considered to be an outcome of the individual being unable to escape their fear of harming the loved object and thus repressing all aggression, resulting in feelings of self-persecution. Narcissistic pathology is thus considered to be a defense against envy and dependence; here, the individual makes use of the other in highly destructive ways, leading to two possible forms of narcissism: *thin-skinned*, in which the individual demands constant reassurance, and *thick-skinned*, in which the individual presents a hostile, often arrogant and self-isolating stance in relation to others (Rosenfeld, 1971).

The work of the Kleinian school of writers has substantially enriched our understanding of emotional development and psychological functioning, while the work of Bion created a bridge between the two (previously separated) areas of cognitive development and personality pathology. The influence of some of Bion's thinking can be seen in recent mentalizing approaches to PDs (described later in this chapter), for example, with parallels being evident between the notion of the function of reverie (in Bion's thinking) and the role of the caregiver's mirroring in helping the child tolerate and ultimately be able to think about his/her own thoughts and feelings, and then others' (in mentalizing theory). In contrast, there are undoubtedly points of divergence between Kleinian thinking and more contemporary work. One notable example derives from the fact that many Kleinians are skeptical about or even somewhat hostile toward the place of empirical investigation in psychoanalysis, whereas the pragmatic and intellectual value of the pursuit of empirical testing is a driving principle of modern psychodynamic therapies. Furthermore, growing understanding of neuropsychology, the role of genetics in mental health and disorder, and the complexity of gene–environment interactions and epigenetics has left the classical Kleinian model appearing, by contrast, prone to over-specification and excessively causally linear in relation to the links between early experience and psychopathology in later life.

### **The British Object Relations Perspective**

As mentioned in the Introduction, Ronald Fairbairn was one of the early leading psychoanalytic figures in the field of PD. One of the key shifts, which was driven in the first instance by Fairbairn, was a new focus on the individual's need for the other and a connection with the other *per se*, rather than the things (e.g., sustenance, libidinal gratification) provided by others. This represented quite a radical change of emphasis in psychoanalytic thinking from psychic structure to psychic content.

Fairbairn (1952b) proposed that the infant has a primary drive for contact—that is, to create object relations. If this need for intimacy is not adequately met, the intolerable experience of a rejecting or unsatisfying caregiver is defensively split and internalized separate from the main, idealized representation of the caregiver and the self in relation to the caregiver. According to this viewpoint, the co-existence of these incompatible representations—the so-called *schizoid condition*—gives rise to psychological disorder (Fairbairn, 1952b).

One of Fairbairn's major contributions was the suggestion that severe early traumas are stored in memories that are "frozen" or dissociated from a person's central ego or functional self (Fairbairn, 1944). The experience of privation, for example, makes the infant view his/her love as bad and destructive, which in turn causes him/her to withdraw from emotional contact with the outer world, and ultimately creates a highly disturbed experience of external reality. Schizoid personality (Fairbairn, 1940/1952, 1952a) arises out of the baby's feeling that his/her love for the mother will destroy her and that it therefore has to be inhibited, along with all intimacy. The ego is split and neither the other nor the self is perceived as a whole person. These individuals hide their love and protect themselves from the love of others. To this theory, Winnicott (1965a) added the idea of a falseness in self-presentation that becomes truly maladaptive only in the context of an intimate interpersonal relationship: this was where the concept of the "false self" originated. Guntrip (1968) further added that the rejection by a hostile object leads to a "hunger" for objects that at the same time are feared.

Winnicott (1965b) also argued that borderline patients employ a number of the same defenses as psychotic patients. Winnicott (1960) notes that these patients have no sense that others—including the therapist—have lives of their own. Such patients respond with intense anger if their sense of omnipotence is threatened. These observations have been confirmed by

research showing that BPD patients have a specific deficit in mental-state awareness in the context of attachment relationships (Fonagy & Target, 1996).

Winnicott, and object relational formulations more generally, did not completely reject the role of constitutional factors in psychopathology, but they often exclusively emphasized the role of the early environment. Such an emphasis is clearly incompatible with the results of behavioral genetic studies that have since taken place (e.g., Plomin & McGuffin, 2003). By contrast, the Freudian tradition showed greater respect for constitutional factors and the role of genetics in, for example, symptom choice and vulnerability to environmental stress. Research on the genetics of PD has in fact shown that PD is highly heritable (Bornovalova, Hicks, Iacono, & McGue, 2009; Distel et al., 2008; Kendler et al., 2008; Torgersen et al., 2008).

The major weakness of Winnicott's theory—which the entire British object-relations tradition displays—is its potentially somewhat naive reconstruction of infancy in the adult mind, leading to often somewhat metaphorical descriptions that on the one hand are clinically immensely useful, but fail to do justice to the complexity of psychological development. In the face of the evidence (e.g. Rutter, Kim-Cohen, & Maughan, 2006), the argument for a linear development from infancy to adulthood cannot be maintained. In fact, longitudinal studies have suggested that personality is subject to reorganization throughout the complex trajectory of development, based on significant positive and negative influences (Lyons-Ruth & Jacobvitz, 2008; Lyons-Ruth, Yellin, Melnick, & Atwood, 2005).

