Attachment, Personality Disorder and Its Psychological Treatment

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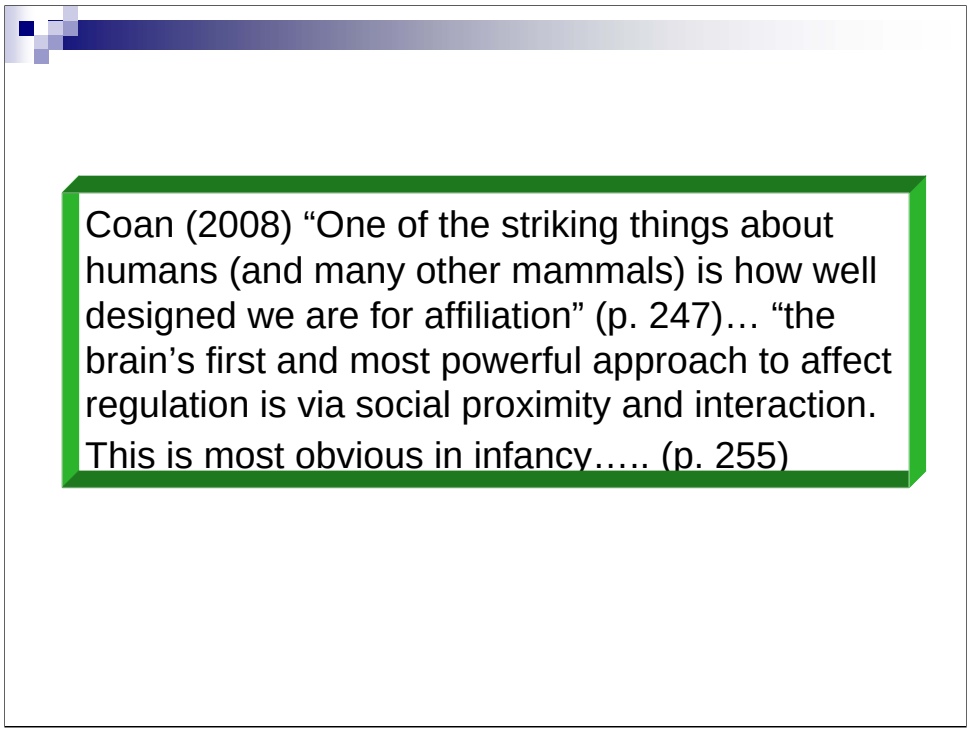
Sroufe and colleagues (Sroufe et al., 2005) conclude "*nothing is more important in children's development than how they are treated by their parents, beginning in the early years of life*" (p. 288).



Coan (2008) “One of the striking things about humans (and many other mammals) is how well *designed* we are for affiliation” (p. 247, emphasis in original). More specifically, the attachment system is “primarily concerned with the social regulation of emotion responding” (p. 251).

> the brain’s first and most powerful approach to affect regulation is via social proximity and interaction. This is most obvious in infancy…. Because the PFC [prefrontal cortex] is underdeveloped in infancy, the caregiver effectively serves as a kind of ‘surrogate PFC’—a function that attachment figures probably continue to serve for each other to varying degrees throughout life. (p. 255)
>
> social affect regulation is a relatively effortless, “bottom-up” process that ameliorates the initial perception of threat and thus decreases the need for effortful distress regulation.
>
> In contrast, self-regulating by a relatively “top-down” process involves more effortful control over attention and cognition (i.e., explicit mentalizing), relying to a greater degree on the prefrontal cortex. He concludes,
>
> “Simply put, affect regulation is possible, but more difficult, in isolation” (Coan, 2008, p. 256).

Clinical Features of Borderline Personality Disorder (DSM-IV: 5 of 9)

unstable relationships

affective dysregulation

impulsivity

aggression

Is Personality Not Just Genetics Anyway?

- Studies of psychiatric patients show BPD is familial
  - White CN, Gunderson JG, Zanarini MC, Hudson JI. Family studies of borderline personality disorder: A review. ***Harvard Review of Psychiatry*** 2003;11(1):8-19.
  - Zanarini MC, Barison LK, Frankenburg FR, Reich DB, Hudson JI. Family history study of the familial coaggregation of borderline personality disorder with Axis I and non-borderline dramatic cluster Axis II disorders. ***Journal of Personality Disorders*** 2009;23(4):357-369.
- Studies of twin samples show it is heritable.
  - Bornovalova MA, Hicks BM, Iacono WG, McGue M. Stability, change, and heritability of borderline personality disorder traits from adolescence to adulthood: A longitudinal twin study. ***Development and Psychopathology*** 2009;21(4):1335-1353.
  - Distel MA, Trull TJ, Derom CA, et al. Heritability of borderline personality disorder features is similar across three countries. ***Psychological Medicine*** 2008;38(9):1219-1229.
  - Kendler KS, Aggen SH, Czajkowski N, et al. The Structure of Genetic and Environmental Risk Factors for DSM-IV Personality Disorders A Multivariate Twin Study. ***Archives of General Psychiatry*** 2008;65(12):1438-1446.
  - Torgersen S, Lygren S, Oien PA, et al. A twin study of personality disorders. ***Comprehensive Psychiatry*** 2000;41(6):416-425.
  - Torgersen S, Czajkowski N, Jacobson K, et al. Dimensional representations of DSM-IV cluster B personality disorders in a population-based sample of Norwegian twins: a multivariate study. ***Psychological Medicine*** 2008;38(11):1617-1625.

-Non twin family studies ➔ increased rates of BPD in family members of BPD patients

-Classical twin studies ➔ heritability estimates of around 40%

-Adding siblings, spouses and parents of twins

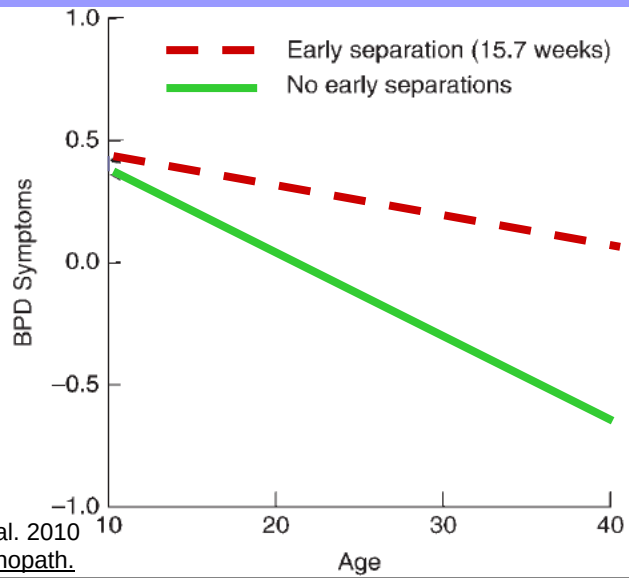
But do we not know that bad things happen in the lives of these patients?

