

Attempting an integration of therapeutic approaches to Borderline Personality Disorder via resilience and epistemic trust

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*The things I feel
proud of
(just showing off,
not relevant so
you don't need to
listen!)*

Some of the Mentalizing Mafia

UCL/AEC/Toxistock



Prof. Dr F
Dr Liz Allison



➤ Dr Liz Allison



➤ Professor Alessandra Lemma



➤ Professor Eia Asen



➤ Dr Trudie Rossouw



➤ Dr Dickon Bevington

And European recruits to the ‘Family’



➤ Dr Dawn Bales



➤ Prof Martin Debané



➤ Professor Svenja Taubner



➤ Dr Tobi Nolte



➤ Professor Finn Skårderud



➤ Professor Sigmund Karterud



➤ Dr Mirjam Kalland

- Bart Vandeneede
- Annelies Verheugt-Pleiter
- Rudi Vermote
- Joleien Zevalkink
- Bjorn Philips
- Peter Fuggle

More mafiosi (The American branch)

■ Menninger Clinic/Baylor Medical College/U Laval/Harvard



➤ Dr Jon Allen



➤ Dr Lane Strathearn



➤ Dr Karin Ensink



➤ Dr Read Montague



➤ Dr Carla Sharp



➤ Dr Efrain Bleiberg



➤ Professor Lois Choi-Kain



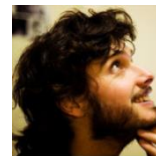
➤ Dr Elisabeth Newlin

■ Yale Child Study Centre



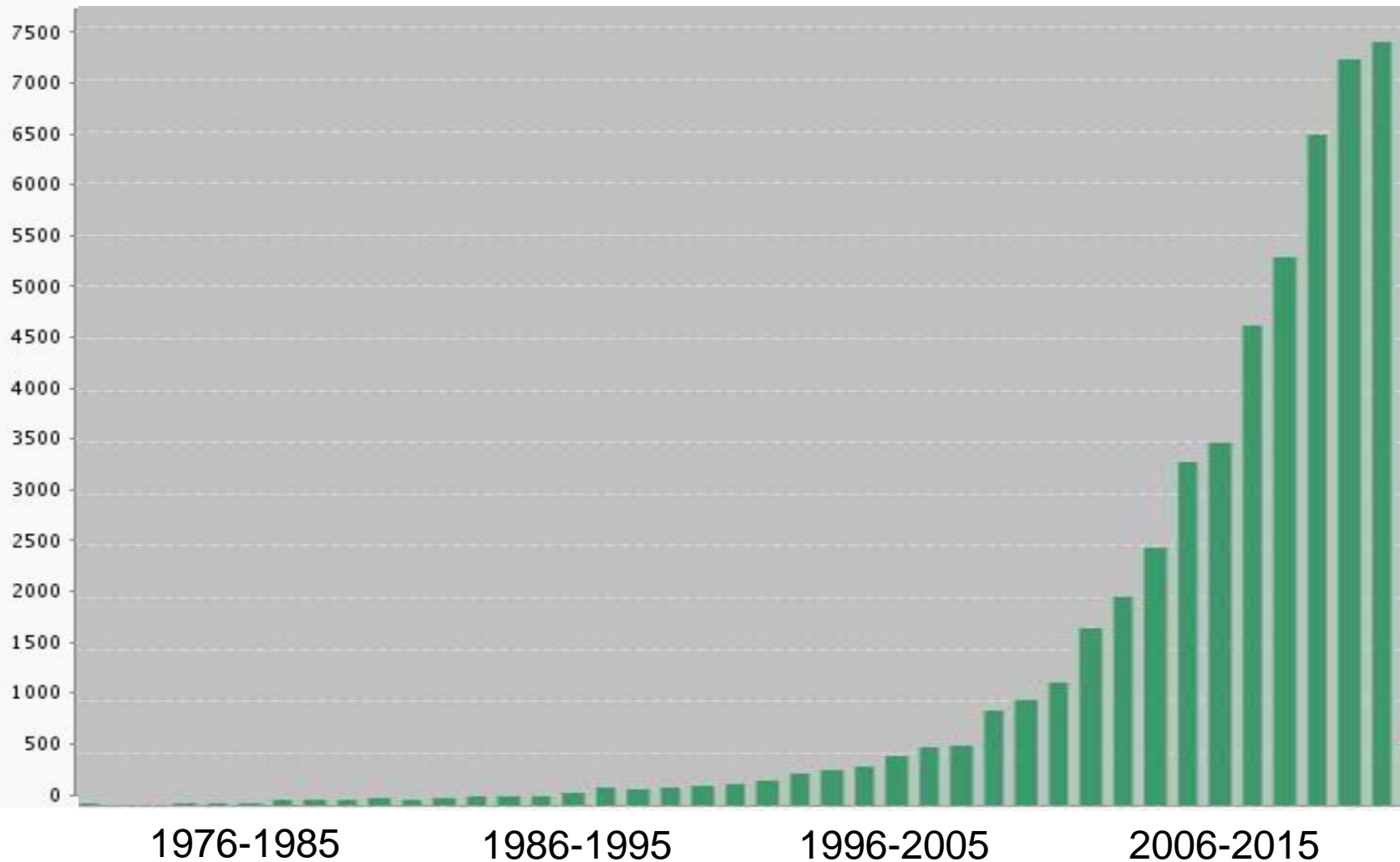
➤ Prof Linda Mayes

UCL & Catholic University, Santiago



➤ Nicolas Lorenzini

Articles Published Citing Papers About Mentalizing or Mentalization



MBT 2016



TBM 2016

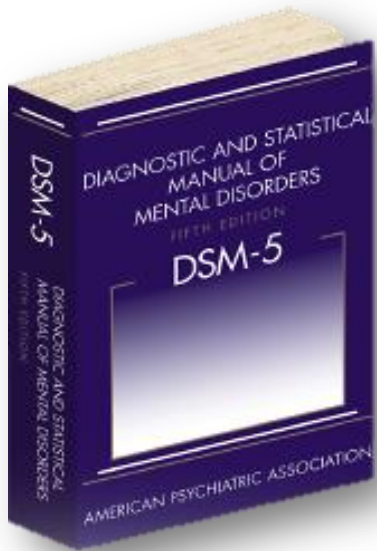
**Thérapies
Basées
sur la
Mentalisation**

The nature of BPD: A developmental view

Conceptualizing BPD from a **dimensional**, rather than a **categorical**, approach is particularly pertinent in the **emergence of BPD**, as a dimensional approach may better account for the **developmental variability** and **heterogeneity** observed during this age period

Section 3: Dimensional model of personality pathology

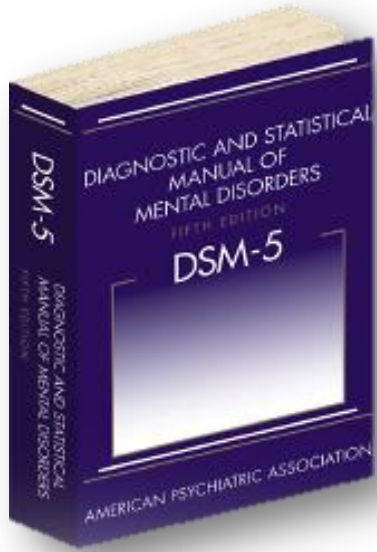
- **Impairments in self**
- **Difficulties in relatedness**



A sensitive and precise diagnosis could be achieved by **combining** both approaches

Dimensional – Categorical

DSM-5: BPD in adolescence



DSM-5 maintains the historical caution to **attribute** personality problems to an adolescent only in “***relatively unusual circumstances***” (APA, 2013; p. 647)

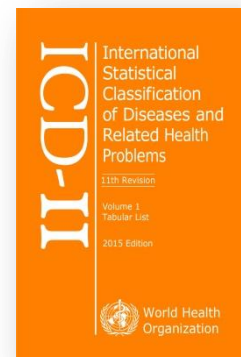
Criteria A Judgment of severity of problems in

- identity
- self-direction
- empathy
- intimacy

Criteria B 4 or more of

- emotional **lability**
- **anxiousness**
- **separation** insecurity
- **depressivity**
- **impulsivity**
- **risk taking**
- **hostility**

ICD 11 has legitimised the diagnosis



Section III of DSM-5: diagnostic criteria for PD

- **Level of personality functioning**
 - *identity* and *self-direction* (category of **self**)
 - and *empathy* and *intimacy* (category of **interpersonal functioning**)
 - **Severity: more** than one PD **diagnoses**, or one of the more typically severe forms of PD.
- **Specific** personality disorder **diagnoses** (ASPD, APD, BPD, NPDM, OCPD, SPD)
- Pathological **personality traits** in five domains: *negative affectivity, detachment, antagonism, disinhibition* and *psychoticism*.
 - Within the domains, there are **25 trait facets**

DSM 5 Section III: Impairment in personality functioning is two or more of four indicators

- **Identity** (impoverished, poorly developed **self-image**, often excessive self-criticism; chronic feelings of **emptiness**; **dissociative** states under stress).
- **Self-direction** (instability in **goals**, aspirations, **values**, career plans).
- **Empathy** (impoverished ability to **recognize feelings** and **needs of others**, obliterated as a result of **hypersensitivity**).
- **Intimacy** (intense, **unstable** and conflicted **close relationships**: **mistrust** /neediness; idealization/devaluation, **over-involvement**/withdrawal)

Evaluation of DSM-5 Section III

- **Strengths**

- **Dimensional** nature - research evidence that personality disorders are continuous with normal personality' (Livesley, 2012/, p.364).
- The functioning scale is **severity** factor, which is a good **predictor of outcome** (Livesley, 2012).

- **Criticism**

- '**unwieldy** conglomeration of disparate models'
- clinical **utility** of trait model: too many **subcomponents** (Shedler et al., 2010).
- retention of a **categorical/typal** model alongside the **dimensional** model → **incommensurability** (psychopathology is either continuous with normality or not) (Livesley, 2012).

ICD-11 (scheduled for publication in 2018)

- **One general dimensional diagnosis** for PD: ‘pervasive **disturbance** in how an individual **experiences** and thinks about the **self, others** and the **world**, manifested in **maladaptive** patterns of **cognition, emotional experience, emotional expression** and behaviour’ (Tyrer et al., 2015).
- **Entrenched** patterns → significant difficulties in **interpersonal** functioning and **social collaboration**
- Disturbances across personal and **social situations**; and are **relatively stable** over time
- **Level** of impairment: mild, moderate and severe assessed as **extent** of **social dysfunction**, level of **risk to self** and others, and overlap of trait domains.

Typology in ICD-11

- **Domain traits** - not 'categories but **five dimensions** that correspond to the underlying structure of personality dysfunction' (Tyrer et al., 2015)
 - **Negative affective domain traits: distressing emotions** such as anxiety, anger, self-loathing, instability, vulnerability and depression.
 - **Dissocial trait: disregard** for **social obligations** and conventions and the rights and feeling of others.
 - **Disinhibition**: a propensity for **impulsive behaviour**, shown in irresponsibility, distractibility and recklessness.

