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ORIGINAL PAPER

Beyond the Borderline: Expanding Our Repertoire to Address Relational Patterns and Power Dynamics Attendant to Diverse Personality Disorders

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Abstract
A present challenge in our field is that diverse and frequently comorbid patterns of personality disorder are not sufficiently addressed by existing evidence-based treatments. Authors in the special section describe promising efforts to address this challenge, including case examples illustrating the utility of each approach. Each approach is consistent with evidence-based principles of change, suggesting the possibility of placing them together within a meta-theoretical integration frame (Magnavita and Anchin in Unifying psychotherapy: Principles, methods, and evidence from clinical science, Springer Publishing Co, New York, 2014). Common threads include use of an individualized case formulation to tailor treatment to diverse patterns; incorporation of affect, behavior, and cognition; and modification of attachment-linked, internal templates using both didactic and experiential forms of learning. Interpersonal Reconstructive Therapy (IRT), our favored approach, offers a similar language and framework, leaving technical choices to the clinician so long as they are consistent with an attachment-based, interpersonal case formulation, and are helpful in establishing new patterns toward adaptive goals. Work with IRT suggests ways to extend further the focus on internalized representations. Direct conversation with "family in the head" can be used to enhance ways of being, thinking, and feeling that allow distance and differentiation from problematic internalizations of loved ones. The authors present suggestions for future research, emphasizing the therapeutic relationship as well as the need to measure therapeutic optimality in a tailored, context-specific manner focused on mechanisms of psychopathology and change.

It is an honor to provide commentary and editorialize in relation to topics raised by the articles in this special section of the *Journal of Contemporary Psychotherapy* focused on treatment of patients with anxious and overcontrolled personality patterns. A primary vantage point for our commentary is from work in a clinical setting that emphasizes complex cases involving personality disorder with high levels of severity and/or chronicity, usually referred after other approaches to treatment have not been helpful. Many of these clients have profiles consistent with personality disorder diagnoses such as obsessive–compulsive (OCPD), avoidant (AVD), dependent (DEP), and passive-aggressive (PAG) personality patterns. From our point of view, it is refreshing, and important, to see our field turning attention to treatments for these kinds of problems. There now exist a number of well-developed, evidence-based treatments that target borderline personality disorder (BPD), notably Dialectical Behavioral Therapy, Transference Focused Psychotherapy, and Schema Therapy. A key challenge for our field is that there are a diversity of personality patterns, and not all of them are addressed well by BPD-specific treatment packages. Authors in the current special section are addressing this challenge directly through their focus on a range of other personality patterns.

Common Threads

Importantly, each of the methods in the special section emphasize use of an individually-tailored case formulation that incorporates patterns of cognition, affect, and relational patterns enacted with self and others. In most framings, there is an acknowledgment that these patterns reflect learning

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with important caregivers that has been internalized, and in turn provides a template for current ways of perceiving and responding with others. This view of personality pathology in many ways traces back to Bowlby's (1977) articulation of attachment theory. The frameworks provided for each treatment seem at once to be new and innovative, while also being familiar and in line with well-known, classic traditions of psychotherapy.

Treatments described in the special section each seek on some level to modify the internalized templates that shape thought, feeling, and relating through forms of expanded awareness (of the self, of others, of possibilities for each). The therapeutic relationship is recognized in each as a key forum for enhancing recognition of problem patterns, exploring alternate possibilities, and eventually practicing new ways of being. Most of the examples offered a contextualizing frame, shared with patients, for how to understand patterns as they relate to therapy goals. The frame in each case is enhanced by some form of experiential learning that is unique to the approach. The work reported by Popolo et al. (2018) is especially interesting in this regard by using the power and perspective of a group setting, inviting participants to engage in role play in order to develop the capacity to think more flexibly about possible ways of understanding self and others. Differences between approaches seem to be about the strategic emphasis placed on affect, behavior, or cognition with regard to specific techniques. Changes in one area are understood to have likely spreading effects to the other domains. Thus, as we see it, the special section offers a range of options for tailored intervention of diverse problem patterns among treatments that bear a family resemblance.