### **Kohut and Self Psychology**

Heinz Kohut's central idea, developed most fully in the 1970s, was that an essential developmental need for the infant, in the context of their helplessness and lack of physical self-mastery, is the experience of an understanding, supportive caregiver (Kohut, 1971, 1977;

Kohut & Wolf, 1978). Kohut further proposed that this need for understanding—*empathy* was a key term in his writing—persists throughout the lifespan. In the early years of life, the caregiver's support and empathy helps support the development of the child's experience of selfhood. This process of self formation is in the first instance supported by the caregiver treating the child as a self in his/her own right, by identifying and recognizing the child's affects and helping the child to tolerate and think about them. Kohut describes the caregiver as acting as a *selfobject*—the person in the environment who performs functions for the self. The caregiver begins this process with the infant by providing empathic and mirroring responses. The child's experience of having his/her affects integrated and presented back to him/her in this way allows the child to achieve a healthy developmental stage characterized by a sense of their own grandiosity, which in turn acts as a defense against vulnerability. The infant's normal stage of "grandiosity" becomes, in healthy development, integrated with more connected, realistic ambitions, via the idealized identification of a selfobject. The self-cohesion provided by the selfobject's empathic and supportive care enables the child to develop the capacity for self-regulation and a stable sense of self esteem.

In Kohut's model, psychopathology arises from the fear of losing one's sense of who one is. Deficiencies in the facilitating experiences provided by the selfobject can lead to a primary psychic defect and an inadequately developed sense of self. According to this model, PD is the result of a weakened sense of self that is susceptible to temporary fragmentation. Kohut was particularly interested in narcissistic PD, and his thinking in relation to PDs initially focused on narcissistic personality, which he interpreted as a developmental arrest at the stage of the grandiose exhibitionistic self, which has not been tempered by integrative and mirroring responses from the caregiver. This failure on the part of the caregiver causes an arrest in the movement from the grandiose exhibitionistic self to realistic ambition, and from the idealization of the parental imago to the formation of a healthier ego ideal. Repression of

the grandiose self leads, according to Kohut, to low self-esteem, vague depression, and lack of initiative (Rosenfeld's (1971) "thin-skinned" narcissism). When splitting dominates, the grandiose self manifests as boastfulness, arrogance, and a dismissive attitude that is out of touch with reality (Rosenfeld's "thick-skinned" narcissism). Fundamentally, both forms of narcissism are characterized by low self-esteem, hypersensitivity to criticism, and the need to continue to be mirrored. According to this theory, violent behavior by narcissistic individuals is triggered by a threat to the self that is experienced as a sense of shame, which generates an overwhelming need to inflict injury on the shaming person and repair the narcissistic injury (Gilligan, 1997). In this self-psychology model, BPD is conceptualized as the outcome of an incapacity to retain access psychologically to soothing selfobjects; this creates an inner emptiness and a failure of integrated self-organization that results in an overwhelming annihilative panic when faced with the possibility of a threat to a relationship.

### **The Structural Object Relations Model**

Otto Kernberg has been a highly influential thinker in the field of personality disorder. His initial contribution was to succeed in integrating the ego psychology and object relations traditions (see Kernberg, 1975, 1980a, 1980b, 1984, 1992). Kernberg's theory positions affect as the primary motivational system. Accordingly, the representation of the relationship between self and object is driven by an "engine" of associated affects (Kernberg, 1982). This triad of self, object, and affect (which Kernberg termed an *object relations unit or dyad*) constitutes the basic building blocks of one's personality.

Kernberg delineated a developmental trajectory that was strongly influenced by the work of Jacobson and Mahler (Jacobson, 1953a, 1953b; Mahler, Pine, & Bergman, 1975), but with less rigidly prescribed timing. According to this trajectory, in the very first stage (named "infantile autism", taking place in the first month or so of life) the infant does not differentiate between the self and the object. During the second stage ("symbiosis"), good



and bad object representations are split by the ego to protect good images from the destructive power of bad images. In the third year of life, the polarized good and bad representations slowly become more integrated “separation-individuation”, enabling the formation of total object representations and self-representations, which is the fourth stage – “object constancy” (Kernberg, 1980b). If this integration fails, splitting remains the principal mechanism of defense.

In PD, split, or part-object relations are formed under the impact of diffuse and overwhelming affective states. These affects activate persecutory relations between the self and object. From this perspective, BPD, for example, is characterized by: (1) ego weakness (poor affect tolerance, impulse control, and little sublimatory capacity); (2) primitive defenses, including splitting; (3) identity diffusion; (4) intact reality testing, but a propensity to shift toward primary process thinking; and (5) pathological internalized object relations. Influenced by Kleinian theory, Kernberg relates these features to the intensity of destructive and aggressive affects and the relative weakness of the ego structures available to deal with them.

Projective identification—which is pervasive in BPD—is seen as the by-product of an absence of differentiation between self and object. Projective identification is seen as resulting from massive primitive denial, ensuring that an individual can ignore his/her good feelings towards the object, leaving bad feelings to dominate his/her consciousness. This gives rise to the extreme and repeated oscillation between contradictory self concepts—as, for example, victim or victimizer, dominant or submissive—that is characteristic of BPD (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989). Transient psychotic episodes can occur because self and object representations are readily fused; however, because reality testing remains adequate, these episodes do not persist. Self-destructiveness, self-injurious behavior, and suicidal gestures are thought to coincide with intense phases of rage against the

object (Kernberg, 1987). Moreover, these gestures can establish control over the individual's environment because they provoke feelings of guilt. Self-injury is also seen as protecting the individual from identity diffusion.