- **Retrospective** studies link harsh treatment early in life with later BPD.
  - Battle CL, Shea MT, Johnson DM, et al. Childhood maltreatment associated with adult personality disorders: Findings from the collaborative longitudinal personality disorders study. **Journal of Personality Disorders** 2004;18(2):193-211.
  - Zanarini MC. Childhood experiences associated with the development of borderline personality disorder. **Psychiatric Clinics of North America** 2000;23(1):89-+.
- Largely confirmed by **prospective** studies
  - Johnson JG, Cohen P, Chen HN, Kasen S, Brook JS. Parenting behaviors associated with risk for offspring personality disorder during adulthood. **Archives of General Psychiatry** 2006;63(5):579-587.
  - Carlson EA, Egeland B, Sroufe LA. A prospective investigation of the development of borderline personality symptoms. **Development and Psychopathology** 2009;21(4):1311-1334.
  - Crawford TN, Cohen PR, Chen HNA, Anglin DM, Ehrensaft M. Early maternal separation and the trajectory of borderline personality disorder symptoms. Development and Psychopathology 2009;21(3):1013-1030.

BPD and childhood maltreatment: recent prospective studies

- **Johnson and colleagues** (Johnson et al., 2006) assessments of family members and their offspring spanning age 6 to 33
  - low levels of **parental affection** and nurturing
  - **aversive parental behaviors** such as harsh punishment
  - BUT: not specific to BPD
- **Lyons-Ruth and colleagues** (Lyons-Ruth, Yellin, Melnick, & Atwood, 2005; Melnick et al., 2008)
  - **disrupted maternal communication** in infancy predicts symptoms of borderline pathology assessed at age 18
  - **total amount of abuse** over the lifetime reported in adolescence also contributes
  - disrupted maternal communication and later abuse make **independent and additive contributions** to pathology associated with borderline personality disorder.

Early maternal separation and trajectory of borderline personality disorder symptoms



Crawford et al. 2010
Dev. & Psychopath.

BPD and Minnesota longitudinal study
(Carlson, Egeland, & Sroufe, 2009)

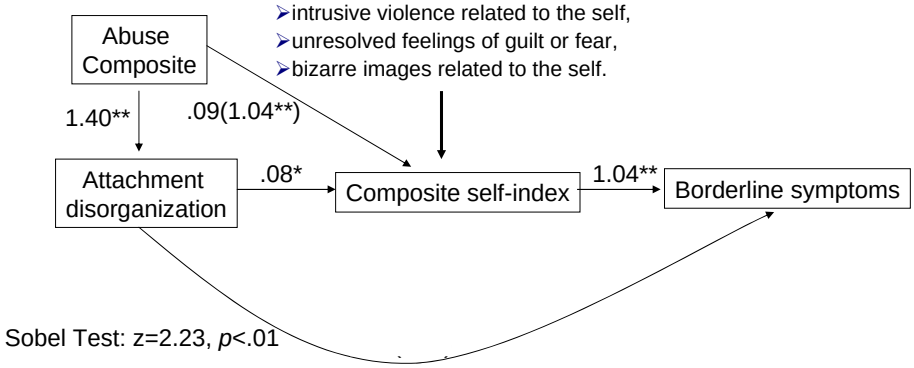
- Correlated extensive assessments from infancy onward with borderline personality disorder symptom at age 28
- Early predictors borderline personality symptoms:
  - attachment disorganization .20*
    - (12-18 months),
  - maltreatment .20**
    - (12-18 months),
  - maternal hostility and boundary dissolution .42***
    - (42 months),
  - family disruption related to father presence .21**
    - (12-64 months),
  - family life stress .29***
    - (3-42 months).

BPD and Minnesota longitudinal study
(Carlson, Egeland, & Sroufe, 2009)

- Early adolescent predictors (12 years)
  - **attentional** disturbance,
  - **emotional** instability,
  - **behavioral** instability, and
  - **relational** disturbance.
- Disturbances in self-representation in early adolescence may mediate the link between attachment disorganization and personality disorder

Mediating Role of Self-Representation (Carlson et al., 2009)

- narrative projective tasks administered at age 12 that included
  - intrusive violence related to the self,
  - unresolved feelings of guilt or fear,
  - bizarre images related to the self.



- Carlson et al. (2009): “representations and related mentalizing processes are viewed as the carriers of experience that link early attachment to later Psychopathology” (p. 1328).

Diathesis-stress theories of BPD etiology

- Theories suggesting an **interaction** between a child's **genetic vulnerability** and adverse **experiences** in the family environment
  - Crowell SE, Beauchaine TP, McCauley E, Smith CJ, Stevens AL, Sylvers P. Psychological, autonomic, and serotonergic correlates of parasuicide among adolescent girls. ***Development and Psychopathology*** 2005;17(4):1105-1127.
  - Fonagy P, Target M, Gergely G. Attachment and borderline personality disorder - A theory and some evidence. ***Psychiatric Clinics of North America*** 2000;23(1):103-+.
  - Gunderson JG, Lyons-Ruth K. BPD'S interpersonal hypersensitivity phenotype: A gene-environment-developmental model. ***Journal of Personality Disorders*** 2008;22(1):22-41.
  - Paris J. The development of impulsivity and suicidality in borderline personality disorder. ***Development and Psychopathology*** 2005;17(4):1091-1104.
  - Zanarini MC, Frankenburg FR. The essential nature of borderline psychopathology. ***Journal of Personality Disorders*** 2007;21(5):518-535.

Diathesis-stress theories of BPD etiology

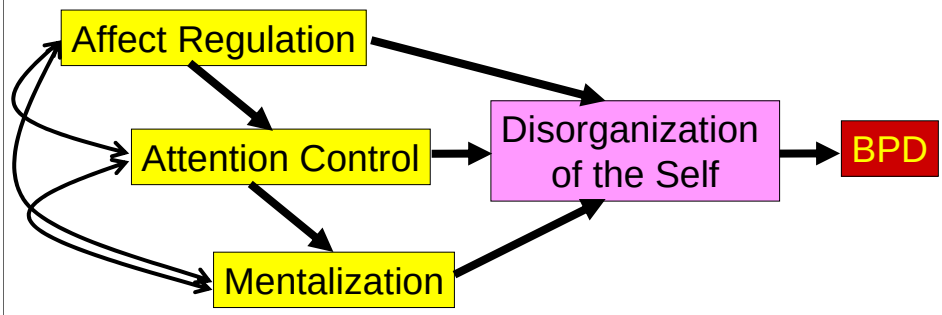
- Need to directly evaluate the diathesis-stress model by *testing for interaction between inherited risk and harsh childhood treatment*.
  - **Prospective longitudinal design** with three things measured
    - familial **liability**
    - **harsh treatment** during childhood
    - **early-emerging symptoms** of borderline personality soon thereafter.

A Test of Diathesis-Stress Theories of the Etiology of Borderline Personality Disorder in a Birth Cohort of 12 Year Old Children

- **Objective.** To test if children with a **positive family history** of psychiatric disorder were more **vulnerable** to developing borderline personality symptoms following **exposure to physical maltreatment** and maternal negative expressed emotion.
- **Design.** Prospective **longitudinal** cohort study of a nationally representative **birth cohort** in Great Britain.
- **Participants.** 1,116 families with **twins** were followed from birth to age 12 years (retention 96%).
- **Main Outcome Measure. Dimensional** borderline personality symptoms **and dichotomous** extreme borderline group membership (dimensional symptoms ≥95th percentile).

Belsky, Caspi, Arseneault, Bleidorn, Fonagy, Goodman, Houts, and Moffitt (submitted)

Some possible attachment related components of the BPD phenomenological phenotype



What is mentalizing?

Mentalizing is a form of ***imaginative*** mental activity about others or oneself, namely, perceiving and interpreting human behaviour in terms of ***intentional*** mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).

What is mentalization?