Typology in ICD-11

- **Anankastic domain:** a narrow focus on the **control** and regulation of one's own and others, expressed as **perfectionism**, perseveration, emotional and behavioural constraint, stubbornness, orderliness and preoccupation with meeting obligations.
- **Detachment domain:** emotional and interpersonal distance, expressed as social **withdrawal** or social **indifference**, isolation, the **avoidance of intimacy** or close friendship
- ..

Severity in ICD-11

- **More severe PD, more than one domain** trait is likely to present (Tyrer et al., 2015).
 - **Just BPD** would classically involve an emphasis on **negative affect**;
 - **BPD** comorbid with **antisocial** personality disorder manifest **as moderate or severe personality disorder with dissocial features** and features of disinhibition as well as negative affect.
 - **Not** using the language of **typal** categorisation,
 - Helps understand behaviours in terms of severity *and*
 - typical styles of behaviour and their underlying cognitive processes.

Common features across new classifications

- **Severity is co-occurrence** of range of manifestations
- Implicit assumption of **dimensional** underlying **structure**
- Key to diagnosis is **low psychosocial functioning** across contexts
- Foregrounding of failure of **interpersonal functioning** (trust in relationships)
- Separation of **diverse manifestation** from a **singular** underlying clinical **vulnerability**

Example of Emergent BPD: Comorbidity

High psychiatric comorbidity and low psychosocial functioning

- **Significant percentage of BPD adolescents meet criteria for externalising problems relative to other inpatients**
 - ADHD
 - Oppositional disorder
 - Conduct disorder
- **Substance-related disorders**
- **Internalising disorders**
 - Mood disorders
 - OCD
 - PTSD
 - Separation anxiety
 - Social phobia
- **At least 60% of BPD adolescents have complex comorbidity**
 - **Confluence of internalising and externalising disorders**
Disruptive behaviour disorders and depressive symptoms in childhood predict adolescent BPD diagnosis

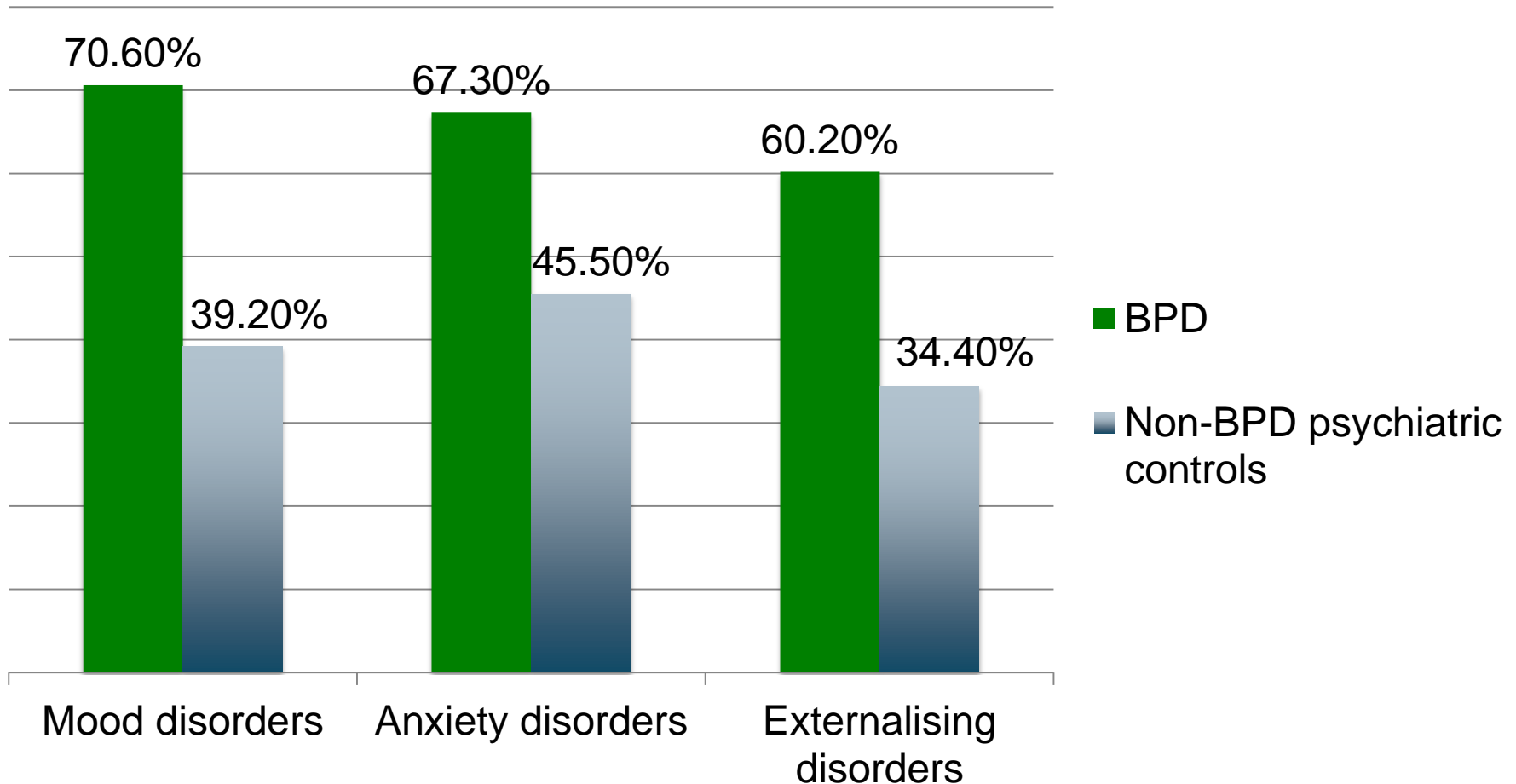


Ha et al., 2014; Eaton, 2011

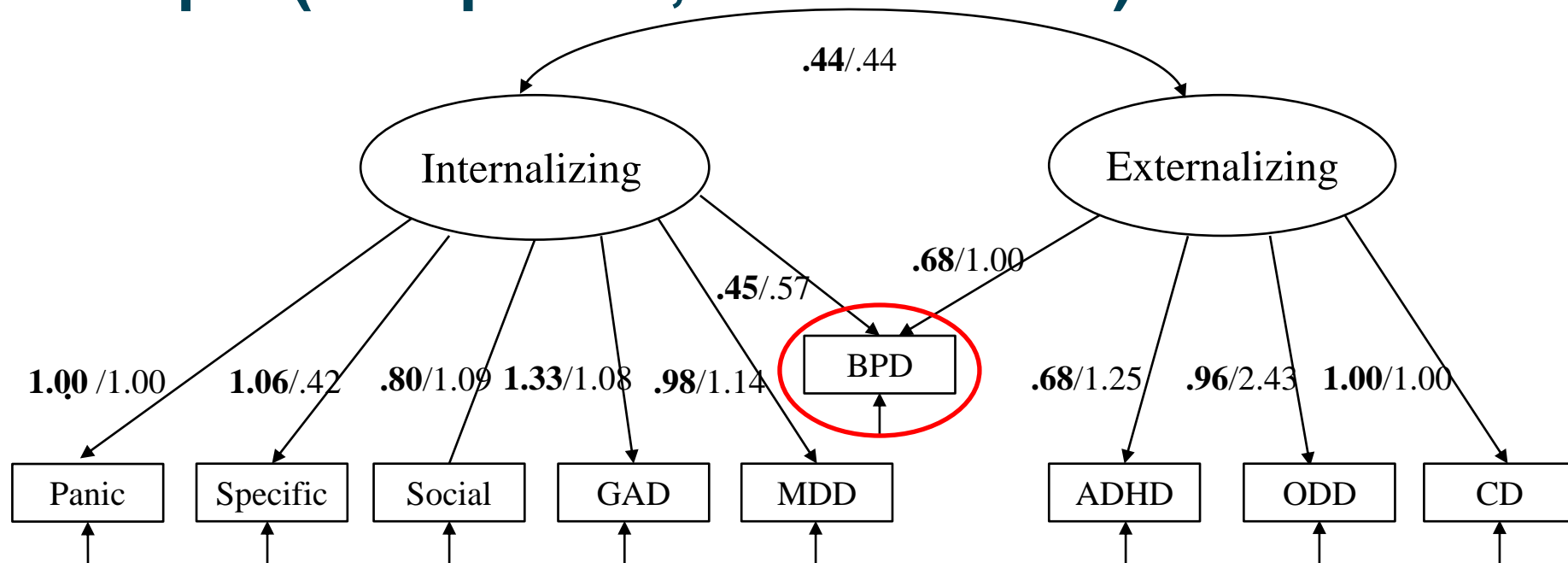
Comorbidity

High psychiatric comorbidity and low psychosocial functioning

Comorbidity in adolescent inpatients



Bridges internalizing and externalizing and shows invariance across gender in adolescent sample (Sharp et al., under review)



The scalar model did not result in a significantly worse fit than the configural model: robust $\chi^2_{\text{diff}}(6, N = 434) = 12.51, p > .05$, CFI = .95, TLI = .93, RMSEA = .05 (90% CI: .03-.07).

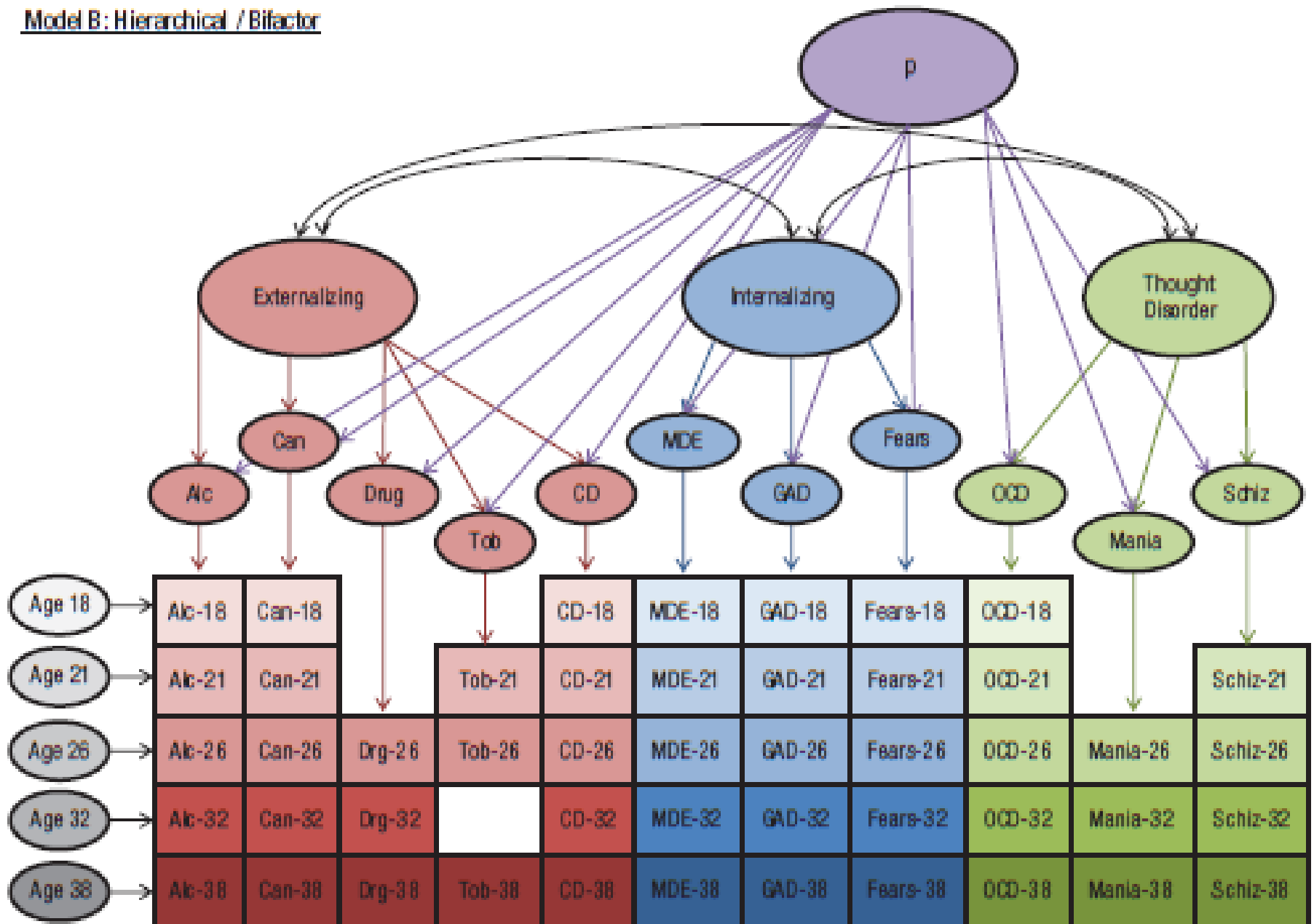
- Unique **association of BPD with attachment (CAI)** after internalizing and externalizing controlled for (i.e. underlying social pathology)