In Kernberg's model, people with BPD have not achieved the developmental capacity to integrate the good and bad self and object images into a single representation. Kernberg leaves open to question the reasons why an individual may not achieve this stage; his model does not rely on a simple environmental explanation centering around suboptimal early experiences. Kernberg's thinking is thus in agreement with emerging evidence about the powerful role of genetic factors in BPD. There are other ways in which Kernberg's work has a richness and openness that keeps it from being superseded by contemporary developments. One key element—which differentiates Kernberg's work from the Kleinian background from which it has emerged—is his engagement with empiricism: Kernberg's commitment to research has rendered both his theory and his therapeutic techniques testable. The development of a systematic treatment approach together with his colleagues based on his views, transference-focused psychotherapy (TFP; described later in this chapter), has involved translating object relations theory into a clinical practice that is realistic and testable.

We would also suggest that Kernberg's (1975) designation of borderline personality organization (BPO) constitutes a creative response to the clinical dilemmas presented by the failure of PDs, or of traditional Axis I diagnoses, to remain in their categorical "boxes" in the lived experience of psychopathology. The BPO is characterized by identity diffusion caused by "the failure of psychological integration resulting from the predominance of aggressive internalized object relations over idealized ones" (Kernberg, Yeomans, Clarkin, & Levy, 2008, p. 603) and can be present in PDs, notably narcissistic and antisocial PD (particularly in their more severe forms), as well as in some forms of depression. As mentioned above, a recent study has suggested that BPD features may represent the core of personality pathology

(Sharp et al., 2015), the implications of which – that BPD criteria may be associated with a general psychopathology severity factor – are intriguingly consistent with Kernberg’s suggestion that BPO represents more than the narrow diagnostic category of BPD (Kernberg, 1967).

### **The Interpersonal–Relational Approach**

The interpersonal–relational approach represents an area in which a psychoanalytic contribution to PD has developed more recently. This approach has roots in the interpersonal psychiatry school of Harry Stack Sullivan (1953), in particular, the view that subjectivity is intrinsically interpersonal (Mitchell, 1988). In this respect, there is also an overlap with the interpersonalist emphasis of Kohut’s self psychology, discussed earlier (Kohut, 1977).

Another area where interpersonal–relational and the object relations schools differ is that the interpersonalist approach regards pathology as being embedded in relational matrixes, whereas object relations tends to understand pathology in terms of an individual’s developmental arrest.

According to the interpersonal model, the purpose of therapy is to help the patient develop a more richly varied relational world (Mitchell, 1991). Because the interpersonal–relational approach focuses on interpersonal patterns rather than psychiatric nosology, its formulations tend to avoid labels such as “depression,” “personality disorder,” or “narcissism”. The individual is seen not as having problems, but as having problematic *relationships*. From this point of view, diagnostic labels reify interpersonal problems and would take attention away from a therapeutic focus on the individual’s relationship difficulties (e.g., Fairfield, Layton, & Stack, 2002).

### **Mentalizing Theory**

A more recent psychoanalytic approach has emerged out of the confluence of attachment theory and research on mentalizing and, more recently, contemporary evolutionary thought. *Mentalizing* refers to one's understanding of the behavior of both oneself and others in terms of thoughts, feelings, wishes, and desires (Bateman & Fonagy, 2016). From this perspective, mental disorders in general can be viewed as the mind misinterpreting its own experience of itself, and, by extension, its experience of others (Bateman & Fonagy, 2010).

The mentalizing model was first developed in the framework of a large research study, which found that, while the security of infant attachment was strongly predicted by the parents' security of attachment during pregnancy (Fonagy, Steele, Steele, Moran, & Higgitt, 1991), it was predicted even more strongly by the parents' capacity to understand their childhood relationships with their own parents in terms of states of mind, which can be best described as mentalizing or reflective functioning (Fonagy et al., 1991). This work began a program of empirical research, treatment development, and theoretical development focused on the concept of mentalizing, which was postulated to emerge in the context of early attachment relationships, as a fundamental determinant of self-organization and affect regulation.

The mentalizing approach to BPD is fundamentally developmental. It focuses on attachment disruptions and related impairments in mentalizing or the capacity to develop second-order representations (i.e., representations of representations). The theory of mentalizing postulates that one's understanding of others depends on whether one's own mental states were adequately understood by caring, attentive, non-threatening adults in early life. Problems with affect regulation, attentional control, and self-control stemming from dysfunctional attachment relationships (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004;

Lyons-Ruth et al., 2005; Sroufe, Egeland, Carlson, & Collins, 2005) are thus thought to be mediated via a failure to develop a robust capacity to mentalize (Bateman & Fonagy, 2010).