- It is a capacity we use all the time
- It is what we need:
  - To collaborate
  - To compete
  - To understand feelings
  - To teach
  - To learn
  - To know who we are
  - To know that we are
- Our awareness of mental states makes us laugh and cry

It is a capacity we use all the time

It is what we need TO EFFECTIVELY :

To collaborate &

To compete

To teach &

To learn

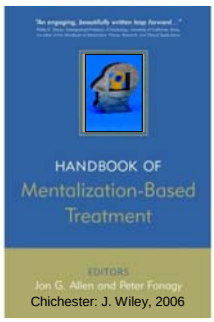
To know who we are &

To know that we are

Our awareness of mental states makes us laugh and cry

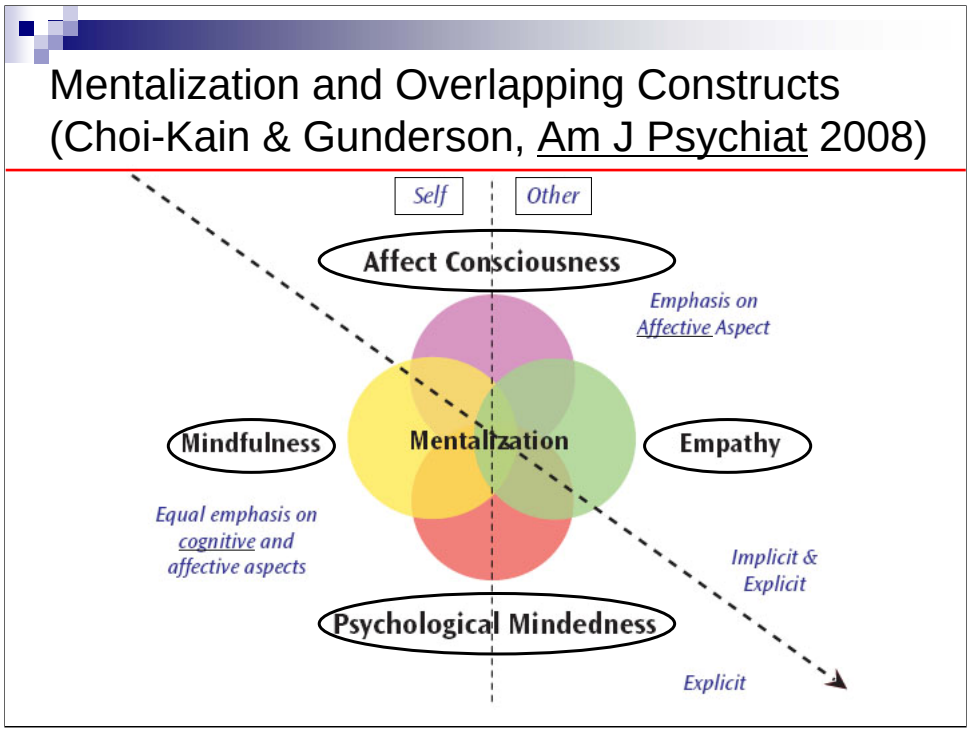
Forewarning – 1.

In advocating mentalization-based treatment we claim no innovation. On the contrary, mentalization-based treatment is the least novel therapeutic approach imaginable: it addresses the bedrock human capacity to apprehend mind as such. Holding mind in mind is as ancient as human relatedness and self-awareness.



Chichester: J. Wiley, 2006

–Allen & Fonagy (2006) Preface.



This Venn diagram maps the conceptual overlaps between mentalization and four related concepts including mindfulness, psychological mindedness, empathy, and affect consciousness, which are represented by the four circles. The lines which bifurcate the diagram according to its three dimensions (i.e., self-/other-oriented, implicit/explicit, and cognitive/affective) are dashed to illustrate the permeable and nonabsolute nature of these divisions. In the self/other dimension, mindfulness focuses more on mental states within oneself, while empathy is primarily understood in terms of one's imagination of mental states within others. Both affect consciousness and psychological mindedness concern both sides of the self and other distinction. While mindfulness and psychological mindedness emphasize both cognitive and affective aspects of mental states and function explicitly, affect consciousness and empathy relate more primarily to affective mental contents and function both explicity and implicity. Mentalization lies at the intersection of these concepts but the boundaries between them are not distinctly drawn.

Forewarning – 2.

This product may contain traces of originality.

These are only trace contaminants, occurring as part of the production process, and should not spoil your enjoyment of the product.

Measuring Mentalization (Baron-Cohen et al., 2001) Reading the Mind in the Eyes Test

Friendly - A

Sad - B

Surprised - C

Worried - D

Measuring Mentalization (Baron-Cohen et al., 2001) Reading the Mind in the Eyes Test

Surprised-A

Sure about something-B

Joking-C

Happy-D

Measuring Mentalization (Baron-Cohen et al., 2001) Reading the Mind in the Eyes Test

Joking-A

Flustered-B

Desire-C

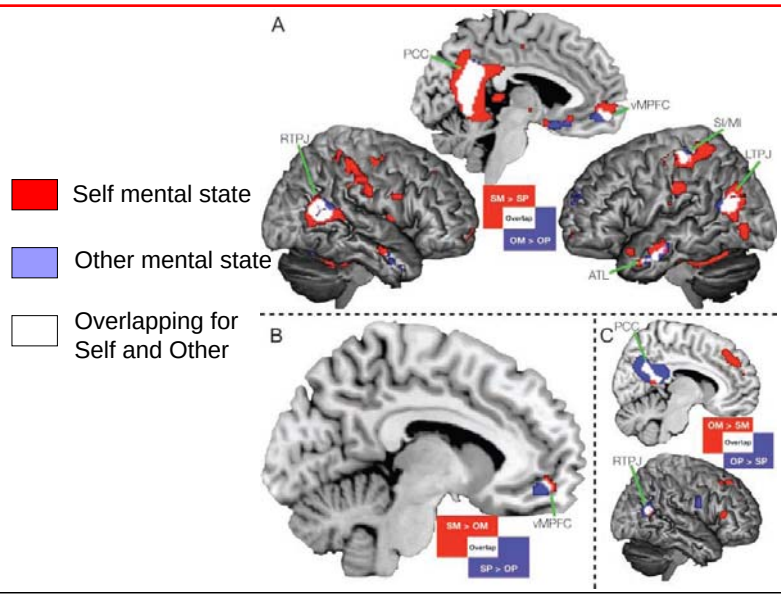
Convinced-D

Mentalizing at the World Cup: How does Robert Green feel after letting in the USA goal?

Mentalization allows us to have common experiences – we need to coordinate our emotional experiences to function in large social groups. Imagine what would happen if we all felt differently about Lampard's disallowed goal! Fortunately not the case.

Have to be able to step into the shoes of another person -

Shared neural circuits for mentalizing about the self and others (Lombardo et al., 2009; J. Cog. Neurosc.)



CAN DEVELOPMENTAL PSYCHOLOGUY RESEARCH HELP US GET CLOSER TO THE POTENTIAL SOCIAL EXPEREINCES THAT COULD SET OF THE EPIGENETIC CASCADE THAT Dr Moshe Szyf was describing to us yesterday?

