From Psychiatry & Psychotherapy Podcast hosted by David M. Puder, M.D.

Similarities & Differences in Evidence-Based Therapies for the Treatment of Personality Disorders

Robert E. Feinstein, M.D.
Clinical Professor of Psychiatry Zucker Hofstra/Northwell
Feinster@RobFeinsteinMD.com (303) 815-6934
Website: www.RobFeinsteinMD.com

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Key Points on Treatment of Personality Disorders

- All Evidence-Based Psychotherapies (EBPs) suggest genetic & adverse/traumatic or invalidating early-life experiences and/or environment are responsible for the development of a personality disorder

- 7 themes commonly described by 6 EBPs to treat personality disorders:

  1) *Structure the Treatment: Set a Treatment Framework*

     i. Use a safe & consistent space where the psychotherapy work can proceed
     ii. Describe specific roles of patient & therapist
     iii. Determine & set the goal(s) & problems to be addressed
     iv. Begin to define the patient's life choices (e.g., work, school, marriage, spirituality, etc.)
     v. Set treatment boundaries (e.g., confine psychotherapy to the sessions; manage phone calls & medications; discuss confidentiality; contact with others; etc.)
     vi. Prioritize treatment focus on suicidal or homicidal threats over other maladaptive behaviors
     vii. Address acting out (e.g., substance use, eating disorders, gambling, etc.)
     viii. Address other threats to the therapy (e.g., not paying fees, missing sessions, travel, etc.)
     ix. Address patient's lying, withholding, or omitting information
     x. Address patient's avoidance of meaningful subjects & emotional topics
     xi. Make sure there is no secondary gain from the psychotherapy
     xii. Allow the therapy to anchor the patient's life

  2) *Therapist Should Increase Their Capacity for Self-Awareness*

     i. Practice mindfulness
     ii. Mentalize -reflect on one's own intentions, thoughts, feelings & behaviors; practice accurately reading the meanings, intentions, thoughts & feelings of others

iii Go for psychotherapy

3) Manage Countertransference, Counter-Therapeutic Reactions, Therapist Interfering Behaviors

i. Use reflection exercises; set limits on patient behaviors; seek supervision, or get into psychotherapy

4) Be Responsive or Adapt Treatment

i. Stick to one evidence-based psychotherapy at a time....to start
ii. Change the kind of psychotherapy you can offered (if at an impasse)
iii. Judiciously borrow some interventions from other forms of psychotherapy (if stuck)
iv. Use best evidence-based psychotherapy with each patient, for current problem or context & at the right point in time

5) Repair the Therapeutic Alliance

i. Treating patients with PDs can bring up alliance disturbances, evoking your feelings (e.g., confusion, ambivalence, anger, feeling incompetent and/or guilt
ii. Acknowledge your mistakes, missteps, miscommunications, & therapeutic ruptures
iii. Develop a strong working alliance; develop specific treatment goals, tasks and emotional bond/connection with the patient
iv. Acknowledge patient's courage/strength to have discussions re: treatment relationship
v. When resistance occurs, remind/repeat treatment purpose, goals & rational for a particular approach
vi. Role play some resistances (role reverse: you as the patient; patient as you)
vii. Modify treatment tasks or goals as needed
viii. Set limits on treatment interfering behaviors

7) Supervision

i. Find a peer group for supervision.
ii. Use a supervision team, if available
iii. Hire your own supervisor... someone you can really trust

The "Big Six" Evidence-Based Psychotherapies (EBPs)

1. **Transference Focused Psychotherapy (TFP)** is based on ego psychology, object relations, and attachment theories; focused on changing self/other object representations, to help patients develop a consolidated identity. Therapeutic alliance is seen as a crucial holding environment, designed to help patients manage emotional storms & create environment for change. Countertransference is an essential focus as part of the treatment. Structured assessment is used, setting a treatment frame, followed by exploratory treatment phase. Patients develop capacity to manage their emotions & behaviors; healthy dependency on others; ability to sustain interpersonal relationships & to realized life goals.

