

Psychodynamic psychotherapies for borderline personality disorders. Current developments and challenges ahead

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This article summarises the current position of evidence-based psychodynamic psychotherapies aimed at the treatment of borderline personality disorder – mentalisation-based treatment and transference-focused psychotherapy – noting the main challenges they face, especially in the area of dissemination.

Borderline personality disorder (BPD) is characterised by significant problems with interpersonal relationships, identity, affect regulation and impulsivity. Self-harm behaviours, suicide attempts, eating disorders or substance use disorders often add to the clinical picture. The presence of BPD makes treatment of affective disorders and post-traumatic stress disorder more difficult and worsens the prognosis. BPD has a high prevalence, around 2% of the general population, although many of those patients do not receive treatment because of either underdetection or low illness insight that reduces treatment demand. Long-term follow-up studies allow us to be relatively optimistic, since, over time, most patients no longer meet diagnostic criteria, perhaps owing to age-related reduction of impulsivity. However, many continue to experience limitations regarding work and relationships throughout life.

There is a broad consensus concerning the most appropriate treatment of these patients (Stoffers *et al*, 2012). Psychotherapy represents the fundamental intervention, whereas medication plays a supporting part through judicious use and targeting of specific symptoms. Several psychotherapy techniques have empirically proven their effectiveness, including two psychoanalytic psychotherapies: mentalisation-based therapy (MBT; Bateman & Fonagy, 2016) and transference-focused therapy (TFP; Clarkin *et al*, 2015).

From the MBT point of view, patients with BPD show reduced capacities to mentalise, which leads to problems with affect regulation and impulsiveness, especially in the context of interpersonal interactions. MBT structures interventions that promote the further development of mentalising abilities. TFP posits that the specific symptoms of BPD stem from a lack of identity integration, corresponding with a lack of coherence in the individual's experience and understanding of both self and others. The major objectives of the treatment are to facilitate better

behavioural control and to increase reflection and affect regulation, with the ultimate goal of promoting identity integration

Both TFP and MBT have provided empirical evidence of their efficacy through randomised clinical trials (RCTs) and are now undergoing investigation of the factors by which they generate therapeutic change and possible relevant outcome measures. Two variables are especially significant in this context: reflective functioning and personality organisation. Reflective functioning, equivalent to mentalisation, can be defined as the capacity to reflect on internal mental states such as feelings, wishes, goals and attitudes, with regard to both the self and others. Measurement of such is now more accessible thanks to the reflective functioning questionnaire (RFQ) instrument (Fonagy *et al*, 2016). The concept of personality organisation refers to the configuration of our inner world based on internal object relations, which are regarded as the basic building blocks of all mental experience. A semi-structured interview called STIPO (structured interview of personality organisation; Hörz-Sagstetter *et al*, 2017) is able to reliably evaluate this organisation of personality. RFQ and STIPO make it possible to assess the patient in greater detail, help in treatment planning and allow a follow-up of possible changes throughout the therapeutic process.

Unfortunately, a significant proportion of psychodynamic psychotherapists are not involved in research and do not know enough about the studies carried out (Kernberg, 2015). Some of them are even dismissive towards research itself, based on the (false) belief that research in and on psychoanalysis is not useful for either the clinician or for the discipline itself. This factor might make it easier for the general mental health community to ignore the important evidence already gathered about psychotherapies in general and psychoanalytic psychotherapies in particular. If those who know and use these techniques do not disseminate the evidence regarding such, then who is going to do so?

The data we have today concerning the efficacy of MBT and TFP are clearly positive. Recent studies (Cristea *et al*, 2017) indicate that psychotherapies, most notably dialectical behaviour therapy and psychodynamic approaches, are effective for borderline symptoms and related problems; nonetheless, it is certainly necessary to increase the number of studies, the sample sizes and the general methodological quality. Methodological and

logistical obstacles are relevant, and it may be advisable to complement research based solely on RCT designs with studies using, for example, case series or single case designs, following the example of researchers in surgery who face methodological challenges similar to those that affect psychotherapies (e.g. pure double-blind impossible, placebo very difficult, low sample sizes, different technical skills of clinicians). We still do not have evidence that allows us to choose which psychotherapy may be the most appropriate for which patient profile (Fonagy *et al.*, 2017). Therapists should therefore employ common sense and their clinical experience to decide on the best evidence-based intervention for each particular patient.

A high percentage of BPD patients around the world do not receive specific care with an evidence-based psychotherapy (Paris, 2015). Sadly, a combination of ‘creative’ psychopharmacology and repeated hospital admissions is a common approach or, at best, a non-specific psychotherapeutic approach. There is still a very limited offer of effective techniques whose origin is complex. A significant effort is currently being made at an international level to disseminate TFP and MBT and to train groups of clinicians, particularly nowadays in Europe and America. By focusing on these techniques we can highlight some important aspects of this training, featuring, as is traditional, two fundamental elements: theoretical seminars and supervised practice.