INTERSUBJECTIVE ORIGINS OF THE SELF

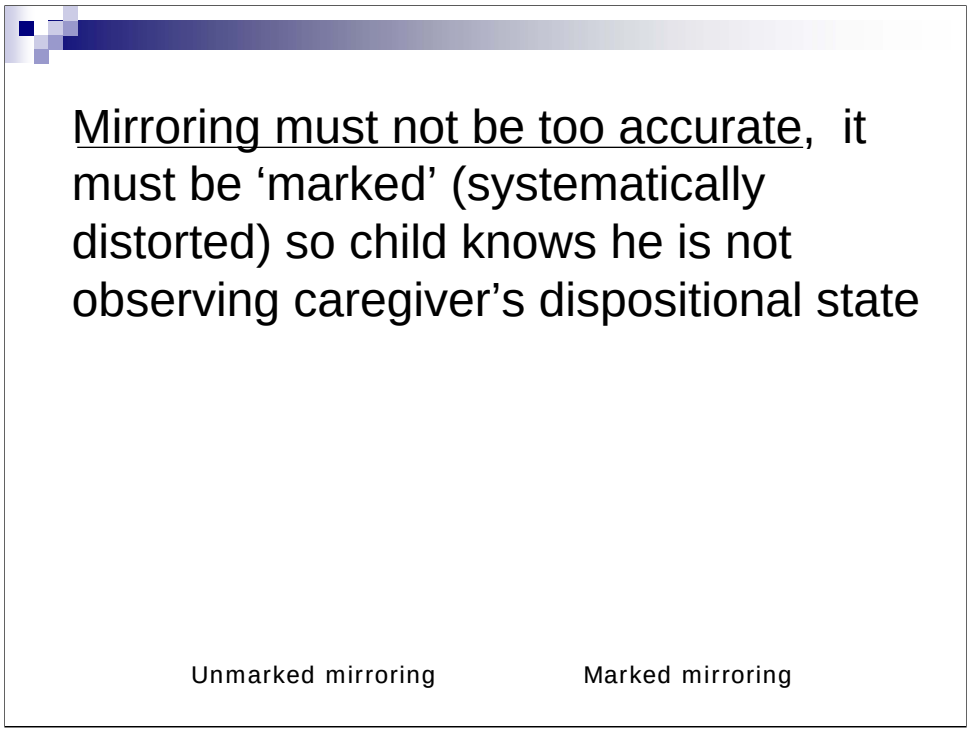
Relational Aspects of Mentalization

- Overlap between neural locations of mentalizing self and other may be linked to **intersubjective origin of sense of self**
  - We **find our mind** initially in the minds of our parents and later other attachment figures thinking about us
  - The parent's capacity to **mirror effectively** her child's internal state is at the heart of affect regulation
  - Infant is **dependent on contingent response** of caregiver which in turn depends on her capacity to be reflective about her child as a psychological being

JUST HOW IMPORTANT CONTINGENT RESPONDING TO AFFECT IS WE KNOW FROM STILL FACE PARADIGM (GERGELY)

High congruent & marked mirroring

Shows the infant ABSOLUTELY EXPECT TO FIND HIS MIND OUT THERE, IS IN NO SENSE PROVIDED WITH A MIND BY THE CAREGIVER BUT HE SEARCHES OUT, SEEKS OUT OPPORTUNITIES FOR SHARING OF SUBJECTIVITY BECAUSE OF EXTREMELY PWOERFUL BIOLOGICAL PREDISPOSITION. SO IN MIRRORING BUT MIRRORING MUST BE OF A SPECIAL KIND – NOT LIKE A REAL MIRROR



Mirroring must not be too accurate, it must be ‘marked’ (systematically distorted) so child knows he is not observing

IN SEVERAL STUDIES WITH Kos and Gergely WE HAVE SHOWN MARKED MIRRORING to LEAD TO MORE ROBUST MENTALIZATION

The Role of Attachment in Humans

- Evolution uses the early attachment relationship as **a signaling system** to the newborn as to the kind of environment he/she might expect.
  - An environment where caregivers do not have the time or resources to devote attention to the infant is far more likely to necessitate the later use of violence in order to ensure the survival of the individual in subsequent struggles for limited resources.
  - Violence and mentalizing are not compatible

Security of attachment and mentalizing are intertwined in an intergenerational transmission process

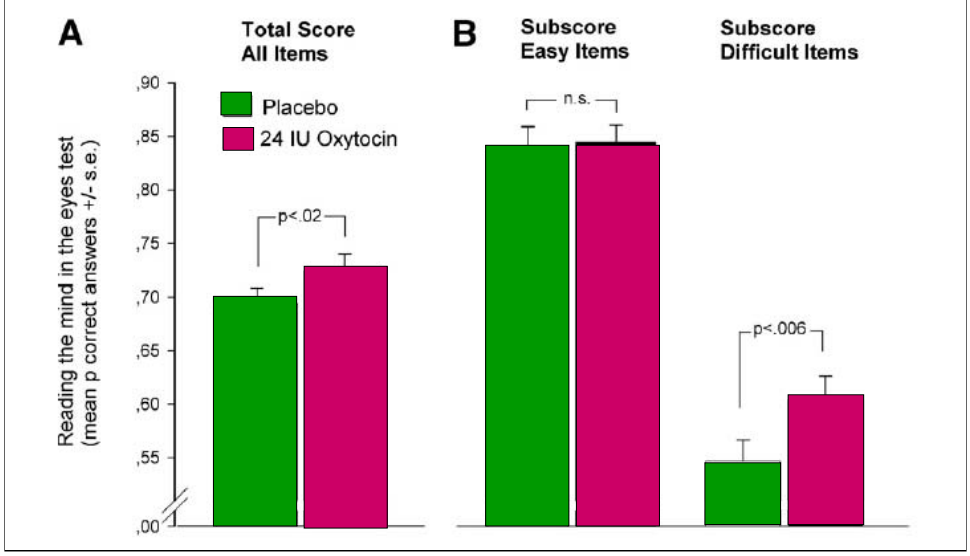
- For better
  - parental security ➔ mentalizing capacity ➔ mentalizing interactions ➔ child security
- For worse
  - parental insecurity ➔ compromised mentalizing capacity ➔non-mentalizing-traumatizing interactions ➔ child insecurity
- The final link
  - infant attachment security ➔ subsequent child mentalizing capacity

Secure attachment is facilitative of mentalizing

- Children **pass theory of mind** tasks earlier if
  - Had **secure** attachment relations with parents in infancy
  - If **parent**'s own state of mind in relation to attachment was **secure**
  - Family members relate to each other in playful, mentalizing way
- Mechanism may well be mediated by oxytocin

Oxytocin is the VIAGRA of mentalization

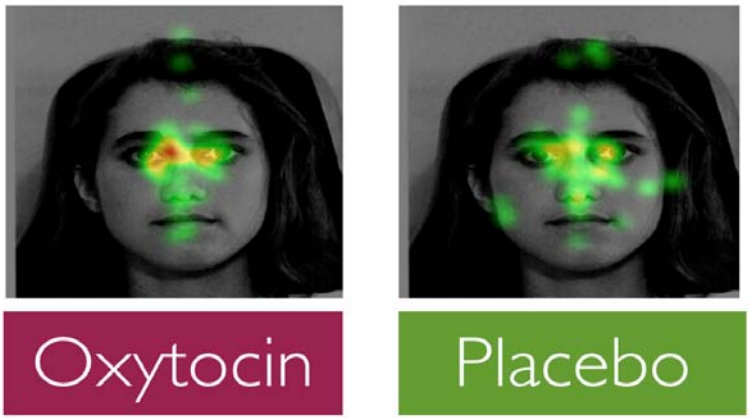
Oxytocin and performance on Mind in the Eyes test (Domes et al., 2008)