2. **Mentalization-Based Therapy (MBT)** integrates psychoanalytic, attachment theory & neuroscience ideas. Defects in mentalization of self & others are responsible for PD manifestations. Therapeutic alliance & stance of *not knowing* are essential. Focused on developing capacity to accurately mentalize self & others. In initial assessment phase, you engage patient by evaluating attachment style, mentalizing ability & interpersonal functioning; Provide psychoeducation about the PD & establish the therapeutic contract. Treatment phase enhances patient's capacity to sustain accurate mentalizing of self &

others during periods of distress; translate this ability to form secure attachments, emotional stability & improved interpersonal relationships.

3. **Cognitive Therapy (CT)** focuses on evaluation & treatment of core beliefs or schemas, associated with each PD; these influence current automatic thoughts, emotions, behaviors, & interpersonal relationships. Therapeutic alliance is based on collaborative empiricism. Focus on modifying therapist's countertherapeutic reactions, so as not to adversely impact the treatment. Structured assessment & treatment phases, designed to change core believes & maladaptive coping, lead patients to develop emotional control, self-sufficiency & adaptive interpersonal relationships. Psychoeducation, teaching specific cognitive & behavioral skills.

4. **Dialectical Behavioral Therapy (DBT)** is a 3rd wave CBT treatment; primarily focused on behavioral change; It is based on dialectical philosophy, behavioral science & mindfulness practices, adopted from Buddhist traditions. Focused on acceptance & change. Therapeutic alliance is a non-judgmental coaching relationship. DBT therapeutic relationship used as a contingency, focused on remediation of patient treatment-interfering behaviors and helping patient develop skills for facilitating behavioral change. Also acknowledges need to remediate therapist-interfering behaviors. Skills taught: mindfulness, distress tolerance, emotional regulation & interpersonal effectiveness, as aids to develop a life worth living.

5. **Schema therapy (ST)** is an eclectic therapy based on cognitive, behavioral, psychodynamic, and experiential therapies. Focused on early maladaptive schemas, dysfunctional coping styles & maladaptive modes of behavior. Therapeutic alliance characterized as *limited reparenting.* Utilizes countertransference to help explain patient's problematic interpersonal relationships. Structured assessment & education phase based on a co-constructed case formulation based on 18 important schemas. Treatment phase is designed to help patients give up maladaptive modes for a healthy adult mode.

6. **Good Psychiatric Management (GPM)** uses supportive psychodynamic psychotherapy and case management strategies for treatment of borderline personality disorder. It is based on psychodynamic, cognitive & behavioral theories with a supportive therapeutic alliance. Countertransference is sometimes utilized to help patients explore dysfunctional interpersonal relationships. Structured treatment frame begins with psychoeducation, reducing suicidal behaviors. Treatment is framed as "a problem with interpersonal hypersensitivity." GPM is a flexible treatment which follows general psychiatric case management strategies.

Schema For Personality Disorders: Patient Coping Styles, Defenses & Interventions
From Chapter 7 in Primer on Personality Disorders Oxford University Press

DSM-5	Level of Functioning	Patient Coping Styles & Defense Mechanisms	Interventions
Paranoid	**PPO or BPO**	***Coping Style*:** Guarded & protective of autonomy; often with arrogant belief in own superiority ***Defenses:*** ***Projection:*** ascribes to others one's own impulses ***Projective Identification:*** projects one's impulses **+** control of others as way to control one's own impulses ***Denial:*** refuses to admit painful realities ***Splitting:*** Self & others are seen as all good or all bad	1. Empathize with patient's fear of being hurt; acknowledge complaints without arguing or ignoring 2. Openly & honestly explain medical illness 3. Correct reality distortions & unreasonable patient expectations 4. Gently question irrational thoughts; suggest more rational ones 5. Don't confront delusions 6. If patient refuses care out of mistrust, rather than insist, ask if it's acceptable to disagree about need for the test 7. Interpret projection (blame) and other defenses
Schizoid	**PPO or BPO**	***Coping Style:*** Inner world insulated from others ***Defenses:*** ***Isolation of Affect:*** thoughts without emotion ***Intellectualization:*** replaces feelings with facts ***Denial & Splitting;*** (See above) ***Regression:*** revert to childlike thoughts, feelings, and behaviors	1. Empathize with patient's need for both privacy & contact 2. Accept patient's unsociability 3. Reduce patient's isolation as tolerated 4. Neutrally impart medical information 5. Don't demand involvement or allow total withdrawal 6. Correct reality distortions & unreasonable patient expectations 7. Gently question irrational thoughts & suggest more rational ones 8. Interpret isolation & other defenses
Schizotypal	**PPO or BPO**	***Coping Style:*** Chaotic, disorganized ***Defenses:*** ***Schizoid Fantasy:*** retreats to idiosyncratic fantasy when faced with a painful experience	1. Empathize with patient's idiosyncratic style/magical thinking & perceptions without directly confronting them 2. Recognize need for privacy & contact 3. Accept the patient's unsociability and reduce the patient's isolation, as tolerated 4. Neutrally impart information 5. Don't demand involvement or permit total withdrawal