Life-course structure to psychopathology

Need for longitudinal research designs

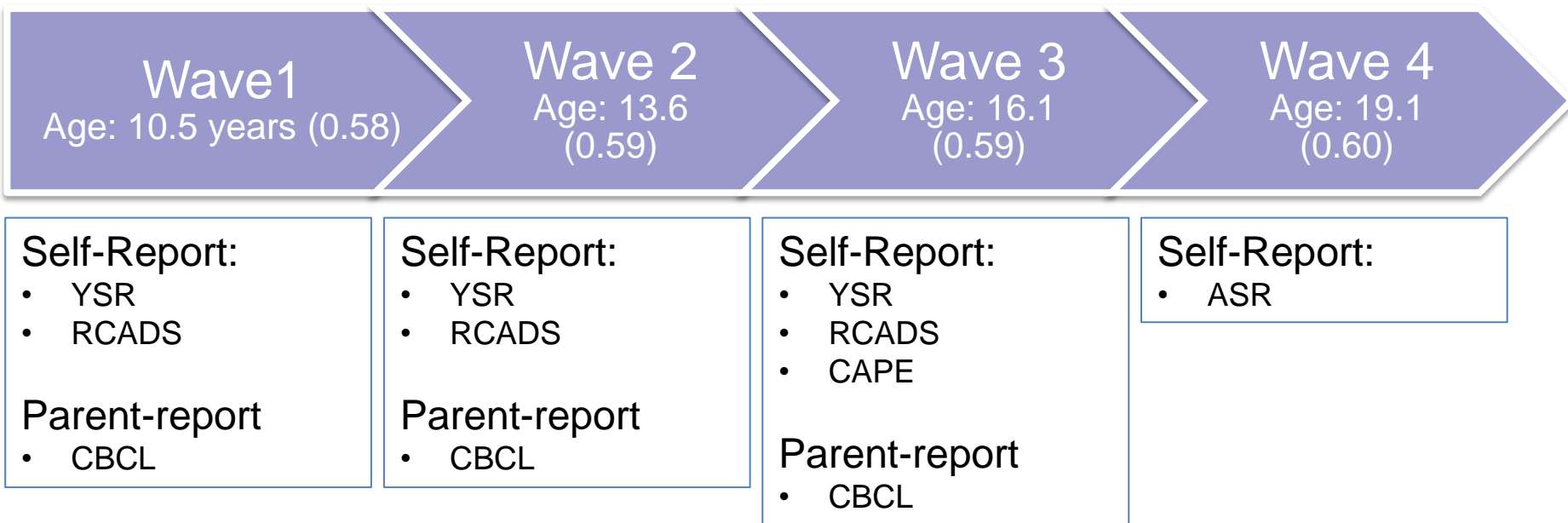
- **Extant research** on structure of psychopathology focuses on individuals who report **symptoms within** a specified **period**
 - Biggest puzzle is why people change clinical presentations over time (adolescent conduct problem adult depression)
- **Mixing single-episode**, one-off cases **with recurrent** and chronic cases which differ in:
 - **extent** of their **comorbid** conditions
 - the **severity** of their conditions
 - **etiology** of their conditions.
- Some individuals more **prone to persistent psychopathology**.