This is not a straightforwardly environmental position; rather, the interaction between genetic predisposition and early (and later) influences on the development of the capacity to mentalize is thought to be of key importance in the development of BPD (Fonagy & Luyten, 2016). We therefore seek to situate these ideas within a broader developmental approach that emphasizes the elements of interaction and diathesis–stress that are implicated in the emergence of BPD.

In recent years, proponents of mentalizing theory have taken the argument a step further to incorporate another important function of attachment relationships and, later on, the broader sociocultural environment. This is the development of *epistemic trust*, that is, trust in the authenticity and personal relevance of interpersonally transmitted knowledge. Epistemic trust enables social learning and salutogenesis (the capacity to benefit from positive social input) in an ever-changing social and cultural context (Fonagy, Luyten, & Allison, 2015). This thinking is largely based on Csibra and Gergely's (2009) theory of *natural pedagogy*. Human beings are faced with a major “learnability” problem: they are born into a world that is filled with objects and customs whose function or use is *epistemically opaque* (i.e., cannot easily be deduced from their appearance).

Humans have evolved to both teach and learn new and relevant cultural information rapidly. Human communication is specifically adapted to allow the transmission of epistemically opaque information; the communication of such knowledge is enabled by an epistemically trusting relationship. *Epistemic trust* allows the recipient of information being conveyed to them to relax their natural *epistemic vigilance*—a phenomenon that is self-protective and naturally occurring because it is not in anyone's interest to believe everything

they are told indiscriminately. Relaxation of epistemic vigilance allows an individual to accept that *what they are being told matters to them* (Sperber et al., 2010).

These views do not diminish the importance of attachment, but place theories concerning the role of attachment in a somewhat different perspective. In terms of psychopathology, we suggest that the most significant implication of the developmental triad of attachment, mentalizing, and epistemic trust lies in the consequences of a breakdown in epistemic trust. We suggest that many, if not all, types of psychopathology might be characterized by temporary or permanent disruption of epistemic trust and the social learning process it enables. It is here that attachment processes may be crucial.

An infant whose channels for learning about the social world have been disrupted—that is, one whose social experiences with his/her caregivers have led to a breakdown in epistemic trust—is left in a state of uncertainty and permanent epistemic vigilance. All humans seek social knowledge, but when such reassurance and input is sought from others, the content of their communication may be rejected, its meaning might be misunderstood, or it may be (mis)interpreted as having hostile intent. From this perspective, many forms of mental disorder might be considered manifestations of failures of social communication arising from epistemic mistrust, epistemic hypervigilance, or outright *epistemic freezing*—a complete inability to trust others as a source of knowledge about the world, which may be characteristic of many individuals with marked histories of trauma and personality problems. For example, someone who was traumatized in childhood has little reason to trust others and will reject information from others that does not fit with their pre-existing beliefs. Therapists may think of such people as “hard to reach,” but they are simply showing an adaptation to a social environment in which information from attachment figures was likely to be misleading or actively intended to be damaging. Hence, from this perspective, personality disorders are

not seen as disorders of personality, but as understandable adaptations to the environment, even if they ultimately are counterproductive in terms of the functioning of the individual.

What is avoided in MBT is the use of complex descriptions of mental states and behaviors that go beyond the patient's ability to process while in states of high arousal. This cautious approach to transference interpretation in MBT underlines a further aspect of treatment, namely, the level of training required to deliver a treatment effectively without iatrogenic effects. Dynamic therapies have often been criticized for their complexity and difficulty to implement well without a long period of training. MBT was developed as a research-based treatment to be implemented by generic mental health professionals, and this may account for its perhaps over-cautious approach. MBT is concerned to avoid the possible harmful effects of overzealous and clumsy transference interpretation. In other words, transference interpretation is a complex technique that is not easily learned and may specifically risk harm in patients with BPD if used inappropriately. Three days' basic training is provided and supervision is offered in the workplace as practitioners see patients for treatment. Current results suggest that reasonable outcomes may be achievable within this framework of mental health services without lengthy specialist training. This supports the general utility of MBT.

### **Contemporary Psychodynamic Treatments ``**

There is a growing evidence for a range of contemporary psychodynamic treatments (for a review, see Leichsenring et al., 2015). Among the most researched are Transference-Focused Therapy, Mentalization-Based Therapy and General Psychiatric Management, which we discuss here.

### **Transference-Focused Psychotherapy**

Transference-focused psychotherapy (TFP) was developed within an object relations theoretical framework of borderline pathology. The conceptualization of the pathology in TFP is not just based on the specific criteria of *DSM-III* (and more recent editions of the *DSM*) but more broadly on the concept of BPO, with major structural deficits in representations of self and others and the use of primitive defenses such as splitting (as described earlier in this chapter). The basic assumption and starting point of TFP for BPD is that typical self-object relations are activated in the therapeutic relationship. These can then be subsequently worked-through using clarification, confrontation and interpretation, particularly of the transference (hence the name of this treatment). The focus is specifically on the split internal representations of self and others that are typical of BPD patients. For instance, BPD patients often mentally represent others as either persecutors or idealized rescuers, and their self representation is characterized by marked identity diffusion.