		Undoing: symbolic, magical action designed to reverse/cancel unacceptable thoughts/actions ***Regression, Denial & Splitting*** (See above)	6. Correct reality distortions and unreasonable patient expectations 7. Gently question irrational thoughts and suggest more rational ones 8. Interpret regression and other defenses
Antisocial	**BPO; PPO**	***Coping Style:*** Seeks autonomy & freedom; seeks advantage or secondary gain ***Defenses:*** ***Acting Out:*** expresses self in action behaviors, rather than words or emotions	1. Empathize with patient's fear of exploitation & low self-esteem 2. See if you're being used for secondary gain; should you suspect dishonesty, verify symptoms & illness progression with others 3. Don't moralize; explain - deception results in your giving patient poor care 4. Correct reality distortions & unreasonable patient expectations 5. Gently question irrational thoughts & suggest more rational ones 6. Interpret defenses
Histrionic	**NPO Or BPO PPO with Stress**	***Coping Style:*** Self-centered, looks to be loved, emotion driven, flirtatious & flighty ***Defenses:*** ***Sexualization:*** functions or people shifts to sexual symbols to avoid anxieties ***Regression, Acting Out & Splitting:*** (see above) ***Dissociation:*** disrupted perceptions/sensations, consciousness, memory, or personal identity ***Somatization:*** physical symptoms caused by mental processes ***Repression:*** involuntarily forgets painful memories, feelings, or experiences	1. Empathize with patient's fear of losing love/care 2. Be friendly, not too reserved or warm 3. Discuss patient's fears; reassure when possible 4. Use logic to counteract emotional style of thinking 5. Set limits, if patient regresses 6. Correct reality distortions & unreasonable patient expectations 7. Gently question irrational thoughts & suggest more rational ones 8. Interpret sexualization, regression, and other specific defenses
Borderline	**BPO or PPO with stress Best Functioning**	***Coping Style:*** Hostile dependency; chaotic lifestyle; threatening, intimidating, or seeking intimacy/	1. Empathize with patient's fear of abandonment/separation; plan for absences by arranging coverage 2. Express wish to help satisfy reasonable needs