Model B: Hierarchical / Bifactor



The p factor in adolescent psychopathology

N= 2,230 Dutch adolescents

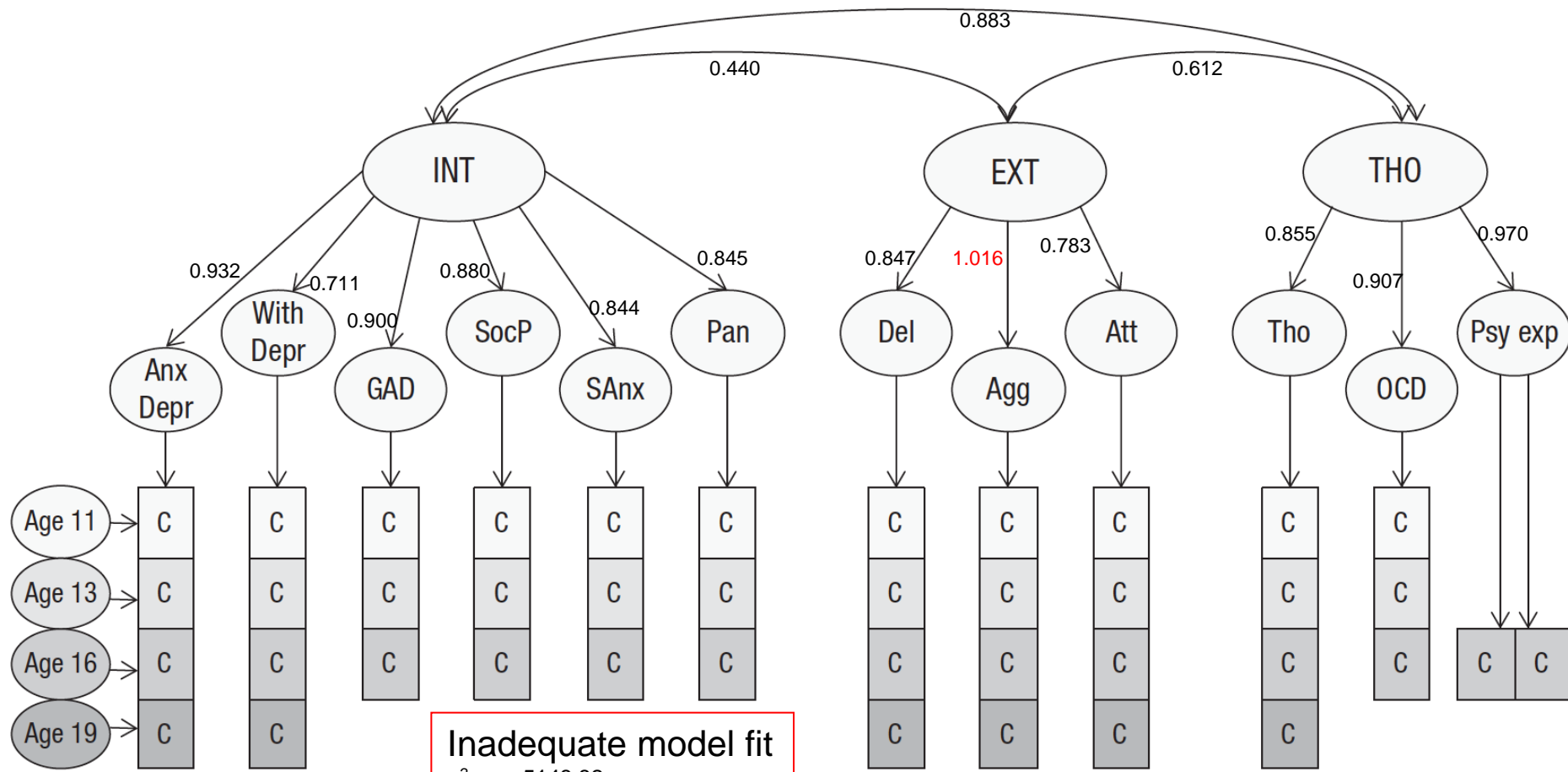


Laceulle et al., 2015 *J Pers*, 83(3), 262-273

The *p* factor in adolescent psychopathology

N= 2,230 Dutch adolescents

Model A: Three-correlated factor



Inadequate model fit

$\chi^2_{(723)} = 5148.82$

CFI = .890

TLI = .875

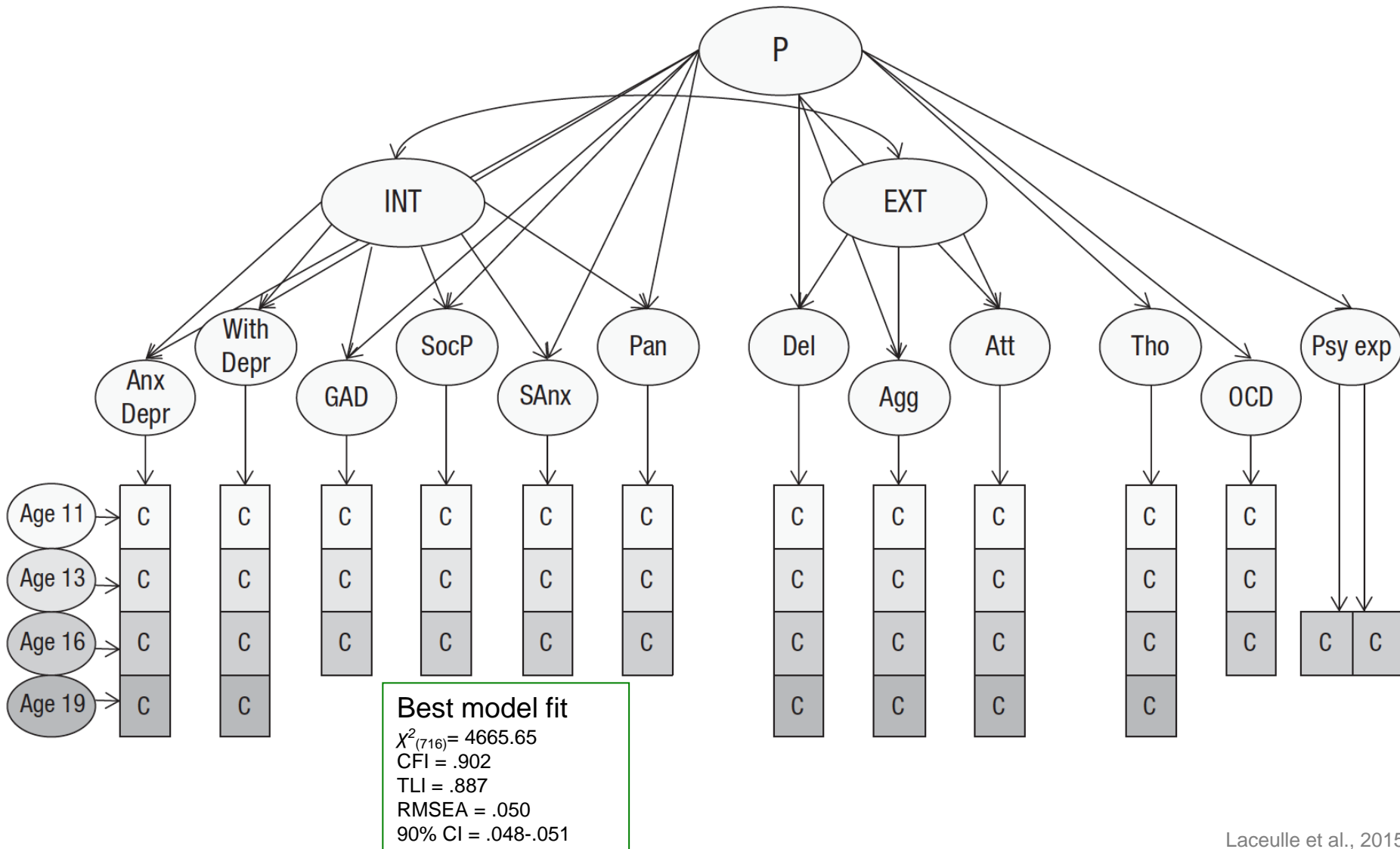
RMSEA = .052

90% CI = .051-.054

The *p* factor in adolescent psychopathology

Model B': Revised bi-factor model

N= 2,230 Dutch adolescents



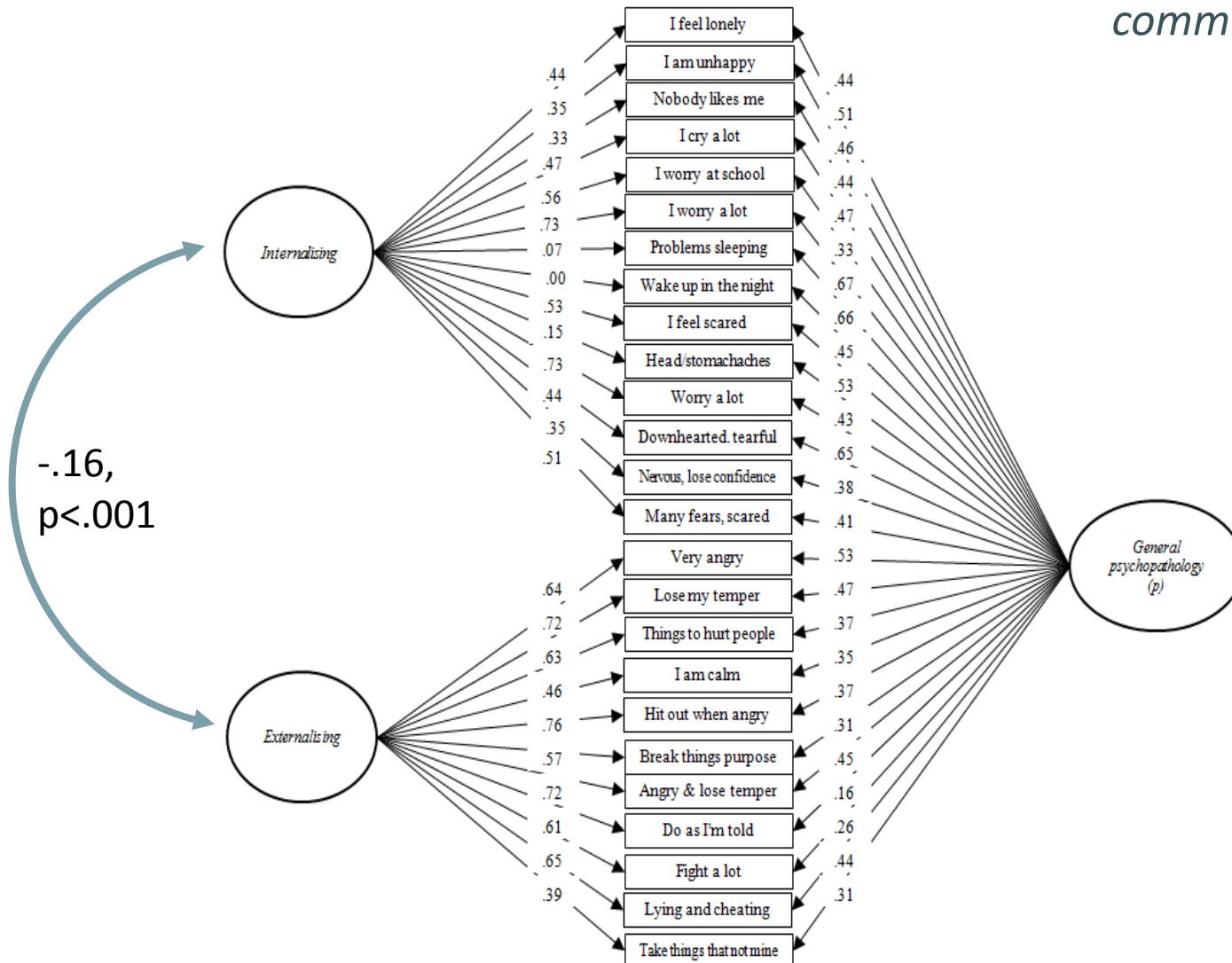
The p factor in adolescent psychopathology

N= 2,230 Dutch adolescents

Statistics, Loadings, and Correlations	Model A			Model B'		
	INT	EXT	Thought	P	INT	EXT
Standardized factor loadings						
Anxious-depressed	0.932			0.856	0.388	
Withdrawn-depressed	0.711			0.736	0.139	
GAD	0.900			0.822	0.368	
Social anxiety	0.880			0.730	0.592	
Separation anxiety	0.844			0.719	0.485	
Panic disorder	0.845			0.835	0.209	
Delinquency		0.847		0.413		0.849
Aggression		1.016		0.655		0.714
Attention problems		0.783		0.726		0.401
Thought problems			0.855	0.869		
OCD			0.907	0.894		
Psychotic experiences			0.870	0.968		
Factor correlations						
Internalizing		0.440	0.883			
Externalizing			0.612			-0.438

Bi-factor model with the item-loadings

community-based sample
aged 11-14 years
(N= 23, 477)



Correlation between factor scores and predictors

Predictor	2-factor model (Model 1)		Bi-factor model (Model 2)		
	Internalising	Externalising	Internalising	Externalising	P-Factor
Gender (Female)	.13**	-.21**	.23**	-.27**	-.007
Free School Meals	.04**	.14**	-.02**	.14**	.08**
Income Deprivation	.02*	.14**	-.05**	.14**	.08**
Special Education Needs	.10**	.14**	.03**	.11**	.13**
School Attainment	-.1**	-.2**	-.001	-.17**	-.14**

Logistic regression predicting future caseness

Predictor N=10,270	B	Wald Chi-square	Odds-ratio
2-factor model			
Internalising	.49***	76.4	1.80
Externalising	1.41***	689.64	4.11
Bi-factor model			
Internalising	.22	4.43	1.25
Externalising	1.43***	413.74	4.16
P-Factor	2.33***	479.01	10.30

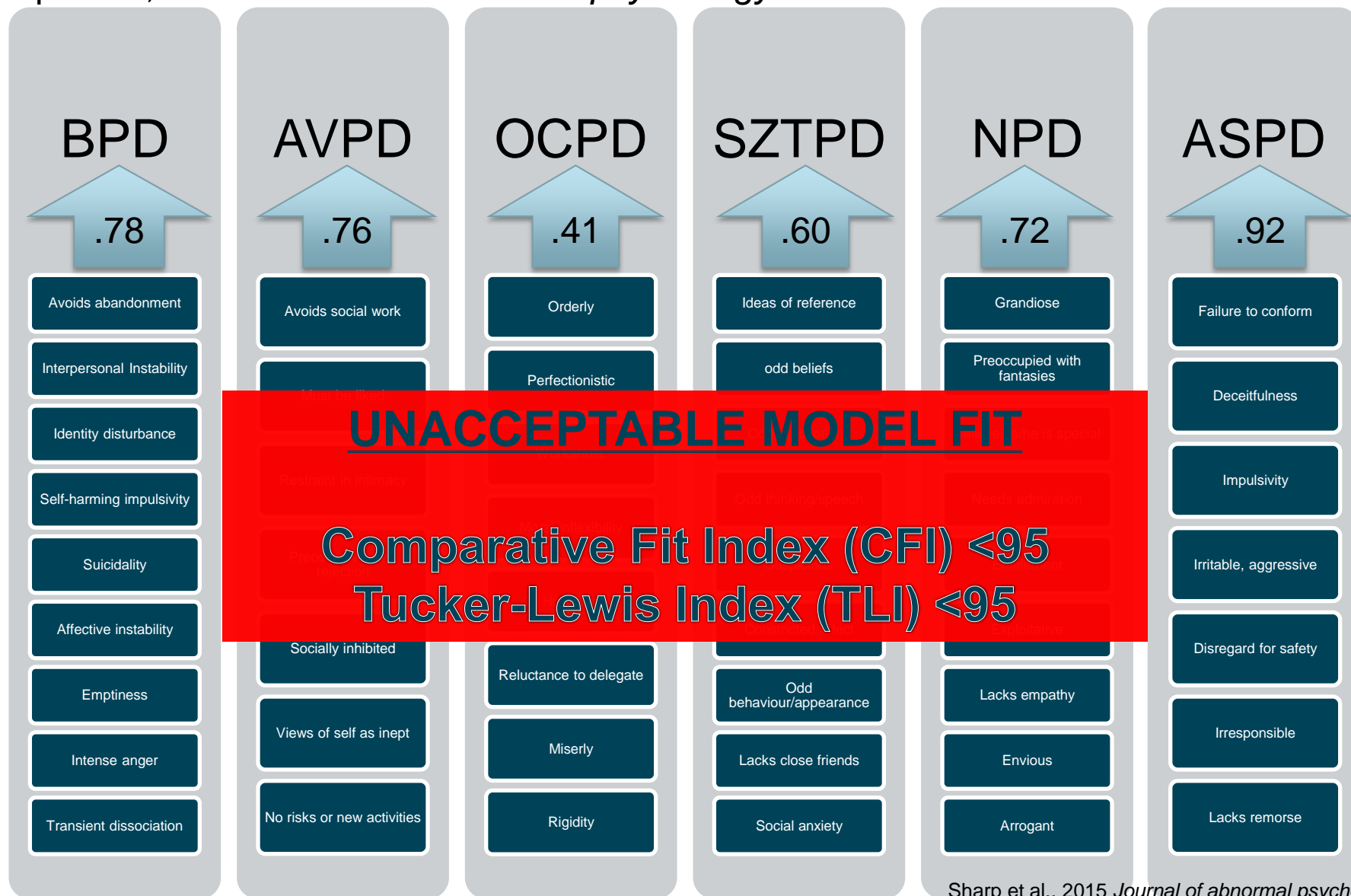
BPD as the 'g/P-factor' of personality pathology (Sharp et al 2015)

- Evaluated a **bifactor model** of PD pathology in which a **general (g) factor** and several **specific (s) factors** of personality pathology account for the covariance among PD criteria
- **966 inpatients** were interviewed for 6 DSM–IV PDs using **SCID-II**
- Confirmatory analysis **replicated DSM-IV PDs**, with high factor correlations

P factor in PDs: the DSM factor structure

Sharp et al., 2015 *Journal of abnormal psychology*

N=966 inpatients



P factor in PDs: the DSM factor structure

N=966 inpatients

	BPD	AVPD	OCPD	SZTPD	NPD	ASPD
BPD	-					
AVPD	.60	-				
OCPD	.48	.46	-			
SZTPD	.61	.43	.22	-		
NPD	.47	.18	.55	.01	-	
ASPD	.55	.31	.04	.16	.56	-

In spite of internal coherence at a criterion level, DSM personality disorders, within individuals, are not neatly separable. **They are not discrete phenomena**

P factor in PDs: does EFA replicate the DSM factor structure?