Given the apparent congruence among these treatments at the level of overarching principles, it seems plausible that a broad, meta-theoretical perspective might be articulated to encompass the shared conceptual space of each approach. We believe that each of the methods conforms well to a set of principles derived from the evidence base of (mostly BPD-focused) PD treatments that existed a little over a decade ago (Critchfield and Benjamin 2006). Those principles underscored the importance of the therapeutic alliance (or group cohesion) as well as a therapist who is able to be flexible, creative, congruent, and empathic. Patient variables were also found to be strong predictors of treatment response, including attachment history. Treatment principles included the need for a comprehensive formulation that included affect, behavior, and cognition. Among other treatment principles, a clear and transparent delivery of the treatment rationale was emphasized, as were use of active change strategies for reducing maladaptive ways of thinking, feeling, and behaving, while also practicing more adaptive ways. Magnavita and Anchin (2014) have referred to use of a meta-theoretical strategy for psychotherapy integration (especially when applied to the field as a whole) as "unified psychotherapy." As multiple approaches converge on a shared set of perspectives that understand patient problems to involve individual learning history, interpersonal context, affect, behavior, and cognition, it becomes easier to see a sketch of what unified psychotherapy might ultimately be.

Common Comorbidities and the Need for Use of an Individual Case Formulation

Illustrative cases in the special section, with the exception of one DEP case, involved presence of both OCPD and AVD patterns, sometimes accompanied by additional patterns or features (Fassbinder and Arntz 2018; Gordon-King et al. 2018; Popolo et al. 2018; Sachse and Kramer 2018; Simonsen et al. 2018). Comorbidity of personality disorders is a complicating factor in the planning and execution of any PD treatment. It is also very common, and evidence suggests it cannot be easily ignored for diagnosis and treatment processes. For example, in a sample carefully selected for inclusion in a randomized control trial for BPD conducted by Clarkin et al. (2007) there were an average of 1.5 PD diagnoses in addition to BPD (Critchfield et al. 2008). Both the type and the degree of comorbidity predicted which specific BPD criteria were likely to be met, suggesting that overall patterning is clinically salient and that pattern expression across PD categories is inextricably linked. The case highlighted by Fassbinder and Arntz (2018) displayed the importance of attending to over-arching patterns when a patient carries complex comorbid diagnoses (in this case depression, avoidant PD, and obsessive–compulsive traits). The therapy was focused on identifying overall maladaptive patterns from childhood, facilitating emotional exploration and awareness, and then experiencing "limited reparenting" within the therapeutic relationship to begin finding new patterns and re-scripting.

It is interesting to consider the issue of clinical severity in relation to avoidant and overcontrolled personality patterns. Some clinical theorists have suggested that these patterns are generally less severe than the other PDs (e.g., Kernberg and Caligor 2005). However, in clinical practice, severe and chronic problems involving high stakes, such as suicidality, or inability to function in important life domains definitely accompany some anxious and overcontrolled patient patterns. For example, in one study, inpatients were referred due to presence of recurrent psychiatric hospitalizations and apparent treatment non-response in the community. This referral process for chronic and severe problems produced a sample characterized primarily by OCPD and PAG patterns, with substantial comorbid presence of both BPD and AVD diagnoses (Critchfield et al. 2015).

There is some evidence to suggest that the patterns considered in the special section also resist change via usual

treatment methods, again suggesting the need for individually-tailored intervention. For example, trait-like perfectionism (the hallmark of OCPD) has been shown to pose a unique set of challenges in terms of resisting the premise or rationale of a treatment, and putting particular strains on the therapeutic relationship (Shahar et al. 2004). The complex, but different, power dynamics associated with avoidant, dependent, and passive-aggressive PDs can also provide difficult challenges to the change process. Reactance in PAG, for example, is another pattern notable for its ability to interfere with treatment, particularly when interventions are more directive (Beutler et al. 2011).

Wisely, each set of authors in the special section uses an approach that incorporates an individual case formulation to characterize patterns in the present and uses that same framework to articulate an alternate set of possibilities consistent with better adaptation. Ultimately, all patients are being helped to have a more benign appraisal of themselves and others, so that avoidant people can engage more, dependent people can be more autonomous, obsessive–compulsive people can be less rigid, and so on. For the disorders emphasized in this section (as well as others), a fair amount of negative self-concept needs to be addressed along the way. Our sense is that a fair amount of nuance is available in these approaches to address the individual needs and comorbid features with each patient. Each one appears to operate according to principles that apply across the spectrum of patterns that constitutes PD. The conceptualization methods do not appear to be disorder-specific, nor do the treatment techniques used in the special section. Instead, the methods and theories appear to represent reasonable ways of formulating and addressing a wide range of personality patterns. In the special section, it is the flexible use of methods that is illustrated with a particular set of disorders, rather than a set of principles or procedures that applies only to these personality types.