	NPO	dependency or pseudo-autonomy ***Defenses:*** ***Splitting, Projection, Projective Identification, Dissociation, Regression & Acting Out:*** (see above) ***Omnipotence:*** seeing self & others as all-powerful' ***Idealization/Devaluation*** vacillates between seeing self & others as ideal; then deprecates/devalues self & others ***Mini-Psychotic Episodes***	3. Ask patient to monitor impulsive behaviors with diary 4. Set firm limits; do not punish 5. Correct reality distortions & unreasonable patient expectations 6. Gently question irrational thoughts and suggest more rational ones 7. Interpret splitting & other defenses 8. Negotiate emergency procedures in advance; if suicidal, patient must go to ER if not safe; if patient refuses, let patient know in advance - this therapeutic breach may end the relationship
Narcissistic	**BPO or NPO**	***Coping Style:*** Superiority & arrogance, self-aggrandizes; self-centered, self-protects, demeans, demands, critical ***Defenses:*** ***Splitting, Projection, Projective Identification, Acts Out, Denial, & Regression:*** (see above)	1. Empathize with patient's vulnerability & low self-esteem 2. Don't mistake patient's superior attitude for real confidence; don't confront entitlement 3. If you're devalued/attacked, acknowledge patient's hurt & any mistakes you made; express continued wish to help 4. If devaluing continues, offer a referral *as an option, not as punishment* 5. Correct reality distortions & unreasonable patient expectations 6. Gently question irrational thoughts & suggest more rational ones 7. Interpret splitting & other defenses
Avoidant	**NPO or BPO**	***Coping Style:*** Withdraw or escape; avoid criticism ***Defenses:*** ***Inhibition:*** restriction of thoughts, feelings & behaviors to avoid shame, exposure to inadequacies, rejection & humiliation **Phobic:** fears of objects, people, and/or situations, which are avoided to prevent anxiety ***Avoidance/Withdrawal, Regression &***	1. Empathize with patient's social fear, shame, shyness & fears of revealing inadequacies, rejection, embarrassment & anger 2. Help patient describe feared situation 3. Encourage/support need for patient to gradually face their fears & stop tendency to avoid; if this seems overwhelming, choose smaller fears to confront; or refer 4. If frustrated or unclear about the nature of the fears, ask for detailed description of the problem 5. Gently elicit irrational thoughts; suggest more rational ones 6. Corect reality distortion 7. Interpret avoidance and other defenses

		Somatization (see above)	
Dependent	**NPO or BPO**	***Coping Style:*** passive, dependent, helpless ***Defenses:*** Yearns for care, clings & needs direction ***Passive Aggressive:*** superficial compliance & passivity, disguising stubbornness & anger ***Reaction Formation:*** unacceptable impulses expressed as the opposite ***Regression & Splitting:*** (See above)	1. Empathize with patient's need for care 2. Frustrate total dependence 3. Avoid telling patient what to do 4. Encourage independent thinking/action 5. Realize that what patient says he/she wants - not necessarily what they need (e.g., caretaking) 6. Ask patient what about independence is so frightening? 7. Don't abandon or threaten termination, (some very dependent patients need regular clinician contact for life) 8. Correct reality distortions & unreasonable patient expectations 9. Gently elicit irrational thoughts; suggest more rational ones 10. Interpret regression & other defenses
Obsessive-compulsive	**NPO or BPO**	***Coping Style:*** Inflexible, constricted, governed by rules & safety or security concern ***Defenses:*** ***Isolation of affect, Intellectualization,*** **Reaction Formation &** ***Undoing:*** (see above) Controls efforts to regulate objects/others to avoid anxiety ***Displacement:*** transfers one's feelings from one person onto another ***Dependent:*** (see above) ***Inhibition:*** restricts thoughts, feelings, or behaviors for fear that unacceptable impulses will erupt &create anxiety or damage ***Phobias & Repression:*** (See above)	1. Empathize with patient's logical, detailed, unemotional style of thinking 2. If obsessive thoughts interfere with medical care, ask about patient's feelings 3. Don't struggle with patient over control & critical judgments 4. Avoid abandoning patient 5. Correct reality distortions & unreasonable patient expectations 6. Gently elicit irrational thoughts; suggest more rational ones 7. Interpret specific defenses
From DSM-III-R Self-Defeating	**BPO or NPO**	***Coping Style*:** Self-defeating & self-destructive ***Defenses:***	1. Empathize with patient's suffering 2. Acknowledge & appreciate difficulty of the illness/treatments

		Ambivalence: co-existence of opposing feelings ***Displacement, Denial, Projective Identification Reaction Formation, Passive-Aggressive & Splitting***: (see above)	3. Emphasize that recovery may be a slow steady process; need for recovery can be presented as necessary to benefit others 5.Inquire about obvious self-destructive or self-defeating behaviors 6.Do not abandon 7. Correct reality distortions & unreasonable patient expectations 6. Gently elicit irrational thoughts; suggest more rational ones 7. Interpret specific defenses