N=966 inpatients

Excellent model fit:

$$\chi^2_{(897)} = 1110.58, p < .001$$

$$RMSEA = .02 [.01, .02], p = 1$$

$$CFI = .97$$

$$TLI = .97$$

Factor 1

Avoids abandonment

Interpersonal Instability

Identity disturbance

Self-harming impulsivity

Suicidality

Affective instability

Emptiness

Intense anger

Transient dissociation

Factor 2

Avoids social work

Must be liked

Restraint in intimacy

Preoccupied with rejection

Socially inhibited

Views of self as inept

No risks or new activities

Factor 3

Orderly

Perfectionistic

Workaholic

Moral inferiority

Hoarding

Reluctance to delegate

Miserly

Rigidity

Factor 4

Ideas of reference

odd beliefs

Odd perceptions

Odd thinking/speech

Suspicious

Constricted affect

Odd behaviour/appearance

Lacks close friends

Social anxiety

Factor 5

Grandiose

Preoccupied with fantasies

Believes s/he is special

Needs admiration

Entitlement

Exploitative

Lacks empathy

Envious

Arrogant

Factor 6

Failure to conform

Deceitfulness

Impulsivity

Irritable, aggressive

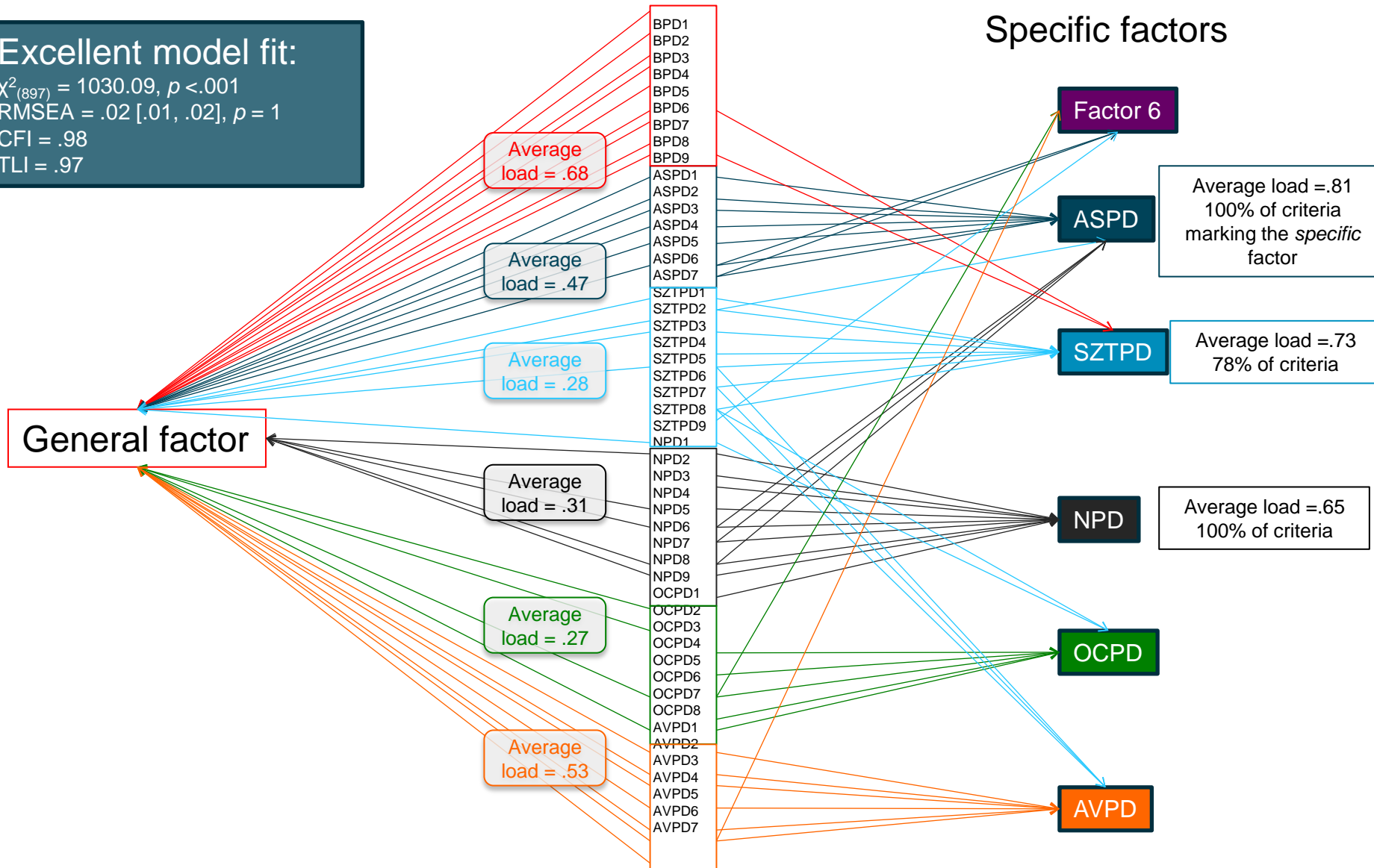
Disregard for safety

Irresponsible

Lacks remorse

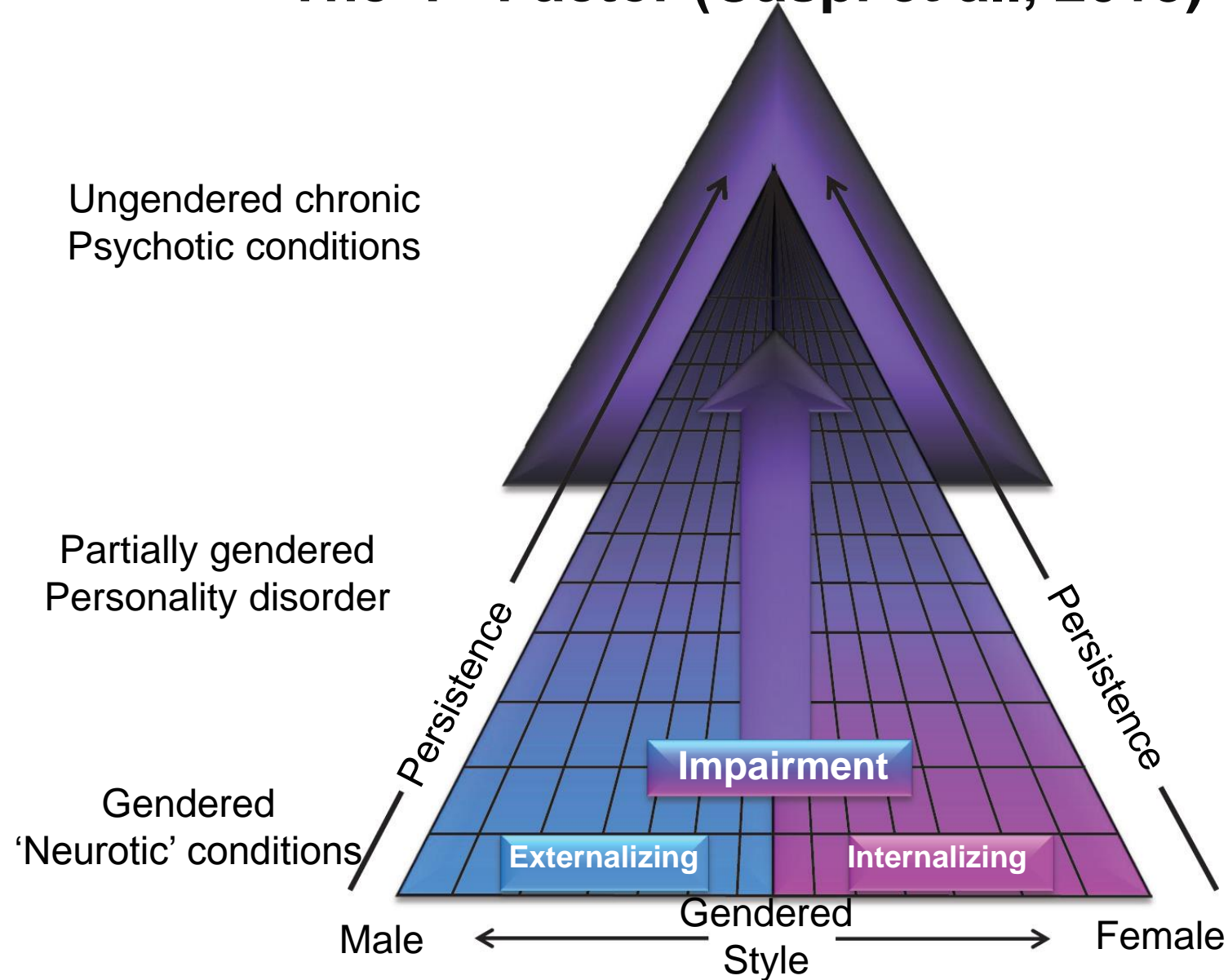
P factor in PDs: Exploratory bifactor model

Excellent model fit:
 $\chi^2_{(897)} = 1030.09, p < .001$
 RMSEA = .02 [.01, .02], $p = 1$
 CFI = .98
 TLI = .97



Only factor loadings >|.30| are shown

The 'P' Factor (Caspi et al., 2013)



