Borderline Personality Disorder: Common Factors In Effective Therapies With Dr. Robert Feinstein

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Dr. Robert Feinstein, Kristen Kim, and Dr. Puder have no conflicts of interest to report.

Introduction

This article complements an episode where we interview Dr. Robert Feinstein, on his new book, *Primer on Personality Disorders*. In a chapter he authored in the book, he writes about the commonalities of effective treatments for Borderline Personality Disorder. Dr. Feinstein states that six major types of psychotherapy achieve around 70% effectiveness in the treatment of borderline personality disorders.

Working with Commonalities in Therapy Modalities

After years of working in clinical settings with patients who have personality disorders, Dr. Feinstein found commonalities in the "Big Six", which are the six evidence-based treatments that have significant research to support that they work (MBT, CBT, DBT, TFT, SFT, good psychiatric management). In recognition of this, therapists can develop the ability to adapt different therapies methods when one may not be working, such as the one they specialize in. He encourages the mindset that there is more than one way to do things and we are ultimately working towards health in the patient in whatever therapeutic form that may come in.

About 89% of outcomes in psychotherapy have to do with factors common to all therapy types: giving the patient empathy, for the patient to be heard and understood, observed, validated, and having a structure to the psychotherapy. Only 10-12% of outcomes are based on patients that need specific treatments because of certain problems where some treatments do work better than others.

While most studies comparing therapy methods focus on comparing one modality against itself (such as nuances within DBT, for example- like doing prolonged exposure increased outcomes when doing DBT- Harned et al., 2014), the studies that have been conducted comparing different modalities show that outcomes are similar and that many therapies work.

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What creates better outcomes is more than any one particular modality—it greatly hangs on the therapeutic alliance between the therapist and the patient (accounts for 35% of outcomes across many studies).

Additionally, some patients may need and benefit from a sequence of different treatments. DBT may work for cutting and suicidal tendencies that are the focus at the beginning of treatment, but once that has been effectively managed they may need to work on attachment issues in relationships, which may require a different type of therapy (possibly mentalization therapy or transference focused therapy). A seasoned provider will know how to best direct a patient's treatment.

Frame and Personality Disorder Treatment

The idea of frame in personality disorder treatment is that it is very important that treatment is well structured and not open-ended. There need to be clear goals and each session needs to be focused on moving towards those goals. All of the treatment methods would agree on the first line of framing structure would be addressing violent or suicidal behavior, substance abuse, eating disorders, and other similar destabalizing behavior.

Most would agree to next address the need for therapy to be a safe space, meeting regularly, and emphasizing (particularly DBT and CBT) having a way to deal with treatment interfering behavior (violence in sessions, missing sessions, not doing homework).

Other important points of framing and structure:

- Having the patient committed to the process of working towards goals during each session.
- Patients working through any shame that might keep them from being completely honest with the therapist. This also means being open about certain ongoing behaviors that would get in the way of moving forward, such as throwing up multiple times per day, intoxicated many times per week, etc).
- Each therapy has its own version of structure in therapy and way to deal with these different problems.

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Commonalities in Personality Disorder History/Early Trauma

Looking into the history of a wide range of patients with personality disorders, there are factors that present very often as common history among them, namely trauma. When it comes to addressing behaviors that get in the way of therapy, often these behaviors are, at their core, trauma driven; trauma is the bedrock behind these behaviors and the big thing that becomes uncovered with this group of patients.

The way to uncover these traumas and begin to treat them really depends on the patient—what they are doing and what they need—and must be tailored to the patient.

Traumas very often found in patients with personality disorders are abuse (sexual abuse- often seen in histrionic personality disorder and borderline personality disorder such as incest), neglect (including functional neglect), a history of violence, and invalidating environments (narcissistic caregivers).

Often we see these patients blocking out sexual abuse, such as in the presentation of dissociative personality disorder. Trauma induces memory changes—you want to put pain out of your mind or need to in order to function. We must let it emerge naturally from patients and not ask leading questions. We don't want to create a false memory because it may not be true and then they go on to believe something happened to them when it did not. Trauma may be present in their current life and that may be where their conversation about any past trauma emerges.

Are personality disorders genetic or environmental?

Personality disorders usually have both components, in addition to a trauma component. We see that genetics (besides narcissism) have modest heritable traits towards personality disorders (tendencies towards negative emotionality, high impulsivity/low agreeableness, tendency towards introversion). Narcissism has the least evidence for genetic input; it is seen as more of a parenting issue and how the patient was raised (although research is emerging about genetics in narcissism).