Around in great quantity (breast feeding) when the infant needs it most – when it totally depends on being understood

Oxytocin turns us towards the face to try to find the mind therein

Gaze duration during oxytocin exposure

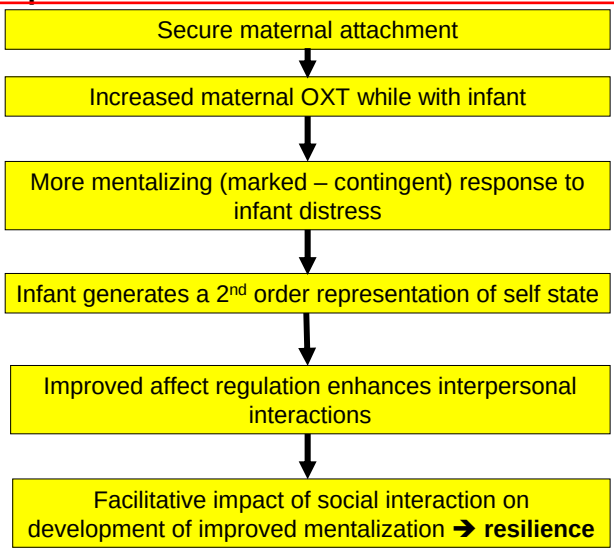


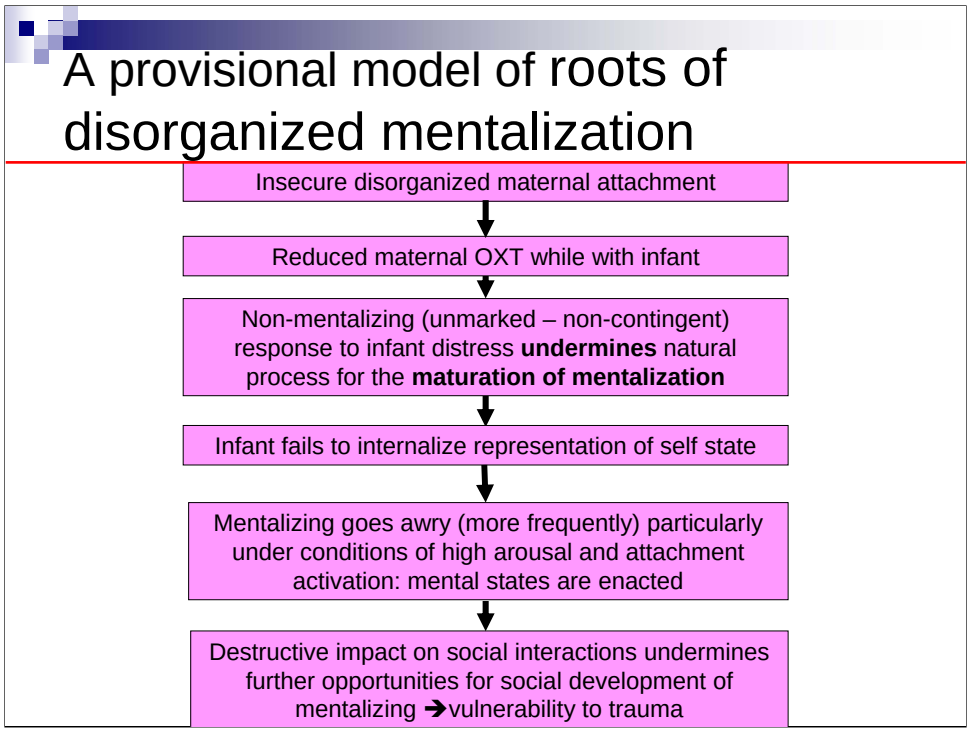
Guastella, Mitchell, Dadds, 2008

BIOL PSYCHIATRY 2008;63:3–5

Is there less oxyticin around when parents have insecure attachment history?

A provisional model of the developmental roots of mentalization

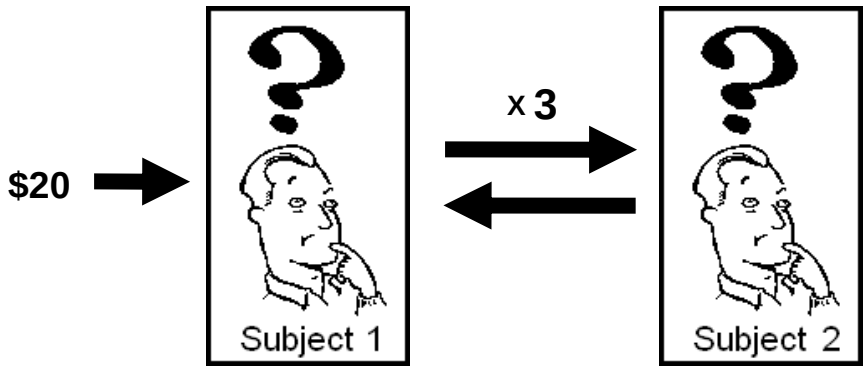




Need Oxy not to undermine natural process of the unfodling of mentalization (infants expect to find the contents of their mind) they look for it

It has developmental roots in genetic or social or epigenetic diathesis that undermines the creation of robust social relationships that might help the child overcome an early deficit

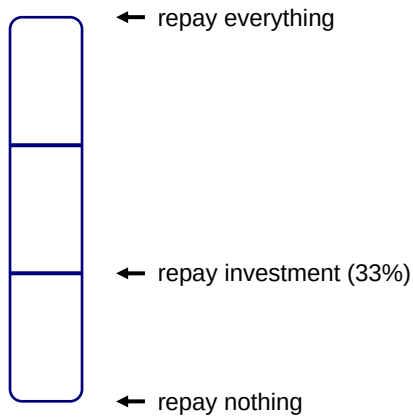
Do patients with BPD have anything wrong with their mentalizing?



healthy investor

BPD trustee

Average Repayment:



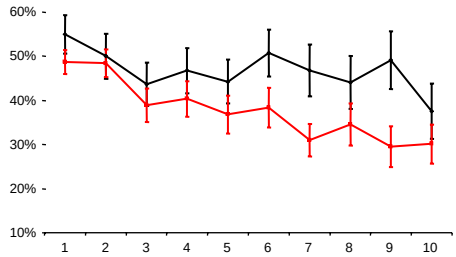
*King-Casas et al, in Science, 321, 806-810

Investor Sent

MU sent / MU available

44 non-psychiatric investors

55 non-psychiatric investors

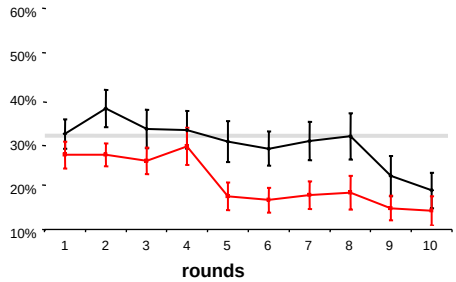


Trustee Repaid

MU sent / MU available

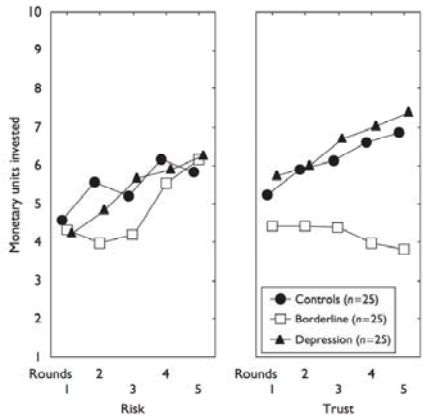
44 non-psychiatric trustees

55 BPD trustees



*King-Casas et al, in Science, 321, 806-810

Specific to social-decision making, not non-social decision-making
Specific to BPD, not mood disorder