Treatment is focused on the patient's present life rather than the past. The goals of treatment are to reduce harmful actions by the patient and to develop a therapeutic relationship in which the patient can come to reflect on his/her active and reactive perceptions of self and others, including within the relationship with the therapist and with important others currently in the patient's life. Techniques of clarification, confrontation, and interpretation in the here-and-now are used to expand the patient's awareness of his/her conceptions of self and others, especially in "hot," conflictual situations when affect dysregulation is strong. The sequence of clarification, confrontation, and interpretation aims to provide a context in which the patient does not simply continue with his/her incoherent, contradictory sense of self and others, but can reflect rather than react, and start to reappraise dominant themes of self-other situations.



TFP is a manualized intervention (Clarkin, Yeomans, & Kernberg, 2006) that was first developed as a highly structured, twice-weekly individual treatment for patients with BPD. More recently, modified versions of TFP have been developed for work with patients with narcissistic pathology and patients with more severe personality pathology (Yeomans & Diamond, 2010).

The basic assumption and starting point of TFP for BPD is that typical self–object relations are activated in the therapeutic relationship. These can subsequently be worked through using a sequence of clarification, confrontation, and interpretation—particularly interpretation of the transference (hence the name of this treatment). The focus is specifically on the split internal representations of self and others typically held by individuals with BPD. For instance, BPD patients often mentally represent others as either persecutors or idealized rescuers, and their self-representation is characterized by marked identity diffusion. Hence, in TFP the focus is on interpreting the content of mental representations.

TFP typically evolves through a series of stages. Initially, the focus is on contract setting including agreement about boundaries of treatment and the role of the clinician in managing self-destructive behaviors, and making an initial evaluation of the patient. These initial steps provide a secure base from which to further explore the patient’s dominant object relational patterns. Next, these dominant object relational patterns are investigated in detail through the use of clarification, confrontation, and interpretation. This stage of treatment focuses on how self–object patterns are activated in the transference relationship. Gradually, these self–object patterns are clarified, and the patient is increasingly confronted with the self–object poles, typical of BPD patients, that are lived out in the transference relationship (e.g., victim and aggressor), and their oscillations between these poles—and this oscillation is linked to their typical patterns of relating to others. These relational patterns are then connected to the patient’s developmental history in a way that explores the potential

defensive functions of their self–object representations. This process is thought to decrease the need for splitting, omnipotent control, and projective identification; to lead to more differentiated and integrated representations of self and other; and to improve reflective functioning (i.e., mentalizing) and affect regulation.

The therapeutic stance in TFP is more active than in “traditional” psychoanalytic treatments, although there is an emphasis on technical neutrality and the use of the countertransference to trace typical self–object dyads. As an example, if the therapist feels terrorized by the patient’s relentless criticism of him/her, he/she uses this feeling in an attempt to clarify, confront, and/or interpret the two poles of the underlying self–object dyad and its defensive functions. The patient might “terrorize” the therapist (who then feels as if he/she is the victim of a relentless perpetrator) because the patient fears that the therapist is bored with him/her and therefore wants to end the treatment. By becoming a perpetrator out of fear of becoming a victim, the patient reverses the roles: Instead of being a victim, he/she becomes a perpetrator. In the later and more advanced stages of treatment, the therapist might also interpret the patient’s underlying but disavowed wish to be cared for by a perfect, idealized caregiver, a key feature of TFP.

### ***Evidence Base***

There is a growing evidence base for the effectiveness of TFP. A 1-year randomized clinical trial (RCT) with a sample of 90 individuals with BPD compared the effectiveness of TFP, dialectical behavior therapy (DBT), and psychodynamic supportive therapy (PST).

Significant improvements in anxiety, depression, global functioning, and social adjustment were observed for each treatment group. In addition, TFP and DBT were associated with significant reductions in suicidality, and TFP and SPT were associated with reductions in impulsivity (Clarkin, Levy, Lenzenweger, & Kernberg, 2007). This study found that TFP

alone was associated with significant reductions in irritability and verbal and direct assault, and with positive changes in levels of reflective functioning and attachment style (Levy et al., 2006).

The effectiveness of TFP as a treatment for BPD was further evaluated in a comparison with schema-focused therapy in a 3-year RCT. In this study, which had 88 participants, TFP was associated with improvements across all domains assessed, although the dropout rate was higher for TFP, and SFT was superior to TFP with respect to reduction in BPD manifestations, general psychopathologic dysfunction, and change in SFT/TFP personality concepts (Giesen-Bloo et al., 2006). A more recent study of TFP versus treatment by experienced community psychotherapists, with a sample of 104 women with BPD, found that TFP was significantly more effective in terms of BPD symptoms, psychosocial functioning, personality organization, rates of suicide attempts, and psychiatric in-patient admissions. TFP also had a significantly lower participant dropout rate (Doering et al., 2010). In the TFP condition, there were significant improvements in mentalizing, and improvements in reflective function were significantly correlated with improvements in personality organization (Fischer-Kern et al., 2015).

### **Mentalization-Based Treatment**

Mentalization-based treatment (MBT) is, essentially, a therapy that places mentalizing processes at the center of the therapy process, rather than directly focusing on object representations. At the core of MBT is the idea that the therapy works through the therapist establishing an enduring attachment relationship with the patient, while continuously stimulating mentalizing in the patient. The objective is for the patient to discover more about how they think and feel about themselves and others, how these thoughts and feelings influence their behavior, and how distortions in understanding themselves and others lead to

maladaptive actions—albeit ones intended to maintain stability and manage incomprehensible feelings.