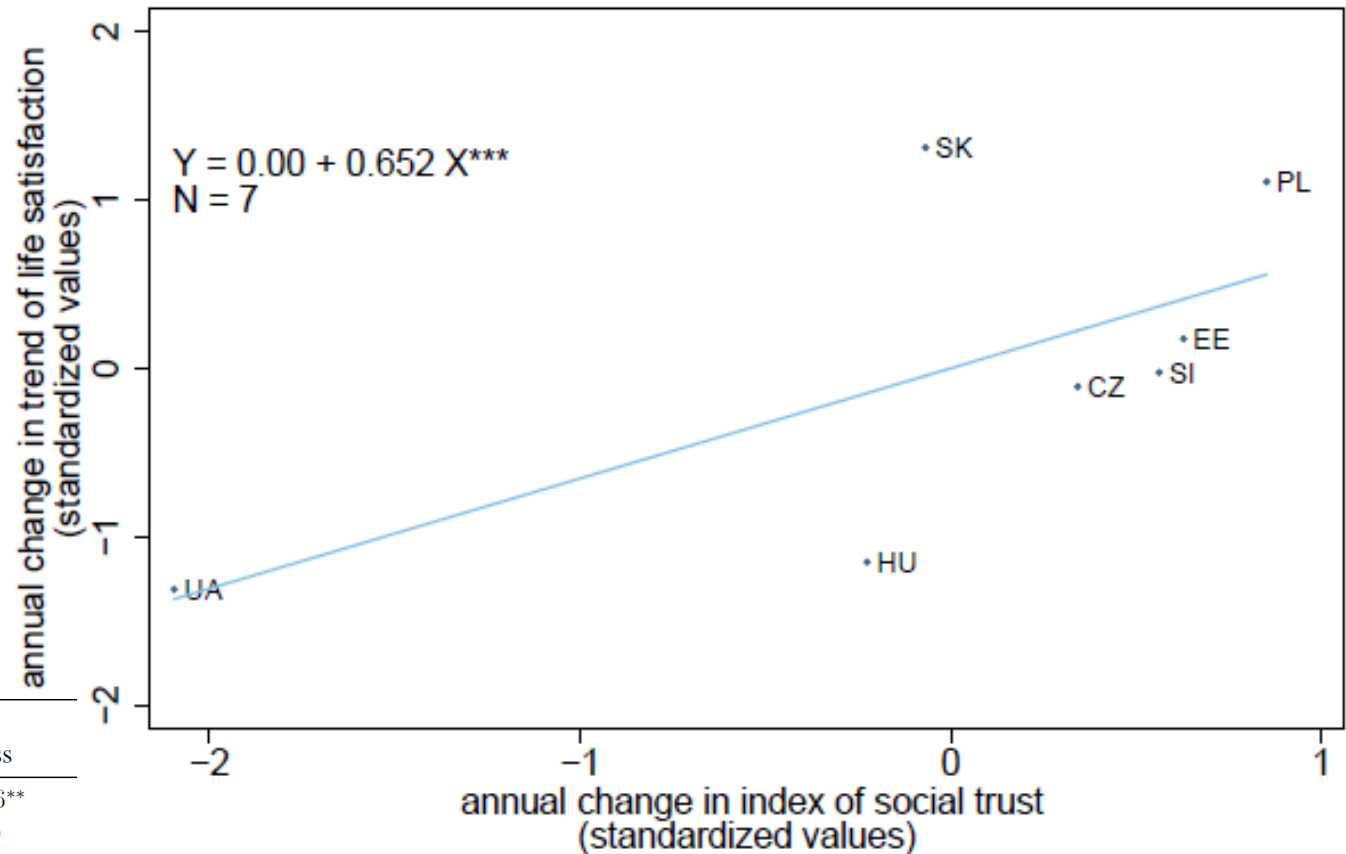
Happiness versus disorder

- What makes you experience **positive mental health** is **not the same** as what makes you develop psychological problems
- Predictors of happiness are **more generally based on social structure**
 - democracy, religiosity, voter turnout
 - social trust shift the distribution
 - self-esteem, success and interpersonal security
- Happiness research has two approaches
 - **Hedonic** approach: defines well-being in terms of **pleasure attainment** and pain avoidance;
 - **Eudaimonic** approach, focuses **on meaning and self-realization** & degree to which person is fully functioning.

Some examples of happiness studies

- Four years after the hurricane only **exposure to hurricane stressors** was **predictive of unhappiness**. In contrast, pre-disaster happiness and **post-disaster social support** were **protective against the negative effect** of the hurricane on survivors' happiness (Calvo et al., 2015, Journal of Happiness Studies, 16, 427-442).
- Relationship between **social trust and happiness** (Bartaloni et al., 2015 Social Interaction Research)
 - “Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?”
 - “Would you say that most of the time people try to be helpful or that they are mostly looking out for themselves?”
 - “Do you think that most people would try to take advantage of you if they got the chance, or would they try to be fair?”

Relationship social trust and happiness



(1) happiness	
index of social trust	0.696** (3.64)
trend of log GDP	0.678** (3.08)
Constant	-6.83e - 09 (-0.00)
Observations	7
Adjusted R ²	0.763

t statistics in parentheses

* $p < 0.10$, ** $p < 0.05$, *** $p < 0.001$

The nature of resilience: BPD as a failure of resilience

Understanding the 'P' or 'g' factor as an absence of expected resilience



From disease- to health-oriented research: A paradigm shift



Formerly: Investigating the mechanisms
that lead to stress-related illness

PSYCHO- PATHOLOGY



Now: Investigating the mechanisms
that protect against illness

RESILIENCE



Basic assumption of resilience research:
Resilience is not simply due to an
absence of disease processes but reflects
the work of active adaptation mechanisms
with a biological basis

(Kalisch et al)



Active refers to any resource demanding process and may apply to cognitive as well as behavioral processes

(Kalisch et al., in press)



Resilience has been conceptualised variously as a...

~~Tool~~

~~Characteristic~~

~~Potential~~

~~Attitude~~

~~Act~~

~~Asset~~

~~Value~~

~~Process~~

~~Trait~~

~~Skill~~

~~Resource~~

~~Strength~~

~~Dynamic
interaction~~

~~Protective
factor~~

~~Recovery~~

~~Knowledge~~

~~Capacity~~

~~Positive
influence~~

~~Disposition~~

~~Response~~

~~Performance~~

~~Transactional
relationship~~

~~Ability~~

~~Competency~~

~~Functioning~~

~~Tendency~~

~~Adaptation~~

*The ability of a system to **resist dynamically** a perturbation or adverse condition that challenges the **integrity of its normal operation** and to **preserve** function as a result in reference to some initial design or normative functional standards (Rudrauf, 2014).*



Bringing order to the conceptual chaos

Factors

Mediating mechanisms

Outcome

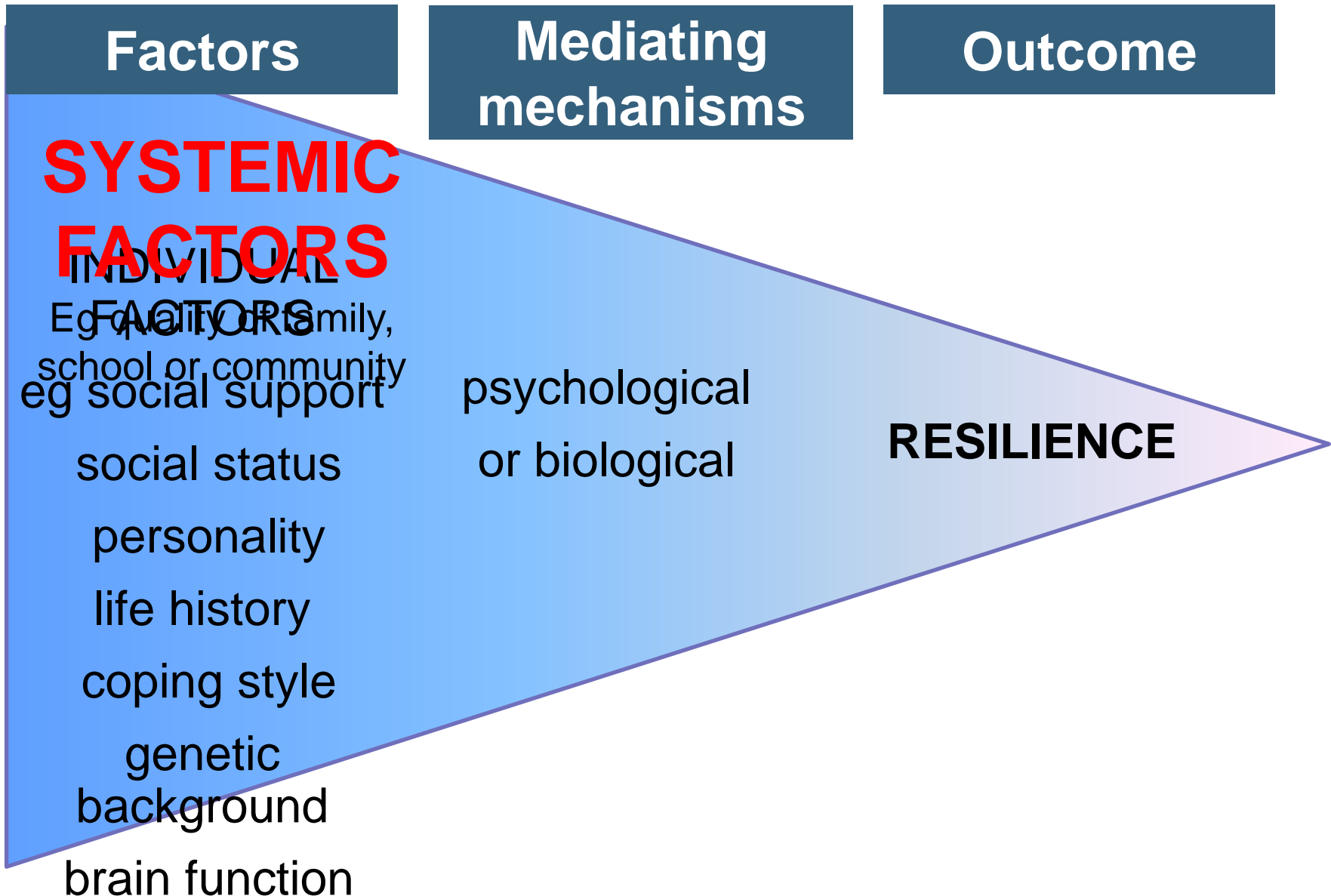
eg social support
social status
personality
life history
coping style
genetic
background
brain function

psychological
or biological

RESILIENCE

*May overlap
conceptually and/or
interact statistically*

The role of systemic factors



What is it that patients with BPD lack?