Attachment, Intervention, and Problem Definition

Our own favored approach to PD treatment, Interpersonal Reconstructive Therapy (IRT: Benjamin 2003/2006, 2018), shares much in common with those of the special section. IRT has its own language and measurement frameworks and, of course, its own relative emphasis on attachment and relatedness. A full explication of that method is beyond the present scope, but a brief orientation will help illustrate what we feel are an important set of ideas related to attachment. IRT generally leaves open the question of what techniques can or should be used, requiring only that they (1) are consistent with the individual case formulation, and (2) will be helpful in moving patients toward adaptive goals given their current stage in the change process. A core algorithm is used to guide therapeutic interventions in a context-specific way.

Like many of the methods in the special section, IRT places emphasis on how internalized representations of past relational experiences powerfully shape current perceptions and responses. When such repetitions are observed in individuals, the details of that learning, and feelings toward those specific figures inform the IRT case formulation quite directly. IRT frames case formulation not just in terms of pattern repetition, but in terms of what patients have learned from key attachment figures relative to safety and threat, using these links to explain how current symptoms "make sense," as well as to suggest therapeutic tasks and goals. In IRT theory, if early input from loved ones conformed to secure attachment patterns, then the adult life will be characterized by reality-based and adaptive choices relative to self and others. However, if maladaptive ways and values were offered and internalized, then safety and threat systems will be miscued (Benjamin 2003/2006, 2018). There are at least two parts of the self in this view. One part repeats the old patterns out of love and loyalty, while another part seeks healthy adaptation. These are referred to in IRT as Red and Green, respectively, and are often in direct conflict with one another. Affect, behavior, and cognition are all involved in both past and present relationships. In IRT, in addition to frank discussion of these patterns and their implications, the therapeutic relationship is considered key to the change process both as a supportive, safe place for facilitating awareness and change, but also one in which characteristic patterns are expected to emerge and allow more direct experiential work with internalized representations.

Coming from this point of view, we find a great deal in the special section to be familiar, resonant, and helpful. For example, the capacity to reflect on and become aware of one's own mental state and experiencing was emphasized in a number of the articles, most notably in the Simonsen et al. (2018), Popolo et al. (2018), and Gordon-King et al. (2018) pieces featuring Metacognitive Interpersonal Therapy. In IRT, it might be assumed that collaborative, explicit discussion of patterns encourages clients (among other things) to develop meta-cognitive capacity. Awareness of these potential linkages across diverse theories and methods suggests to us that our field needs to focus much more attention on underlying principles of change—and to be less precious about which specific techniques or conceptual language systems are required to activate those principles. However, due to our investment in IRT, we became aware of potential areas of divergence. As with the methods in the special section, the work of IRT therapists involves a fair amount of focus on becoming aware of patterns in the present and assisting with the process of articulating, choosing, and practicing healthier alternatives. Especially when this process is blocked, IRT uses the concept of attachment

in a way that seems more active, affectively and narratively, than was suggested by special section authors. While the concept of an internal working model, or schema is relevant, in IRT, personality pathology is understood to be part of an active relational process, an ongoing dialogue, with internalized loved ones, or "family in the head." The phenomenology associated with internalized models (i.e., of love, loyalty, important memories, and so on) is to be worked with directly. Processes of attachment lead patients to seek proximity (intrapsychically or actually) to those particular loved ones when under threat. Repetition of the ways and values learned with those figures bring a sense of closeness and loyalty to those loved ones, and a sense of things being as they should be, even when those ways are highly self-destructive. As such, "copy process" repetitions are understood to be rooted in attachment-based motivations—disordered behavior is on some level a "gift of love" to those internalized figures. Extremely paradoxical statements that override objective views of reality can "make sense" when held in this light. For example, terror and suicidal ideation may occur at the prospect of succeeding down a different career path, or with a different kind of relational partner, than loved ones demand. Benjamin (2008) collected several such paradoxical examples from patients, including "If I am happy, I make my family sad; being different is murderous. I lose if I take care of myself. If I fall apart, then they will love me; I am more at home with situations that are not working; it doesn't feel good, but it feels normal; if you are strong, you cannot be nice." (p. 417).

