# 18a Contemporary Psychodynamic Treatments: Commentary on Psychoanalytic/Psychodynamic Approaches to Personality Disorders

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Fonagy and colleagues (this volume) are to be commended for a wonderfully rich and nuanced presentation of contemporary psychodynamic treatments (PDTs) for personality disorders. This is no easy feat as psychodynamics approaches with a long history are not monolithic and are quite diverse. Fonagy and colleagues begin their chapter with a brief overview of the psychodynamic approach to PDs, followed by an elaboration of the contributions from the major traditions within the psychodynamic perspective. Although they focus on models, this section provides a rich historical perspective as well.

Following their overview in the first section of the chapter, they focus on two of the primary contemporary psychodynamic approaches to PDs, with a particular focus on mentalization-based treatment (MBT) and transference-focused psychotherapy (TFP). In this section, Fonagy and colleagues provide a nice explication of the respective models, and a detailed consideration of the evidence for their effectiveness. It is important, as they note, that on the basis of numerous randomized controlled trials (RCTs) and comprehensive meta-analyses, the evidence for psychodynamic treatments for personality disorders is as strong as the evidence for treatments from other orientations (some have suggested that because there are more studies of DBT than other treatments, that there is more empirical evidence for DBT than other treatments; however, another way of thinking about it is that because there are more studies of DBT, we can be more confident in its effect size, which is no different than what is found for other treatments, including PDTs).

Fonagy and colleagues then close by articulating a model based on their more recent thinking and the findings in the literature regarding the equivalence of outcomes for various treatments irrespective of theoretical orientation. Although I was disappointed that the authors did not take up the implications of a general psychopathology or "p" factor as fully as I expected, I found this closing section to be an interesting, timely, and integrative conceptualization. It provides a valuable pearl with which to end the chapter.

In reading the chapter, I asked myself, who is the reader that this chapter is written for? Most of the chapter is written, as I think the editors intended, for a broad audience ranging from psychopathologists and clinicians at all stages of their career including those in training for these positions. This is a challenging task, and the chapter delivers the kind of information that would be of value to all individuals across the broad target audience. As one example, the reader of this chapter will derive an excellent understanding of the contemporary models for treating BPD and its corresponding evidence.

This success notwithstanding, in order to meet the needs of a broad audience the historical review could have benefited from more explication. Although such history is important and often neglected, the main points can be obscured by the use of psychoanalytic language that might be foreign to such readers (e.g., objects). It would be useful to provide clarification of what the terms mean and/or elaboration of how they evolved. As such, I felt this section missed the opportunity to educate those less familiar with the psychodynamic model and the value of such an approach. Below I highlight some of the points that I think could have had more emphasis in stressing the unique contributions and utility of a psychodynamic approach.

Psychodynamic approaches to personality disorders, although diverse, all share certain basic tenets. Arguably there may be additional tenets for consideration but I will focus on the following: (1) that early childhood relationships with caregivers play an important role in shaping how we experience and view subsequent relationships (this is the idea of transference); (2) that some mental processes, such as motives, desires, and memories, are not readily available to awareness or conscious introspection (the idea of the unconscious); (3) people are sometimes motivated to keep threatening thoughts or feelings out of awareness (this is the idea of defense); and (4) the importance of individual or personal meaning (this is the idea of psychic reality and explains why two people can experience the same event very differently or why an event can be traumatic to one person but not another).