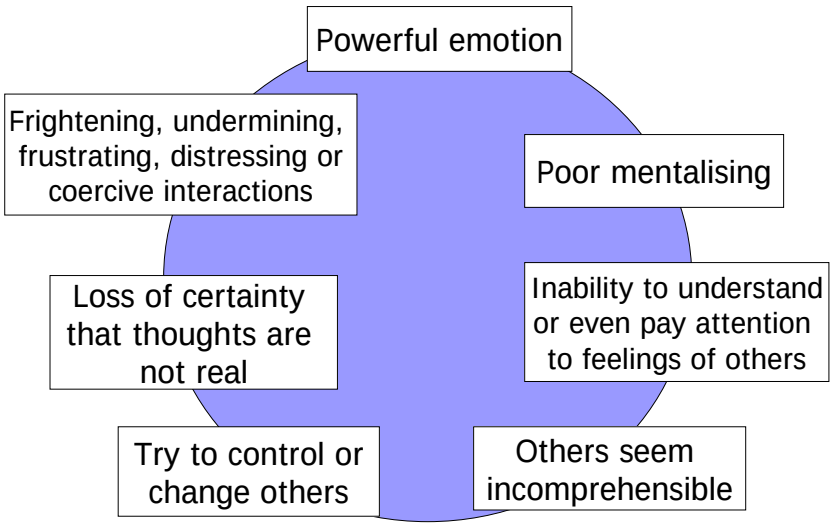
The figure shows the amount of monetary units invested by the participants from the three experimental groups. It is apparent that, in contrast to healthy controls and patients with depression, patients with borderline personality disorder invested less money during the five transactions of the trust game (modified from ref. [16]).

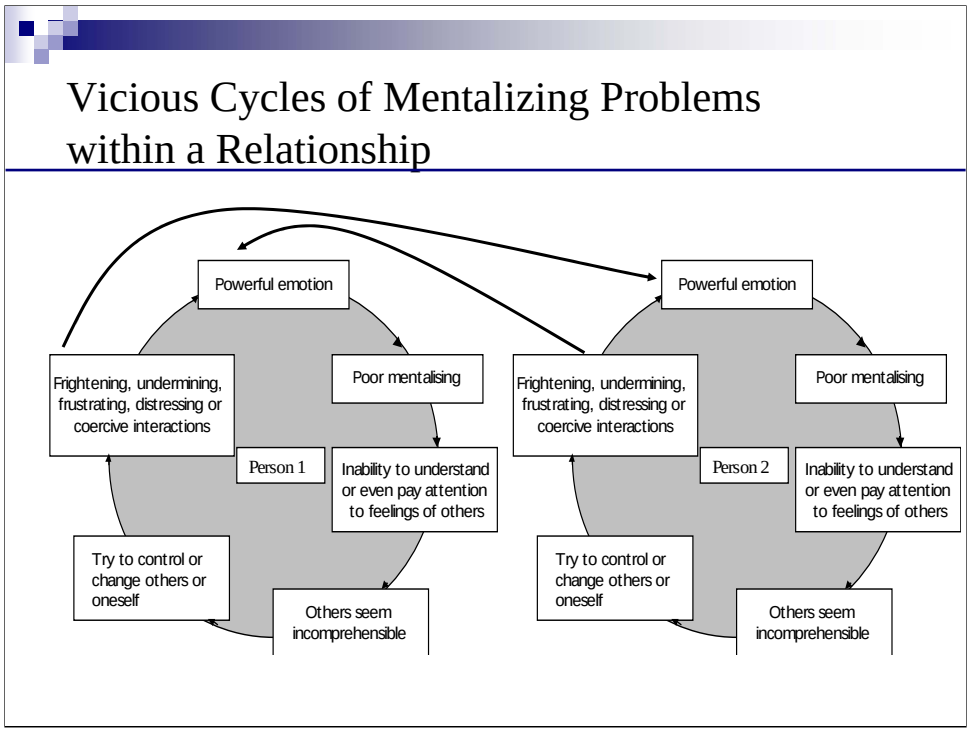
Unoka, Seres, Aspán, Bódi, Kéri (2009)

Do BPD patients have anything wrong with their mentalizing?

- Most likely to happen in in interpersonal context when they misunderstand and feel misunderstood by someone they care about
- The non-mentalizing viscous cycle

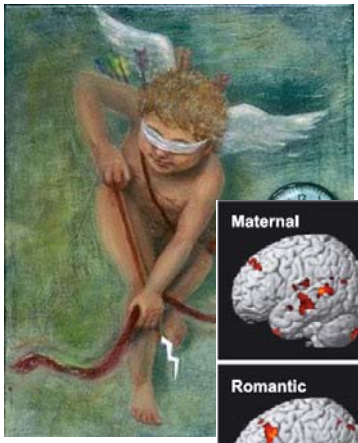
Cycles of inhibition of mentalizing





Powerful emotions in an interpersonal context activate the attachment system

Is there a human language which does not recognize love to be blind?



Common regions of deactivation with maternal and romantic love (Bartels & Zeki, 2008)

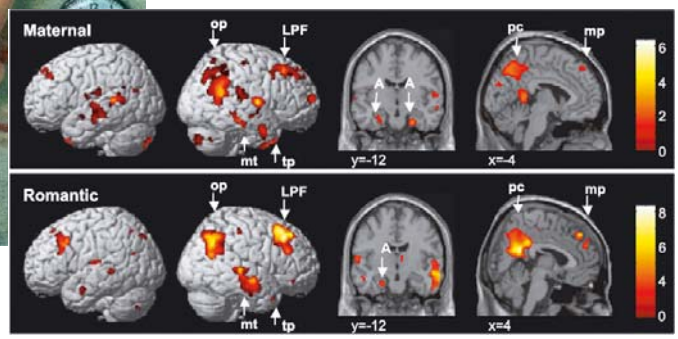


Fig. 2. Deactivated regions with maternal and romantic love. The sections and rendered views show regions whose activity was suppressed with maternal love

(cO vs. cA) (top). These regions were the same as those that were deactivated with romantic love (viewing loved partner vs. friends) in our previous study

(bottom). All labelled regions reached significance at $P < 0.05$, corrected for small volume (for illustration, following thresholds were used—top: $P < 0.05$,

uncorrected; bottom: $P < 0.001$, uncorrected). Abbreviations: A = **amygdaloidal** cortex, pc = **posterior cingulate cortex**, mp = **medial prefrontal/paracingulate**

gyrus; mt = middle temporal cortex; op = occipitoparietal junction; tp = temporal pole.

Two areas:

•middle prefrontal, inferior parietal and middle temporal cortices mainly in the right hemisphere, as well as the posterior cingulate cortex ➔ attention, long-term memory, variable involvement in both positive negative emotions ➔ underpin interface of mood related cognition

•amygdala, temporal poles, parietotemporal junction and mesial prefrontal cortex ➔ social trustworthiness, moral judgements, 'theory of mind' tasks, negative emotions, attentions

BUT IS IT JUST AROUSAL OR IS IT SPECIFICT TO ATTACHMENT?