MBT was originally developed in the 1990s for the treatment of adults with BPD in a partial (day) hospital setting (Bateman & Fonagy, 1999). MBT has subsequently evolved into a more widely applied approach that has been used in work with patients with a range of PDs (most notably antisocial PD) and other mental health disorders (e.g., eating disorders, depression) in a range of treatment settings, and with adolescents as well as adults. As such, a program of MBT does not necessarily always have the same shape. However, the structure of treatment is broadly replicated across the different contexts in which it is applied. The original outpatient program involved patients attending 5 days per week for a maximum period of 18–24 months (Bateman, 2005; Bateman & Fonagy, 1999). For the treatment of PDs, MBT now most commonly consists of an 18-month outpatient program comprising weekly individual sessions of 50 minutes and weekly group sessions of 75 minutes (Bateman & Fonagy, 2009).

The structure of MBT for PDs normally consists of three phases. The first comprises an assessment of the patient's mentalizing capacities and personality function, contracting and engaging the patient in treatment, and identifying any problems that might interfere with treatment. Specific elements of this phase include giving a diagnosis, providing psychoeducation, establishing a hierarchy of therapeutic aims, stabilizing the patient's social and behavioral problems, reviewing the patient's medication and defining a pathway of actions to be taken in the event of a crisis.

The second phase consists initially of individual therapy, followed by the introduction of group therapy alongside the individual sessions. There is a fairly firm insistence in MBT that consistent attendance of both the individual and group sessions is necessary in order for the patient to be able to continue on the program, and that simply attending for individual

treatment (as is most often the case for patients who do not attend all of their sessions) is not an option. During this second phase of the program, the main work of seeking to develop more robust mentalizing skills is undertaken.

The final phase of MBT, which normally begins at 12 months of treatment when there is a further 6 months remaining, involves preparing the patient for the end of treatment. Typically, at this point, many of the most obvious and worrying aspects of BPD symptomatology, such as impulsive behavior and affective instability, have diminished. However, patients may still struggle with interpersonal and social/vocational functioning, and may experience considerable difficulty in their general functioning and ability to form constructive relationships. Therefore, assuming that symptomatic and behavioral problems are well controlled, this final phase focuses on the interpersonal and social aspects of functioning. The final phase must also involve consideration of the end of treatment and the feelings of separation and loss that might be associated with such an ending. This is not just about facilitating the end of treatment; working on these issues may be of great value in consolidating the gains made in therapy. A final component of this phase is to collaboratively develop with the patient a follow-up treatment plan. There is no prescribed follow-up treatment in MBT, but this plan may, depending on the patient's needs and preferences, consist of couples therapy, group therapy, outpatient maintenance treatment, or educational/vocational counseling connected with returning to education or work.

The fundamental aim of MBT is to re-establish mentalizing when it is lost and maintain mentalizing when it is present. The MBT clinician focuses on the patient's subjective sense of self. To do so, they need to (1) identify and work with the patient's mentalizing capacities, (2) represent internal states in themselves and in the patient, (3) focus on these internal states, and (4) sustain this focus in the face of constant challenges from the patient over a significant period of time. To achieve this level of focus, mentalizing

techniques need to be (1) offered in the context of an attachment relationship, (2) consistently applied over time, and (3) used to reinforce the therapist's capacity to retain mental closeness with the patient.

In agreement with the mentalization-based theoretical model of BPD described earlier, MBT is aimed at gently expanding the patient's mentalizing capacities while paying attention to the stability of his/her sense of self, and managing the interpersonal intimacy between therapist and patient and helping the patient maintain a level of arousal that ensures his/her engagement in the process. The well managed (i.e., not too intense and not too detached) attachment relationship between the patient and therapist optimizes the level of arousal. In MBT, the aim and the actual outcome of an intervention on the patient's immediate emotional and cognitive state is thought to be more important than the insight gained from interpreting particular defenses or understanding aspects of the transference relationship, although of course such insights emerge during treatment. The therapist assesses and attends to breaks in mentalizing, which are assumed to represent a break in the patient's continuity of experience of their mind. When these occur, the therapist's task is to "rewind" to the moment before the break in subjective continuity occurred. The therapist then explores the current emotional context in the session by identifying the momentary affective state between patient and therapist. Identifying the therapist's own contribution to the break in mentalizing—and showing humility in relation to this and taking responsibility for it—is often key.

As should be clear, the focus is on the process rather than the content. At the heart of MBT practice is the concept of the therapist's *mentalizing stance*. Typically, the mentalizing stance includes the following components: (1) humility deriving from a sense of "not knowing"; (2) patience in taking time to identify differences in perspectives; (3) explicit legitimizing and accepting of different perspectives; (4) active questioning of the patient

about his/her experience, asking for detailed descriptions of experience (“what” questions) rather than explanations (“why” questions); and (5) careful eschewing of the need to “help” the patient to understand what makes no sense (e.g., by saying explicitly that something is unclear). This last aspect in particular sets MBT apart from predominantly insight-oriented therapies. The MBT therapist is there to help the patient learn about the complexities of the patient’s thoughts and feelings about him/herself and others, how that relates to his/her responses, and how “errors” in understanding him/herself and others lead to actions. It is not for the therapist to “tell” the patient about how he/she feels, what he/she thinks, how he/she should behave, or what the underlying conscious or unconscious reasons for his/her difficulties are.