- Individuals with intense persistent distress (high 'P' scorers) are by definition **not resilient**:
- They are oversensitive to possibly difficult social interactions (they **cannot interpret the reasons for other's actions** reliably)
- **Cannot set aside** (put out of their mind) potentially upsetting memories of experiences leaving them vulnerable to emotional storms

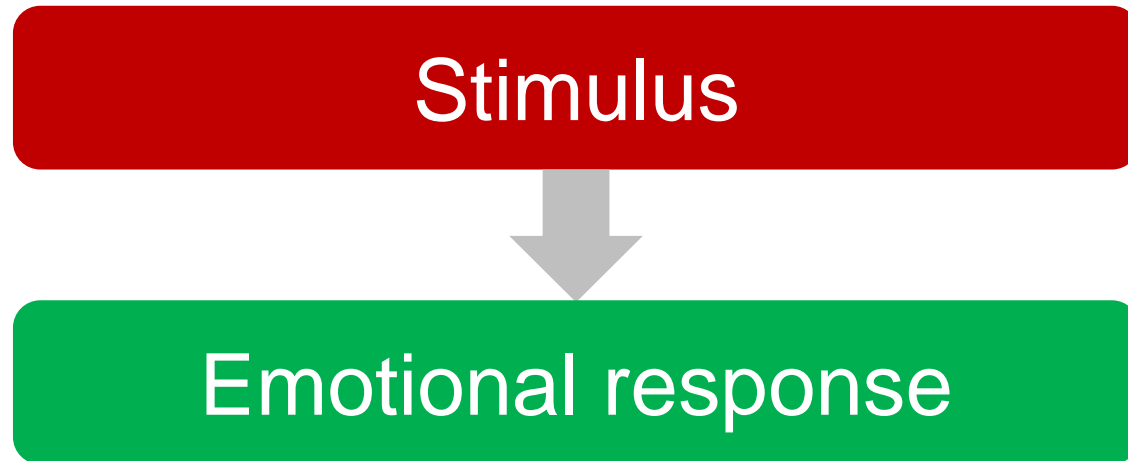
How appraisal shapes our experience

**Not
Enough**



Except our experience is social: not with physical objects but with people

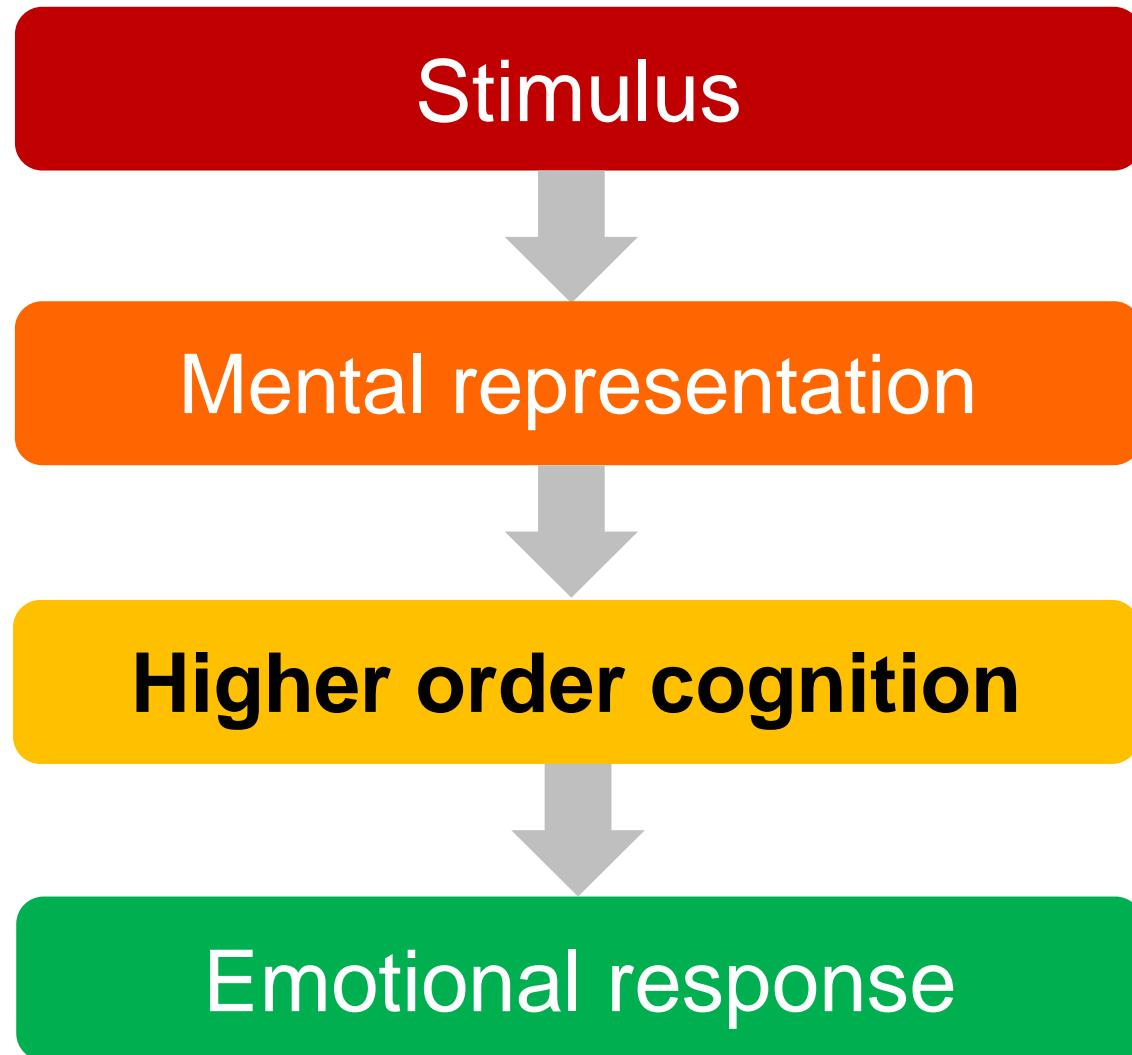
Appraisal theory



The type, quality and extent of emotional reactions (including stress reactions) are **not** determined by simple fixed stimulus-response relationships...

The process underlying **resilience** is driven by **top-down cognition**

Appraisal (higher order cognition) theory



...but by **context-dependent evaluation of motivational relevance**

A theory of PD and Resilience

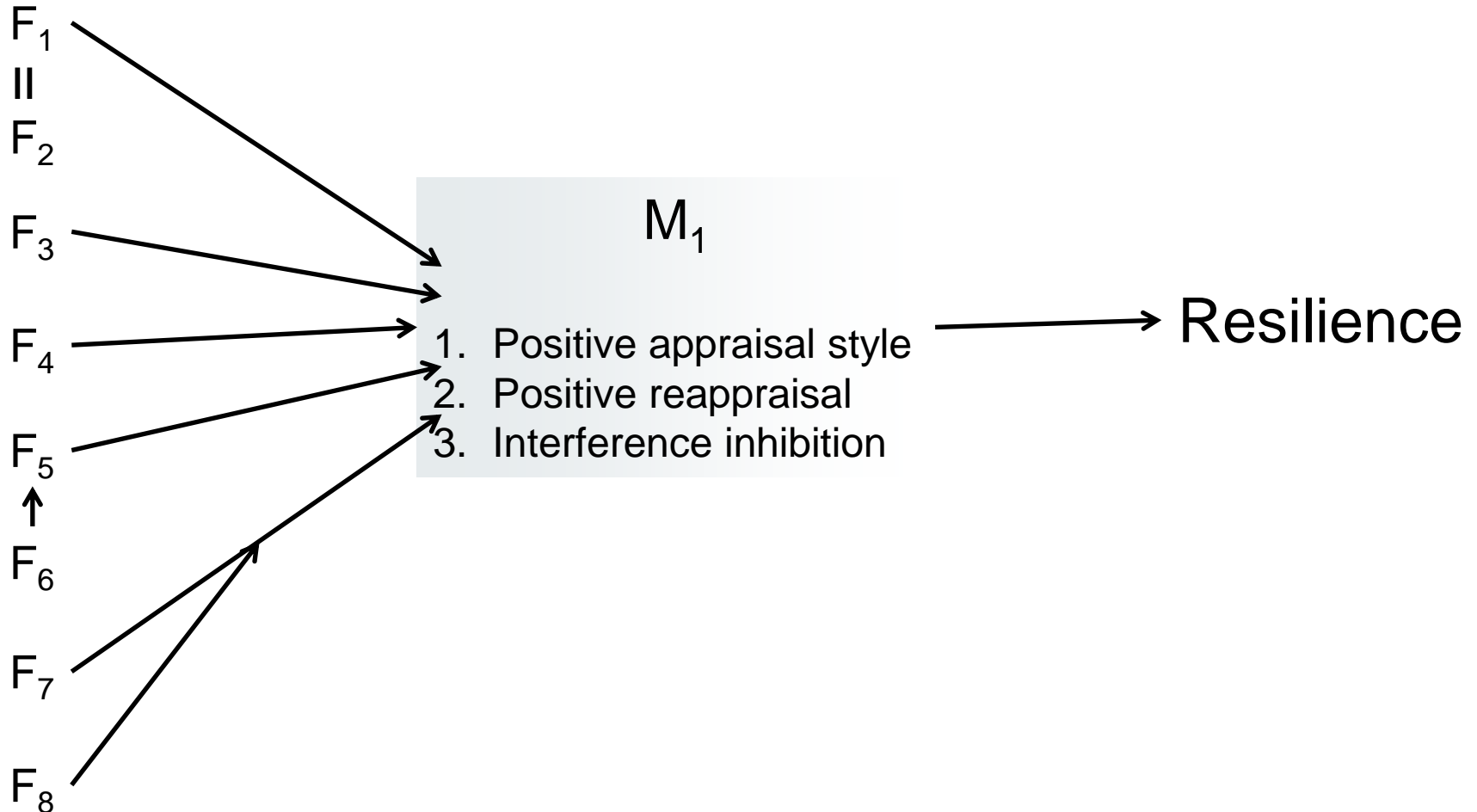
- **Multiple processing units** cover the same function in the brain
 - **Some** processing units **more efficient** than others and output is taken from most efficient processing units
 - Circumstances change and demands for **adaptation** may **reverse** the **hierarchy** of efficient functioning of these processing units
- **HOC** is capable of **shifting processing** between units of the brain to identify **most effective** processing **units**
- **Resilience** is appropriate **appraisal** (monitoring) of
 - **External** (social) **environment**
 - **Internal** functioning of **processing units**
- **HOC** is developmental capacity **based on** early relationship with caregivers because it is **intersubjective capacity** (Rudrauf, 2014, Advances in Neuroscience)

Positive appraisal style theory of resilience (PASTOR)

Factors

Mechanism

Outcome



Lack of resilience in BPD: Interpretative and regulatory role of explicit mentalizing

- Individuals with BPD have **limited capacity** to exercise this regulative role of mentalizing and the **appraisal processes** needed to **reduce stress** of any experience are **not there**
- Ample **evidence** of **limitations** of **appraisal** in BPD
- **In BPD** poor appraisal may be **more severe** than in MDD or GAD (but no evidence for this).

Lack of resilience in BPD: Failure of reappraisal of negative experience

- Mentalizing model for trauma has **reappraisal of physical and psychological experience** at its core (Allen, 2013)
- Patients with **BPD** have **specific deficit in reappraisal** proper
 - BPD partially **closed to acquiring social information to support** process of **reappraisal** (epistemic mistrust)
 - Reappraisal **requires mentalising traumatic event** (depicting mental states around traumatic event (TF-CBT, EMDR all enhance Mz of trauma)
 - **Cannot generate positive reappraisals**
 - **Cannot mitigate (adjust) negative appraisals**
- Links to Gunderson and Lyons-Ruth's **interpersonal hypersensitivity** model except that hypersensitivity is **consequence** of failure of reappraisal following **stressful interaction**

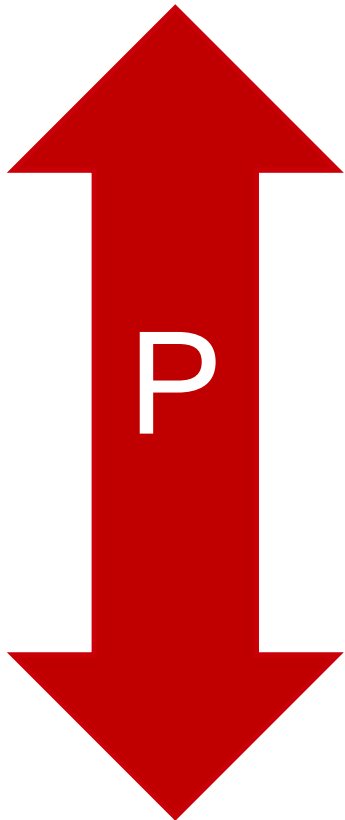
Lack of resilience in BPD: Failure of inhibition of negative appraisals and emotional reactions

- BPD limited in capacity for the inhibition of **conflictive negative appraisals** and **interfering emotional reactions** to information processing
- **Cannot inhibit re-traumatizing triggers** leaving them vulnerable to the **threat-associated sensations** when remembering a traumatic event & **reinforce** sense of **threat**.
- Consistent with Marsha **Linehan's emphasis on emotion dysregulation** as the basic problem in BPD
- Links to **impairment of habituation** notion that New, Koenigsber and others (2014) identified and which **may have genetic basis** (Goodman et al., 2014)
- This description of the subjective outcome also dovetails with the **concept of the alien self** -the *looming of unmanageable anxiety incapable of reappraisal*.