The effect of attachment-related stress on the capacity to mentalize: Induction imagery scripts to participants (Nolte, Hudac, Mayes, Fonagy & Pelphrey, 2009)

- Scripts obtained in a visit prior to scanning with the aim to **create stress-related arousal states**
- Idiosyncratic content, personally meaningful
  - Common themes **attachment stress**: e.g. relationship breakup, funeral etc.
  - Common themes **normal stress**: e.g. exam preparation, lost objects etc.

Scripts obtained in a visit prior to scanning with the aim to **create stress-related arousal states**

Idiosyncratic content, personally meaningful

Common themes **attachment stress**: e.g. relationship breakup, funeral etc

Common themes **normal stress**: e.g. exam preparation, lost objects etc.

Edited, recorded, semi-standardized about 5 mins. of length each

Only scripts that were subjectively rated 8 or above on a 1-10 scale of subjective stress accepted.

No differences in subjective level of stress ratings between ‘attachment’ and ‘normal’ stress

The effect of attachment-related stress on the capacity to mentalize: Modified Reading Mind in Eyes
Nolte, Hudac, Mayes, Fonagy & Pelphrey (2009)

Stimuli

Subjects were asked to make a judgment as fast and accurately as possible

Which attitude?

Resentful Bored

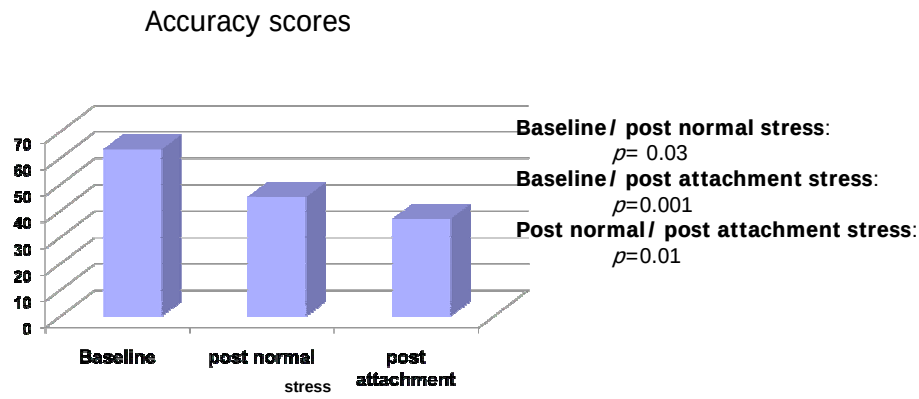
Which age?

Twenty-three Thirty

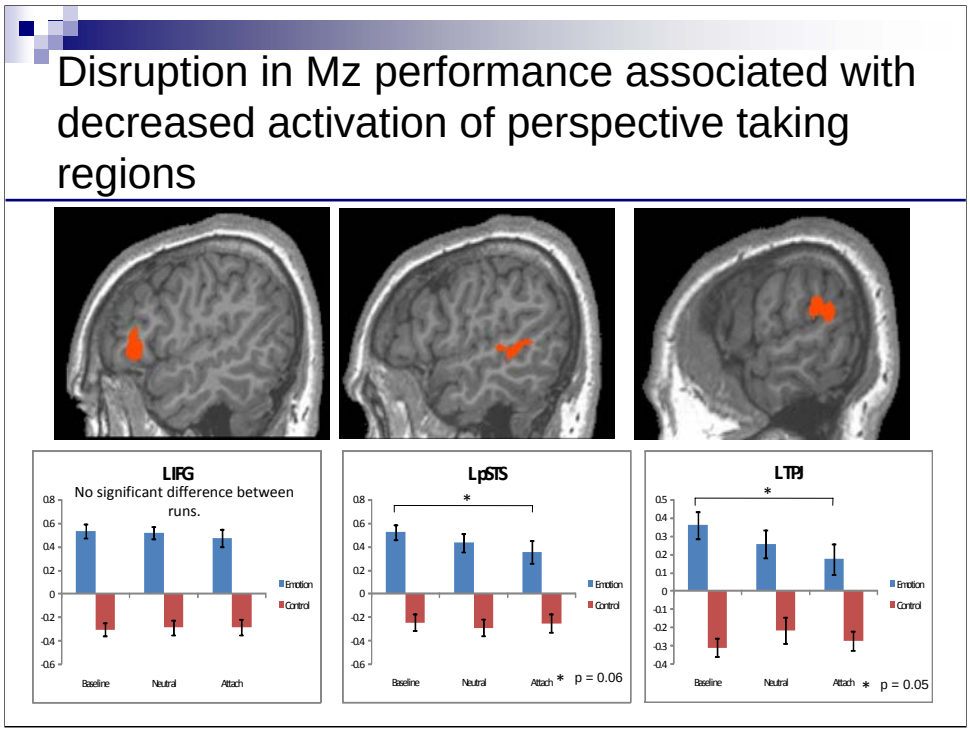
Examples of single trial stimuli, RMET (top), control task (bottom).

Attachment stress selectively disrupts mentalization performance

Nolte, Hudac, Mayes, Fonagy & Pelphrey (2009)

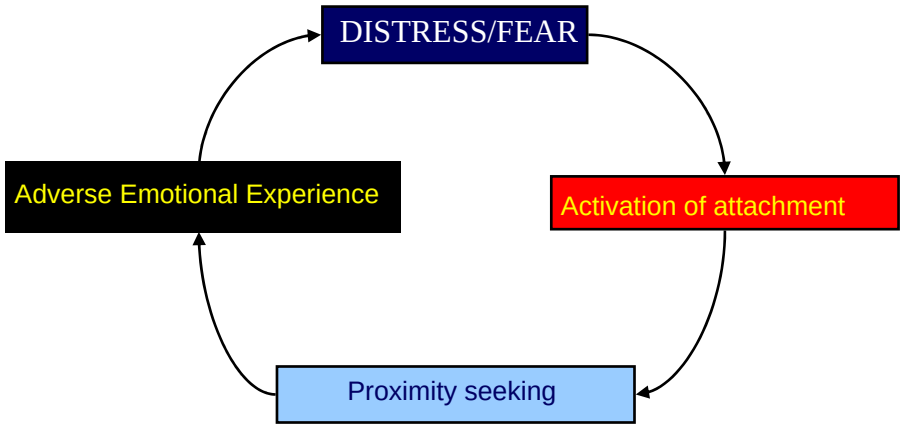


Attachment stress disrupts RMET performance more than normal stress!



Identified brain regions that show greater activation during the Reading the Mind in the Eyes Test (highlighted) and control task, see table. Below: Activation maps of the regions with greater activiaty during the REMT task. Left inferior frontal gyrus, posterior superior temporal sulcus and temporal parietal junction are areas that have repeatedly been associated with mentalization/ social cognition tasks (5), (6).