- (a) The theoretical content of both techniques is not significantly complex and requires no previous psychoanalytic training.
- (b) Neither TFP nor MBT require an experience of personal (or ‘didactic’) analysis of the therapist in training. The fact that these sophisticated psychoanalytic techniques can be put into practice without a training analysis may have healthy implications for psychoanalysis in general and propitiate closer contacts with mental health clinicians, universities and the world of empirical research.
- (c) Supervision is a core element in the training of TFP and MBT. Patients with BPD often use primitive defensive mechanisms and generate strong countertransferential reactions. Supervisors are still scarce for both TFP and MBT, and this significantly hinders training programmes.
- (d) One particular obstacle is the linguistic ability of the supervisor, as supervision is greatly enhanced when the supervisor is able to speak the language used by the patient. Hopefully, the gradual development of new training programmes in different countries will generate more therapists and more supervisors.
- (e) TFP and MBT recommend ‘peer supervision’ beyond the therapist’s initial stage of training and throughout their entire

professional career. Clinicians of varying levels of expertise meet periodically to discuss cases and clinical problems and offer mutual help, especially to explore countertransferential aspects that may otherwise go unnoticed by the therapist involved.

Given the high prevalence and widespread comorbidity of BPD, it is unlikely that in the future a majority of patients will be cared for using evidence-based psychotherapies in super-specialised centres. These teams may well act as reference centres, producing training or research, as well as taking care of especially complex patients. Nevertheless, it is necessary to design basic or minimal techniques that, based on what we already know, provide benefits to the patient, avoid iatrogenesis and are available in most mental health facilities. Some valuable attempts have been made in this context – for example, good psychiatric management (GPM) (Gunderson, 2014) – with strong psychodynamic inspiration. However, GPM requires substantial resources beyond the possibilities of most health systems in the world.

Both MBT and TFP have recently explored new applications, outside the initial context from which they emerged, whether different intensity (single weekly session, group format), different scenarios (hospital units, out-patient clinics), children and adolescents, or other diagnoses (antisocial personality disorder, narcissistic personality disorder, affective disorders, eating disorders, comorbid psychiatric or medical pathology) (Bateman & Fonagy, 2011; Hersh *et al.*, 2017). More research is needed to produce evidence regarding the efficacy of these new applications.

In short, MBT and TFP are evidence-based psychodynamic psychotherapies that are clearly effective in the treatment of BPD. The research effort has been great, overcoming important methodological and logistical obstacles. Dissemination of these therapies is bringing psychoanalysis back to the mental health community and strengthening its links with empirical research and universities. At the same time, they have aroused a certain degree of mistrust among more traditional psychoanalytic circles. Both MBT and TFP are now expanding their initial field of application beyond BPD, proving their usefulness in group approaches, hospital units and other diagnoses. The major challenge lying ahead is to extend training programmes, generating a sufficient number of therapists and supervisors.

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COUNTRY PROFILE

Mental healthcare in Saint Lucia

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St Lucia is a small island in the eastern Caribbean with a population of approximately 200 000 people. Although St Lucia is formally ranked as a high middle-income country, there are pockets of deprivation and relatively low living standards. Mental health services in St Lucia have increased considerably and advanced over recent years because of a coalition between the government of the island and South East Asian partners. The National Mental Wellness Centre opened several years ago and has much improved facilities. There remains a significant shortage of community-based services, no mental health law, and a pervasive community stigma and apprehension regarding those with mental health problems.

In St Lucia there is a relative lack of data regarding the provision and outcomes of mental health services. St Lucia is an island state in the eastern Caribbean with a population of 200 000. It is classified as an upper middle-income country by The World Bank (2012). Despite this, there are pockets of deprivation and many people live under the poverty line. An institution previously known as ‘Golden Hope Hospital’ was the first step towards mental healthcare on the island. The hospital was run as a custodial asylum, with a strong medical focus and little input from other professionals. Although designed as a ‘place of refuge,’ in reality it was more about the containment of some of the island’s most

vulnerable people. It was replaced in 2010 by the National Mental Wellness Centre in a collaborative effort between the governments of St Lucia, China and Taiwan. The centre provides a multidisciplinary model of care with doctors, nurses, psychologists, occupational therapists and social workers collaborating closely. Services (including medications) are available free of charge to individuals regardless of age, nationality and economic status (WHO, 2009).

Structure and demographics

National health expenditure is 8% of the gross domestic product and 4% of that is allocated to mental healthcare, of which 97% goes to mental hospitals (WHO, 2011). There is no separate budget for community-based mental health services, and what exists is financed from the hospital budget. As a result, limited funds are available to strengthen the delivery of primary care services for people with mental disorders. The majority of hospitalised patients have a diagnosis of schizophrenia, other psychosis or substance-induced psychosis, but good quality data are hard to find (WHO, 2009). There are 71.8 beds per 100 000 people, none of which are specifically designated for children and adolescents. These beds are all at the wellness centre where there are two acute wards (one male and one female), three rehabilitation wards, and a drug rehabilitation and counselling service, known as Turning Point.

Two psychiatric consultants and two registrars take charge of the day-to-day care of patients. There is one psychotherapist and one social