The idea that early childhood relationships with caregivers play an important role in shaping how individuals experience and view subsequent relationships is not unique to psychodynamic approaches. However, more unique to the PDT approach is that the representations (schemas or internal working models) built up slowly over years through these interactions with others and the environment result in what Freud called transference. Transference is simply the tendency in which represented aspects of important and formative relationships (e.g., with parents) are attributed to other people. This process of transference can be conscious, but also is often unconscious or implicit (Levy & Scala, 2012). Within any interaction, there are individual differences in transference in terms of the degree, extent, rigidity, and awareness of transference. Transference can be in line with reality or reality-based, in that it is based on aspects of the individual or the situation that can pull for transference. It can also be evoked – that is, people encountered can act in ways to elicit reactions and behaviors that are consistent with one's transference tendencies. The amount of transference can vary as a function of the individual, the target, and the situation. Lastly, an important feature of transference is that some aspects are not only unconscious but are related to conflicts and defensive processes. In healthier individuals, initial transference reactions quickly give way to the more reality-based aspects of the real relationship (Gelso, 2010; Gill, 1979). In less psychologically healthy individuals transferences are often inconsistent with the social reality and are rigidly held despite evidence to the contrary. While transference is not necessarily the focus in treatment in all psychodynamic approaches as it is in TFP, most psychodynamic approaches, including supportive ones and MBT, track and attend to transferential processes (Appelbaum, 2007; Bateman & Fonagy, 2007; Gabbard, 2007) because awareness of these processes can assist with the managing of the patient–therapist relationship.

Thus, to summarize from above, the concept of transference is not simply a jargon filled term referring to a vestige of an obsolete model but it is a concept that has clinical utility both diagnostically (and phenomenologically in the moment for both the patient and the therapists) and for conceptualizing treatment dynamics, whether or not one is engaged in tracking the transference like in MBT or a supportive dynamic therapy, or the therapist is engaged in the process of interpreting it as it relates to thoughts, feelings, and behaviors in the patient, such as the case in TFP.

Moreover, from a psychodynamic approach, mental representations not only serve as templates for viewing later relationships, but they have certain qualities. For instance, in comparison to CBT approaches, psychodynamic theory emphasizes the structural aspects more than the content or valance of the representations. These structural aspects include not only the organization of the representations but include the developmental aspects of representation. This developmental focus is important because it means that not all representations are encoded or can be retrieved through the same mechanism across individuals or even within individuals. Thus, there are inter- and intra-individual differences that must be accounted for. Structural aspects of representation also include the affective components of representation. For example, much like Marcel Proust, Kernberg (2001) stresses that every representation has an affect attached to it and every affect has representations associated with it. This means attending to the affect provides a window to the representations associated with emotion – representations that can be explicated and understood. Likewise, as Fonagy and colleagues contend, representations of emotional experience affect mental states and vice versa (what Fonagy, Jurist, and their respective colleagues refer to as mentalized affectivity; Fonagy et al., 2004; Greenberg, Kolasi, Hegsted, Berkowitz, & Jurist, 2017; Jurist, 2005).

Beyond the developmental, affective, and structural aspects of representations discussed above, the psychodynamic approach is unique in that it not only recognizes the conscious phenomenological aspects of experience but also the implicit or unconscious aspects of representation. In recent years, cognitive-behavioral (de Jong, 2002; Teachman & Allen, 2007; Teachman & Woody, 2002; Teachman, Woody, & Magee, 2006) and even behavioral approaches (if one considers experiential avoidance an implicit process) have begun to recognize and even focus on implicit processes but not quite in the same way as from a psychodynamic perspective. Implicit processes are not simply automatic, quick, reflexive processes outside of awareness but can involve motivational influences and defensive processes (Moeller, Johnson, LeBreton, & Levy, in press).

Another issue that deserves elaboration is that Fonagy and colleagues limited the focus of their review to MBT and TFP. On the one hand, this makes sense given the prominence of these two treatments within the psychodynamic world, in the personality disorder literature, their recognition among treatment guidelines, and in psychiatric and psychology training (Sansone, Kay, & Anderson, 2013). On the other hand, as a more general chapter on psychodynamic treatments, it is important to at least identify that other important approaches exist including Dynamic Deconstructive Psychotherapy (DDP; Gregory, Delucia-Deranja, & Mogle, 2010), Psychodynamic Supportive Therapy; Appelbaum, 2007), and Gunderson's Good Psychiatric Management (GPM; Gunderson & Links, 2015; McMain et al., 2009). Granted, the current articulation of the GPM model while consistent with a psychodynamic approach (for example, seeing emotion dysregulation as activated by defensive processes in reaction to an attachment based interpersonal hypersensitivity), is organized in a psychoeducational structure. Nonetheless, in the RCT (McMain et al., 2009) examining DBT as compared to GPM, the psychotherapy utilized was based on Gunderson's psychodynamic approach