The key features that facilitate the therapeutic aim of MBT—the recovery of more robust mentalizing—may be seen in terms of the following structural properties of the treatment: (1) an extensive effort to maintain engagement in treatment (validation in conjunction with emphasis on the need to address behaviors that interfere with therapy such as alcohol or substance abuse or self harm); (2) utilization of a model of pathology that is explained to the patient; (3) an active stance by the therapist, that is, an explicit intent to validate and demonstrate empathy, generate a strong attachment relationship, and create epistemic trust (a sense in the patient that the therapist’s views of the world can be trusted as relevant to the patient); (4) a focus on emotion processing and the connection between actions and feelings (e.g., how suicidal wishes link to feelings of abandonment); (5) a genuine inquiry into patients’ mental states (behavioral analysis, clarification, confrontation); (6) adoption of a structure of treatment that suggests increased activity, proactivity, and self-agency (avoiding the use of an expert stance, and encouraging collaboration with the patient and a “sit side-by-side” therapeutic attitude); (7) acceptance of a structure for the nature of the relationship between patient and therapist is defined that is robust to distortions by the

patient's emotional dysregulation (i.e., what is crucial is that the therapist is able to think without having to withdraw from exchanges or fall back on "mindless" rules established by prior contract or precedent); (8) therapeutic work is supported by the structure provided by a manual, and adherence to that structure is sustained by supervision; (9) the therapist and the entire therapeutic milieu reflect commitment to the mentalization-based approach and underscore the importance the therapist attaches to the patient's thoughts and feelings. Enabling mentalizing and developing epistemic trust and the capacity for salutogenesis that results from the restoration of these capacities, is perhaps a component of other effective therapies for BPD, as we shall discuss more fully below.

### ***Evidence Base***

There is an ample evidence base for MBT, beginning with an RCT of an 18-month program for 44 patients with BPD in a partial hospital setting (Bateman & Fonagy, 1999, 2001), which found significant and enduring changes in mood states and interpersonal functioning. Outcome measures included frequency of suicide attempts and acts of self-injury, number and duration of in-patient admissions, service use, and self-reported depression, anxiety, general symptom distress, interpersonal function, and social adjustment. Relative to treatment as usual (TAU), the benefits were large, with a number needed to treat of approximately two. The benefits were also observed to increase during the follow-up period of 18 months. The day hospital MBT program has been investigated in a series of outcome studies, culminating in an 8-year follow-up study (Bateman & Fonagy, 2008), the longest follow-up of treatment for BPD conducted to date. Compared with TAU, MBT was associated with fewer suicide attempts, emergency room visits, in-patient admissions, less medication and outpatient treatment utilization, and lower impulsivity. At follow-up, far fewer patients in the MBT group than the TAU group met criteria for BPD (13% vs. 87%). In addition to symptomatic



improvement, patients in the MBT group showed greater improvement in interpersonal and occupational functioning.

Similarly in an RCT involving 134 patients, an intensive outpatient MBT program proved more effective than structured clinical management for BPD at the end of the 18-month treatment period (Bateman & Fonagy, 2009), particularly for patients with more than two PD diagnoses (Bateman & Fonagy, 2013). Compared with TAU, the outpatient treatment resulted in lower rates of suicidal behavior and non-suicidal self-injury as well as fewer hospitalizations. The MBT group also showed improved social adjustment, coupled with diminished depression, symptom distress, and interpersonal distress.

Elsewhere, an RCT in Denmark investigating the efficacy of MBT versus a less intensive, manualized supportive group therapy program in patients diagnosed with BPD found that MBT was superior to the comparison treatment on clinician-rated Global Assessment of Functioning (Jørgensen et al., 2013). These results were sustained 18 months later in a naturalistic follow-up (Jørgensen et al., 2014). In another study from Denmark (Petersen et al., 2010), a cohort of patients treated with partial hospitalization followed by group MBT showed significant improvements after treatment of on average 2 years on a range of measures, including Global Assessment of Functioning, hospitalizations, and vocational status, with further improvement at 2-year follow-up.

A naturalistic study by Bales et al. (2012) in the Netherlands investigated the effectiveness of an 18-month manualized program of MBT in 45 patients with severe BPD. Treatment was associated with significant positive change in symptom distress, social and interpersonal functioning, and personality pathology and functioning, with moderate to large effect sizes. However, this study is limited by the lack of a control group. Another study by the same group (Bales et al., 2015) used propensity score matching to ascertain the best matches for 29 MBT patients from within a larger (n=175) group who received other

specialized psychotherapeutic treatments. Generally moderate improvement across all domains was found in the group receiving other psychotherapeutic treatment, while effect sizes were consistently large for MBT, with Cohen's  $d$  for reduction in psychiatric symptoms of  $-1.06$  and  $-1.42$  at 18 and 36 months, respectively, and Cohen's  $d$ s ranging from  $0.81$  to  $2.08$  for improvement in areas of personality functioning. However, between-condition differences in effects should be viewed with caution because of the non-randomized study design and the variations in treatment dose received by participants.