Attachment Disorganisation in Trauma



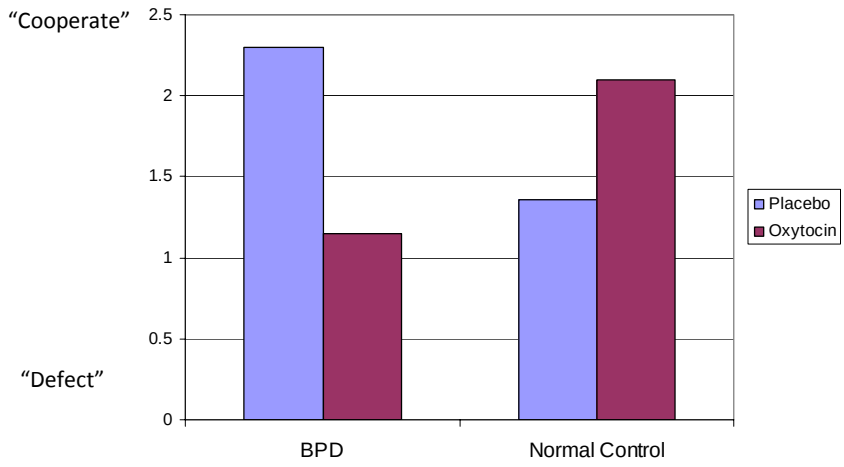
The ‘hyperactivation’ of the attachment system

Hyperactivation of attachment system may be core aspect of BPD

The hyper-reactivity of the attachment system in BPD

- We assume that **the attachment system in BPD is "hypersensitive"** (triggered too readily)
- Indications of attachment hyperactivity in **core symptoms** of BPD
  - Frantic efforts to avoid abandonment
  - Pattern of unstable and intense interpersonal relationships
  - Rapidly **escalating tempo** moving from acquaintance to great intimacy

Response to partner's hypothetical cooperation in Assurances Game



Group x Oxytocin: F(1, 23)=4.82, p < .05 (Bartz et al, in prep)

Participants: 13 healthy (male=7) and 14 BPD (male=4);

Study design: Participants randomly received 40 IU intranasal oxytocin (n=14) (Syntocinon) or placebo (n=13);

45-min after administration, participants played the Assurances Game with an ostensible partner (confederate);

Baseline and post-dose mood assessed with the POMS; no mood changes observed.

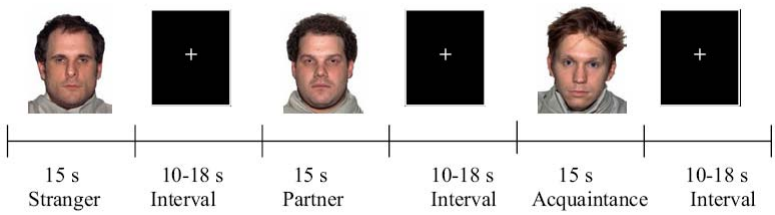
Prisoner's dilemma emphasizes self-interest (payoff is greater for defecting)

AG emphasizes trust:

- locates the selfish and interpersonal solution in the same, mutual cooperation cell (i.e., payoff is highest for both players when they cooperate)
- However, one should only cooperate if one is assured that one's partner will do the same; if partner's are mistrustful, they should pursue mutual defection, which is sub-optimal (i.e., the payoff is less than it would be if your partner cooperated, but the more than it would be if your partner defects)

Romantic relationships and BPD

Pictures (romantic partner, stranger, acquaintance) were shown for 15 seconds in 9 random permutations of the 3 types.



- Ongoing study with Carla Sharp at Menninger

The simple idea behind MBT

- Failure of mentalization in attachment associated contexts is key aspect of BPD psychopathology
- An individual with BPD is vulnerable to the **collapse of subjectivity** associated with
  - intolerable mental pain
  - amplified experience of negative emotions
  - cognitive dyscontrol
- A psychotherapeutic approach focusing on sensitively and **gently expanding and clarifying** the patient's representations of mental states serves to reduce impulsivity and improves sense of subjective well-being.

How do you do that – is there a technique. PERHAPS THERE ARE SOME OF YOU THERE WHO HAVE NO IDEA WHAT WE ACTUALLY DO IN MBT?

The MBT technique

- Simple **sound-bite** interventions
- **Affect focused** (love, desire, hurt, catastrophe, excitement)
- Focus on patients **mind** (not on behaviour)
- Relate to **current** event or activity – mental reality (evidence based or in working memory)
- Use of **therapist's mind** as model (?disclosure)
- **Identify non-mentalizing** and recover it on the many occasions when apparently lost

Clinical summary of intervention

- Focus is on a **break in mentalizing** – psychic equivalence, pretend, teleological
- **Rewind** to moment before the break in subjective continuity
- Explore current **emotional context** in session by identifying the momentary affective state between patient and therapist
- Identify **therapist's contribution** to the break in mentalizing (humility)
- Seek to **mentalize** the therapeutic **relationship but only very slowly and carefully**

Psychic equivalence:

Mind-world isomorphism; mental reality = outer reality; internal has power of external➔Fran

Intolerance of alternative perspectives➔"YOU LOOKED AT YOUR WATCH"

Pretend mode:

Ideas form no bridge between inner and outer reality; mental world decoupled from external reality ➔FRAN

"dissociation" of thought, hyper-mentalizing or pseudo-mentalizing ➔ ENDLESS HOURS OF 'THERAPY'

Teleological stance:

A focus on understanding actions in terms of their physical as opposed to mental constraints

Cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.

WHAT ARE THE THERAPISTS AIMS?

So what should the therapist aim do?

- Care taken **not to assume** the presence of social cognitive capacities that cannot be relied on
- **Empathy** with experience of disrupted subjectivity
  - Psychic equivalence ➔ ego-destructive shame
  - Pretend mode ➔ sense of disintegration
  - Teleological mode ➔ the urgency to cause observable change
- Constant awareness of the potential for iatrogenic **harm**
  - Over-activating the attachment system ➔ reduces the capacity for mentalization

So what should the therapist aim do?

- Help the patient learn about the **complexities** of his thoughts and feelings about himself and others, how that relates to his responses, and how 'errors' in understanding himself and others lead to actions

- It is **not for the therapist to 'tell'** the patient about
  - how he feels,
  - what he thinks,
  - how he should behave,
  - what the underlying reasons are, conscious or unconscious, for his difficulties.

- An inquisitive or '**not-knowing**' stance. Conveys a sense that mental states are opaque

Fairly generic formulation before you try to do it. At its heart is the idea that patient will get better if therapists makes mind available for patient to find their own capacity to think – much like with early development – INFANT'S SEEKING OF SUBJECTIVITY CAN BE UNDERMINED

Psychotherapy for BPD

- A range of structured treatment programmes for BPD shown to be effective in studies
  - DBT
  - TFP
  - SFT
  - DDP
  - CAT
  - MBT
- Do they work for the reasons the developers suggest?
- Are the demonstrations of effectiveness compelling in terms of
  - Statistical power
  - Long term follow up
  - Generalizability (treatments tested are mostly cost specialist interventions requiring extensive training
  - Meaningful comparison group

ONE MAY BE FORGIVEN FOR CONTEMPLATING IF ANY Treatment WITH A 3 LETTER ACRONYM HAS A CHANCE OF IMPROVING THE WELLBEING OF INDIVIDUALS WITH BPD

All provide structure – Perhaps it is the structure that is crucial because allows people to think. If we just provide a structure that tells therapists what to do will we remove the effective component.

Treatment for Borderline Personality Disorder

- Meaningful trial IDEALLY should provide a:
  - comparison group receiving a structured (manualized) treatment organised in a coherent treatment programme with equivalent supervision
  - delivery of both treatments by professionals trained from the same level to the same level over the same period
  - adequate statistical power to detect relatively small differences
  - representative sample of clinically referred men and women with confirmed diagnosis of BPD and at high risk of suicide

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