(Gunderson & Links, 2008), which shares many principles and a structure that is similar to aspects of MBT and TFP. Thus, although these approaches may not deserve the same space devoted to them as TFP and MBT, they do deserve mention to ensure the reader gets a perspective that is broad and inclusive of the wide range of work done in this domain of treatment for PDs.

The final point I would like to make specific to Fonagy and colleagues' concluding section (this volume) concerns the convergence of a psychodynamic model of personality disorders, particularly Kernberg's, with the findings of a general psychopathology or "p" factor (Caspi & Moffitt, 2018), the Alternative Model for Personality Disorders (AMPD), the recent findings within assessment of personality pathology about general ('g') and specific ('s') factors (Sharp et al., 2015), and the Cognitive Affective Personality System (CAPS) model (Mischel & Shoda, 1995; for reviews, see Clarkin, Levy, & Ellison, 2010; Huprich & Nelson, 2015). This convergence provides validity for the psychodynamic model and shows its clinical utility. These convergences also show that rather than being an old antiquated model deserving to be jettisoned from contemporary consideration, the psychodynamic model is theoretically and clinical useful and has been absorbed, knowingly as in the case of the alternative model and the p factor, and maybe unknowingly in the case of the CAPS model.

First articulated in the late 1960s, Kernberg proposed a model for understanding a range of personality disorders along two dimensions – severity and internalizing vs. externalizing (Kernberg, 1967; Kernberg & Caligor, 2005). Various personality disorders could be arrayed along this two-dimensional space. Consistent with recent research (Sharp et al., 2015; Wright, Hopwood, Skodol, & Morey, 2016), Kernberg conceptualized the severity dimension in terms of level of borderline functioning. This conceptualization is also consistent with the AMPD in Section III of the DSM in that borderline pathology is of central heuristic value for representing what is common to all personality pathology (Criterion A). The progression from lower levels of severity in personality pathology to higher levels of severity is tied to more impaired and maladaptive self–other representations and functioning. Thus, in Kernberg's model, the central BPD symptoms – abandonment fears, unstable relationships that alternate between idealization and devaluation, affect instability, identity disturbance, paranoid ideation, and chronic feelings of emptiness, and angry outburst – arise from an individual's impaired and distorted internal images of self and other, what Kernberg called identity diffusion. The data from Sharp et al. and Wright et al. are consistent with this idea. So is recent data from our lab (Scala et al., 2018) where in an intensive repeated measurement design examining BPD patients as compared to anxiety disordered patients over a 21-day period, we found, as many might predict, that affect regulation deficits in terms of negative affect predicted suicidal urges. However, this relationship was only found when patients were in identity diffuse mental states. Although BPD patients scored significantly higher and experienced more identity disturbance, negative affect, and suicidal urges than those with anxiety disorders, the process worked similarly across both groups.

In summary, Fonagy and colleagues (this volume) have provided an important explication of the contemporary psychodynamic treatments for borderline personality disorder with a focus on transference-focused psychotherapy and mentalization-based treatment. I have tried to highlight and elaborate the theory behind these models and show that rather than being outdated and irrelevant, contemporary psychodynamic models are consistent with evidence from general psychopathological models. The psychodynamic model, with its focus on the developmental psychopathology of self–other representations, conscious and unconscious mental processes such as defense and transference, and the importance of psychic reality have much to offer and the resulting treatments have shown comparable efficacy.



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