More recently, research has been undertaken to assess the effectiveness of MBT in different diagnostic contexts. An RCT in the UK (Robinson et al., 2016) compared MBT for eating disorders (MBT-ED) against specialist supportive clinical management for patients with eating disorders and symptoms of BPD. There was a high dropout rate in this study (only 15 of the 68 participants eligible for randomization (22%) completed the 18-month follow-up), making results difficult to interpret, but MBT-ED was associated with greater reductions in Shape Concern and Weight Concern on the Eating Disorder Examination, relative to the control treatment. Another recent RCT of MBT for individuals with comorbid antisocial PD and BPD found that MBT was effective in reducing anger, hostility, paranoia, and frequency of self-injurious behavior and suicide attempts, and brought about improvements in negative mood, general psychiatric symptoms, interpersonal problems, and social adjustment (Bateman, O'Connell, Lorenzini, Gardner, & Fonagy, 2016).

### **Conclusion: Going Forward**

Recent meta-analyses have suggested that there are now several forms of psychological therapy for BPD and other types of PDs that are of some value (Cristea et al., 2017; Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Stoffers et al., 2012). What is more, these meta-analyses have suggested that there is little substantial difference in effectiveness

between specialized and non-specialized treatment approaches, at least in the treatment of BPD (Cristea et al., 2017). Meta-analytic findings so far thus clearly suggest that there is no one single treatment method—psychodynamic or otherwise—that can claim exclusive therapeutic potency.

These findings are congruent with the recent emphasis in psychoanalytic approaches to PD on epistemic trust—that psychopathology is a form of disordered social cognition, perpetuated by the obstacles to communication that these social cognitive difficulties create. What is called “psychotherapy” may simply be, from this perspective, a recent variant of an activity that has been part of the repertoire of communicative behavior for a very long time—turning to other people’s thoughts to help us make sense of our own. For individuals with PDs, the loss of epistemic trust is a powerful obstacle to this process of beneficially accessing other people’s minds in order to reinstate the capacity to tolerate and understand one’s own mind.

This may lead to a new view on the mechanisms of change in the treatment of individuals with personality problems, and particularly with regard to their so-called “hard-to-reach” or “treatment-resistant” character (Fonagy et al., 2015).

Effective modes of psychological treatment for PDs that now exist all involve, in our opinion, three distinct processes of communication that cumulatively render them effective (Fonagy & Luyten, 2016):

- *Communication System 1: The teaching and learning of content*

The different therapeutic schools belong to this system. They may be effective primarily because they involve the therapist conveying to the patient a model for understanding the mind that the patient can understand, as it includes a convincing recognition and identification of his/her own state. This feeling of being recognized and understood may in itself lower the patient’s epistemic vigilance.

- *Communication System 2: The re-emergence of robust mentalizing*

When the patient is once again open to social communication in contexts that had previously been marred by epistemic hypervigilance, he/she begins to show increased interest in the therapist's mind and the therapist's use of thoughts and feelings, which stimulates and strengthens the patient's capacity for mentalizing. Improvements in mentalizing or social cognition may thus be a common factor in different interventions.

- *Communication System 3: The re-emergence of social learning*

The relaxation of the patient's epistemic hypervigilance achieved via the first two systems of communication enables the patient to become more open to social learning. This allows the patient to apply his/her new mentalizing and communicative capabilities to wider social encounters, outside the consulting room. This final part of the process depends upon the patient having a sufficiently benign social environment to allow him/her to gain the necessary experiences to validate and bolster his/her improved mentalizing, and to continue to facilitate the relaxation of epistemic mistrust, in the wider social world.

These three systems of communication, we suggest, provide a framework for investigating the effectiveness of psychotherapies. Beyond the therapeutic treatment itself, the model also directs attention to the social environment, and to interventions that may directly target environmental factors that could contribute to the origin and maintenance of psychopathology, and those factors that could have the potential to support recovery and the patient's capacity to benefit from benign aspects of his/her environment. This widening of the view of what determines therapeutic outcomes to include the social environment beyond the consulting room represents a challenge to the potential omnipotence of all psychological

therapies, but perhaps more archetypally, to the therapeutic primacy of the psychoanalytic relationship.

What role do these speculations leave for the psychoanalytic approach in particular? We suggest that its future may lie in helping us make sense of how we think about PD, how we conceptualize psychopathology, and what it is that makes treatment effective. This is not simply an intellectual exercise: traditional diagnostic categories, and the treatments accordingly assigned to them, are increasingly viewed as failing to recognize the complexity of mental health presentations throughout the life span (Skodol et al., 2011). These issues are particularly pertinent in the field of PD, in which recurrence, comorbidity, and complexity are very common (O'Connor, 2005; O'Connor & Dyce, 1998). The psychoanalytic approach encompasses a uniquely sophisticated model of the mind, which, if applied with intellectual openness rather than rigid orthodoxy, can tolerate the categorical complexity of personality-disordered states.

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