Lack of resilience in BPD: Failure of inhibition of negative appraisals and emotional reactions

- This shift in perspective involves a recognition of the significance of **enhancing the capacity for inhibition in the treatment** of BPD
- Individuals who are **really poor at mentalizing** require more than cognitive interventions (talking), but interventions that **relate to the body** more directly.
- We have always had a view that **mentalizing** was **embodied** but we haven't treated this fact with enough seriousness.
- The role of **physical activity** in **strengthening** the for **inhibition** at the same time as **helping to restore mentalizing** (e.g. systemic family therapy techniques, or if you have an adolescent you can't communicate with, **go running** with them, and discuss what the running was like).

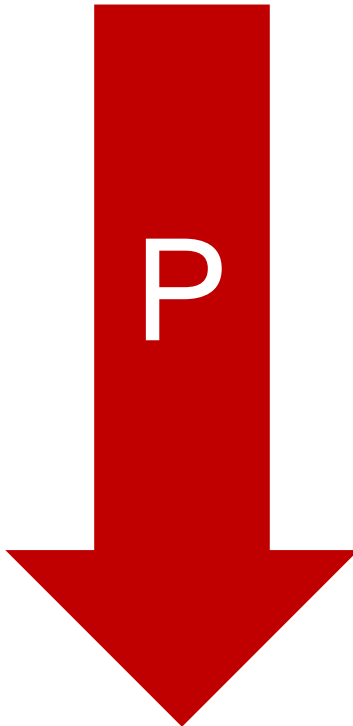
'P' Factor



Resilience



'P' Factor

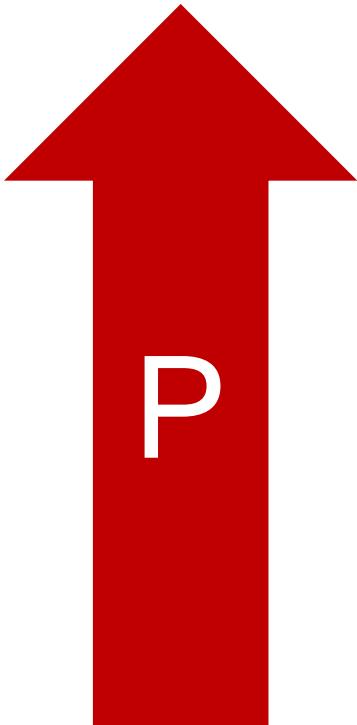


Normal/
Typical

Resilience



'P' Factor

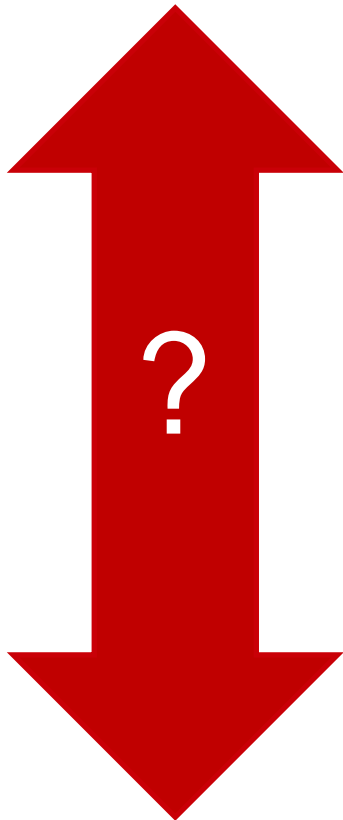


BPD

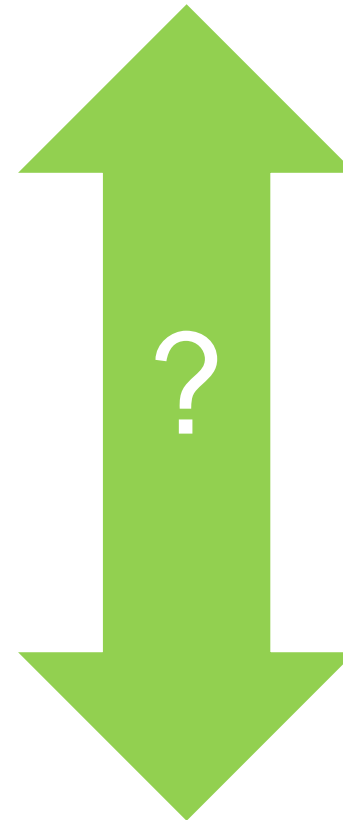
Resilience



'P' Factor

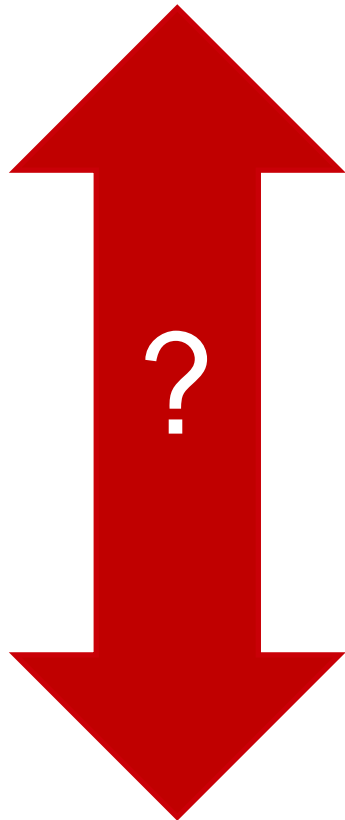


Resilience

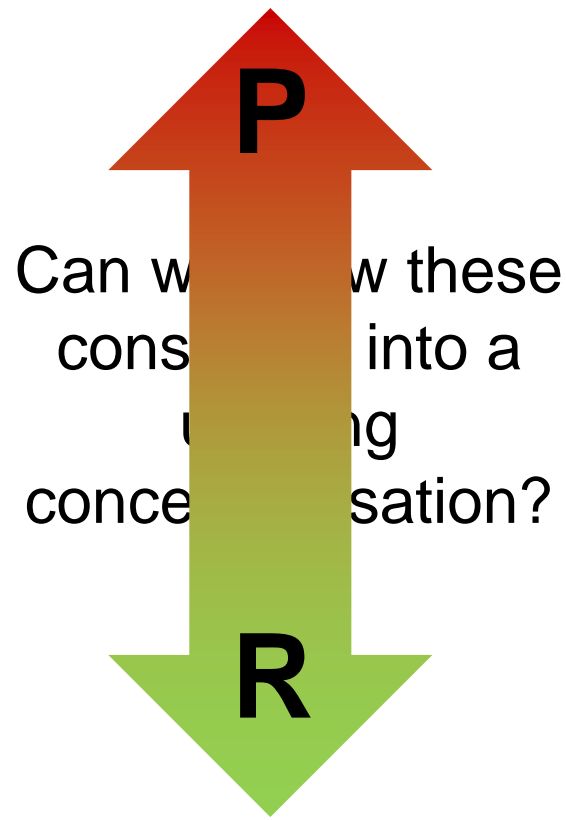
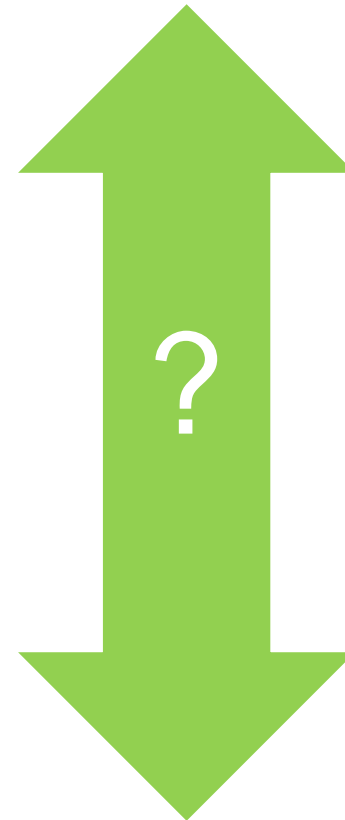


Can we draw these
constructs into a
unifying
conceptualisation?

'P' Factor



Resilience



The current bio-psycho-social MZ model of BPD as an absence of resistance to social stress

- The '**P**' factor of **general vulnerability** to psychopathology is actually an indication of the **absence of resilience** (**psychological** equivalent of **immune system** response, Higgitt & Fonagy, 1992)
 - The **nature of the stressor** (abuse, bullying, neglect, maltreatment or everyday social stress) is **not relevant**
 - **Most toxic** stressors **attack** the **mechanisms** of **resilience**
- While patients with 'neurotic' problems (regardless of severity) have high resilience (unlikely to be effected by subsequent stressors) those with **BPD** have **low resilience** and are likely to **succumb to psychosocial stress**

The current bio-psycho-social MZ model of BPD as an absence of resistance to social stress

- **‘P’ and ‘R’** are inversely related because they are **identical** at the level of **mechanisms**
 - **Low ‘R’** reflects an **adaptation** consequent on serial **communication** problems in development combined with genetic vulnerability characterized by **epistemic hypervigilance** which prevents or **undermines a reappraisal process** and results in **apparent rigidity** (imperviousness to social influence)
 - The **failure** to engage in **meaningful reappraisal** creates a general **vulnerability to psychosocial stress** (low ‘R’) which yields to the **high** prediction of future **psychopathology** from ‘P’
 - Increasing **mentalizing** increases **epistemic trust** which in turn generates **resilience through** improved capacity for **appraising** and **re-appraising** stressful **events**
 - The underlying deficit is **inflexible utilization of brain processing systems** because of **developmental limitations of HOC** (higher order cognition)

Asen's Summary of our model of resilience: The Mental Immune System (MIS)

(steps towards an ecology of health-oriented therapies)

- There 'exists' (sort of) a '**mental immune system**'
- If the Mental Immune System is down, the individual is **more likely to 'catch' illnesses**
- **Symptomatic treatments** may be necessary but will **not protect** against future relapses
- Symptomatic treatments **may stop the MIS from developing** ('trauma mafia' interventions)
- **MIS enhancing** interventions may lead to long-term **reduction of 'p'** – they aim to strengthen resilience

Summary: Resilience

- **Resilience** is an **active** process / mechanism (and outcome) – not a static entity
- It can be defined as ‘the quality of a system to **maintain integrity** when challenged’ (*i.e. maintaining its functioning*)
- Resilience (outcome) is related to
 - a) **Predictive Factors**: social support, personality, life history, genetics (*systemic factors are most important – what’s undermining the functioning of MIS*)
 - b) **Mediating mechanisms** **The Black Box**



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