Narcissism

There are subcategories of narcissism:

- Malignant Narcissist: the worst degree of narcissism; cruel, sadistic, all-powerful, antisocial features, psychopathic tendencies, exploit others; we don't know how to treat

them. These people likely have psychopathy overlapping with them and low affective empathy.
- Suspicious: paranoid of others and their intentions; less severe and on the edge of treatability
- Neurotic: healthier; but no sense of themselves/who they are; very treatable

Another structure used to differentiate between narcissism levels is to look at personality tendencies and how these patients function:
- Psychotic personality disorder level: they don't have a relationship with reality; hallucinations and delusions; primitive defenses
- Borderline personality level: not psychotic, but disturbances with reality, a little dissociation and confusion as to who they are; splitting defenses
- Neurotic level: basically in touch with reality and context; repressive-based defenses

Patients may not stay at one level throughout their lifetime, but function at different levels at different points in time. For example, they may fluctuate between psychotic and borderline depending on their environment (although psychotic-level patients don't usually make it down to the neurotic level).

Therapeutic Alliance Approaches and the Big Six

Each therapy has a different approach in how they think they should relate to the patient.

- Schema therapy: role is to be a good parent (modeling what a good parent should be), with boundaries (limited reparenting); other therapies tend to be against this although measures can be common to all treatments
- DBT: take a coaching approach, non judgemental; very warm; coaching to use the skills DBT teaches (mindfulness, stress tolerance skills, interpersonal skills), even approaching suicidality this way
- CBT: not as focused on relationships, but on collaborative work and trial and error; experimenting with what behavioral techniques work for each patient; What skills do they need? Skills are important.
- Transference Focused Therapy: take an "expert" role; focus is not on having a warm, caring relationship first (although it is still valued), but to contain the emotional storm of the patient so the patient isn't destroyed and the relationship is maintained

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- Mentalization Based Therapy: egalitarian over “expert” and use “not knowing stance”; “we don’t know what people are thinking”; very curious about what the patient is thinking and their own thoughts
- Good psychiatric management is being a supportive relationship, as with a good friend or family member; What services can we offer? How can we help you?

Countertransference

Countertransference is what we bring from our history that causes problems with client relationships (classic), but there is also “global transference”, which we see with personality disorders. With global transference we see commonalities in reactions that would indicate that the transference is coming from the patients and not the therapists (Is it me or is it you?). In these instances with global transference in personality disorders, much of what the therapist is feeling is coming from the patient versus their own personal history transference.

We also need to think about transference to the therapist by the patient. At some point, they may have a therapeutic rupture about something they perceive that we did or did not say that they wanted or expected us to do. This is usually stemming from an unresolved need in their life and we can help resolve this by asking questions and empathizing with their feelings, instead of becoming defensive and taking the accusations personally. This helps us understand how they were seeing us and how they were seeing themselves, which is the critical part of all work with patients with personality disorders.

It is important to be able to talk about any negative feelings the patient may have towards the therapist early on so they can feel comfortable in therapy. Patients tend to drop out if these issues aren’t addressed early on. We find that many times therapists are not being trained in this skill.

Final Thoughts from Dr. Feinstein

We really need to stop the wars about which therapy is superior to the other (psychotherapy wars). We all do pretty well with 70% efficacy rates. That means that 30% of the time these therapies are non efficacious, but we can learn and try other forms and approaches. Looking at the Big Six reinforces this. It is also helpful to use less technical language (different therapies use different language to describe similar processes).

It is important, however, to learn each model separately, versus pulling from each at random, until we learn the benefits and limitations of each. Then we can borrow from the other models once we understand the structure. When we pull from other models randomly we end up not having a structured treatment and we are not treating systematically.

Acknowledgments: This article was supported by "Mental Health Education & Research".

Citations:

Feinstein, R. (2021). *Personality disorders*. Oxford University Press.

Harned M., Korslund K., Linehan M., A pilot randomized controlled trial of Dialectical Behavior Therapy with and without the Dialectical Behavior Therapy Prolonged Exposure protocol for suicidal and self-injuring women with borderline personality disorder and PTSD, Behaviour Research and Therapy, Volume 55, 2014, Pages 7-17, ISSN 0005-7967,