In IRT, patients and therapists are encouraged to "speak to" the internalized figures in rather direct ways. The goal is to get permission to be, think, or feel separate from them—to differentiate from important figures or their internalized representations. This process can be stormy and entail significant grief as yearning, the limits of loved ones, and awareness of time and opportunities lost, is accepted and accommodated at deep levels. Once this internal permission is wrested, then a patient may more easily practice and explore healthier ways of being—including benefitting from the wealth of useful procedures our field has developed.

To be fair to the special section authors, we are inclined to think that we could come to terms about what an optimal treatment process looks like with regard to attachment. A number of authors cited passages from their illustrative therapy processes that suggested very important conversations were had about loved ones, including elicitation of specific memories, recurring narratives, and their bearing on the present. The language appeared to be driven by patients and followed up reasonably and humanely by therapists in a manner that invokes the vexing (for psychotherapy researchers) concept of therapeutic responsiveness. Our frustration, of course, is that we believe these moments may have been at the very heart of the change process, rather than merely an event, or "working through," along the way to changing the schematics and/or affect drivers in the present. Ultimately, we can likely agree about the overall arc and set of important elements in a successful therapy, but still emphasize, attend to, and narrate change processes differently. As IRT practitioners, we are inclined to think that attachment figures are alive and present in the hearts and minds of patients, and can be addressed as such. Part of our current research is to see whether our propositions hold water—to determine empirically the degree to which work with the gift of love is indeed necessary or central to change with diverse PD patients (Critchfield and Benjamin in preparation).

The role of attachment relationships as either (1) alive in the present and distorting realistic appraisal of options, or (2) the historic learning context out of which current patterns were formed also made us aware of another set of tensions between some of the approaches in the special section, and those of IRT. The distinction involves the question of what personality pathology consists—if it represents a deficit of knowledge and experience, ameliorated by therapeutic input about better ways of thinking and behaving, or if it is more complex than this. In the IRT view, it is most often the case that patients have a good capacity for logic and problem solving. In a setting where patients have had multiple prior therapists, they have typically learned a variety of helpful coping skills and strategies for thinking and feeling that "should" work, but are at a loss to know why they do not use them at crucial moments. In some cases, this "failure" to use helpful input is perceived by the patient as yet another reason to indict and mistrust themselves, twisting competent therapy input into something iatrogenic. In IRT, patient problems are not usually seen as a simple lack of ability to think, feel, or reason well, but instead as reflecting conflicted loyalty to differing ways of being, as a love story gone wrong. The yearning desire to be loved by internalized attachment figures, to express loyalty to their ways and thus achieve psychic proximity, can override realistic appraisals and awareness of what they "should" do, especially under perceived threat. The idea that PD is often a function of love, rather than a simple deficit of knowledge or experience, can make for a more nuanced approach to the change process, one that ultimately embraces the core self, even a maladaptively-behaving self, as having great capacity, and at some level being positive and well-intentioned.

In IRT, when patients do not respond to therapeutic input as desired, they are seen as likely blocked by their love or loyalty to important others who would disagree in some way. The problem is a conflict between their new attachment to a therapist or treatment milieu versus that of earlier attachment figures. One patient expressed the dilemma in vivid terms regarding proposed reasons for severe self-sabotage:

> What makes your opinion of me more accurate than theirs? They have known me longer, and therefore know me better … There are also more of them and they all have the same opinion of me that significantly differs from yours. You can't know the true me the way they do. Why should I believe you over them?

There are a variety of ways to helpfully respond to this question. Our intent here is to point to conflicted motivational states that can arise with change attempts as a result of internalized attachment relationships, and how the clinical situation is not simply a matter of providing new information, or even new affective experiences, about how to be healthy. In this example, the therapist is facing a conflict between a part of the self that has engaged with the therapist to pursue healthier ways (her Green), while another part (Red, mostly given voice here) is clearly loyal to old messages from family in the head and resists new options. Such examples have led Benjamin (2008) to pursue parallels with autoimmune disorders in which a miscued immune response attacks healthy cells. Therapists can be internalized as additional voices that serve the function of helping a patient differentiate from other internalized figures, in essence to help re-cue the psychological immune system. This relationship is often not as strong as prior attachments, especially at first, but can grow with the experience of working together.

Research Implications

Psychotherapy research with PD is challenged by presence of a wide range of personality patterns and comorbid feature profiles. Application of randomized control trials can help us know whether a given treatment is on average better than some control condition. However, that methodology is not optimal for questions of more direct clinical concern such as the validity of specific change mechanisms and treatment principles. An alternative approach might be to develop adherence/fidelity measures that track the degree to which therapy processes and procedures are optimally implemented, given the individual case formulation, context, and so on. Such a measure of therapeutic optimality, defined for each theory, could be used in an attempt to (a) predict outcomes among cases with diverse formulations, and (b) determine how similar or different the recommendations of each treatment approach actually are at the level of principles. If therapist application of theory-specified methods does not correlate with outcome, then the theory itself is not strongly supported (even if patient outcomes are strong). The method would be correlational and so would need additional follow-up studies to replicate effects and rule-out various competing hypotheses to explain the data pattern. But this is true of all science. The method of associating adherence with outcome is an approach we are using in IRT research to test putative mechanisms of change. We recently published data about the reliability, sensitivity, and specificity of the case formulation method (Critchfield et al. 2015). Preliminary analysis of adherence data regarding use of the case formulation to guide interventions with specific cases is promising (Critchfield and Benjamin in preparation).

The standard model of our field to conduct RCT trials of brand-name therapies for specific DSM-defined disorders has led, we believe, to an accelerated fracturing of psychotherapy knowledge. It is interesting to note, for example, how scholarship and citation practices around methods in the special section (even this commentary!) tend to stay within the circle of a given therapeutic approach, and not to cite far back in time, despite the fact that we all "stand on the shoulders of giants." Integrative scholarship across methods and approaches requires a great deal of effort to decode theory-laden language to see principled consistency across a wide range of specific operationalizations. Rather than circling the wagons around specific treatment packages, it seems more important to articulate cross-cutting principles of change. Once evidence-based principles are established, it should become possible to ask more searching questions about the relative efficiency of various techniques for activating those principles in a context, or to get greater clarity about the relationship between specific techniques and specific forms of patient psychopathology. The question, "if all techniques have a use somewhere, then why use these techniques now with this patient, and not some other technique?" should have an answer rooted in validated principles of psychopathology and change.

Finally, as noted previously, Kramer and Stiles (2015) provide review of literature involving (typically) unmeasured degrees of therapist responsiveness to emergent patient need. This kind of responsivity can make the treatment for one person systematically different from another in ways that are not necessarily specified by theory. For example, if our patients steer us to 'where it hurts' and our theories don't prevent discussion, then therapy effects will not correlate well with an adherence measure that neither recommends nor proscribes this responsivity. Measures of adherence have potential to address this possibility so long as they are designed to intentionally track specific, theory-predicted forms of responsivity. For example, if an adherence measure defines optimal intervention in terms of a relevant dimension of responsive tailoring, then correlations will be stronger and the associated theory will have support. An individual case formulation can provide for theory-specified responsivity.

Therapeutic Relationships, a Final Thought

When I (KLC) need to reschedule sessions to go to a conference or similar meeting, I sometimes ask my patients "Is there any message I should carry with me to the therapists

of the world?" Despite the nuance and sophistication of our theories, the message from patients who have had many therapists is usually "just tell them to listen and care." Along those same lines, I recently received the message below (and permission to use it) from a former patient who fit the general profile discussed in this special section. She offers a few cross-cutting principles of psychotherapy for us to take seriously:

> I know that you are helping many become better therapists. Remember my advice. Many nods of validation. Be nice even if you don't like the crazy ones. Looking bored is counter-productive. Maybe spend more time on the good teachers than so much on the bad ones. (I had some issues with that with some of the therapists I tried.) Having a good picture to focus on when it is too hard to be in the present with a therapist can be very helpful. (I still look at your Autumn trees picture when I need to center myself.) ☺ And no evil meds! ☺

The first few lines are self-explanatory, we hope, in their invocation of the therapeutic alliance. The comment about "teachers" (meaning important attachment figures) ultimately has to do with the idea that positive attachment relationships matter, and that sole therapeutic focus on problems, maladaptive messages, or trauma can be out of balance. In other words, Green, resilient ways of being often have links to important loved ones, not just Red. The "Autumn trees" comment refers to how this patient innovated use of a picture in my office for purposes of centering herself and remaining present when facing overwhelm. Methods for affect regulation, including benign forms of containment, are important for therapists to offer and use judiciously given how difficult therapy work can be at times. The last line about "meds" contains complex humor, but ultimately is a reminder that work with severe problems typically occurs in an interprofessional context and that we are wise when we communicate and align approaches not just among ourselves as psychotherapists, but across all our mental health related disciplines to the degree possible.

Compliance With Ethical Standards

Conflict of Interest The authors have no conflict of interest.

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