DISCLOSURES

• Paulina F. Kernberg Memorial Fund

• International Psychoanalytical Association-Research Advisory Board

• Springer Book Royalties
Evolution of an Idea
The AIT treatment development group
SIGNIFICANCE

- Frequency of BPD in adolescent females ranges from 11.5 – 18% (Bernstein et. al, 1993; Chabrol et al, 2001)
- Personality pathology has been found to predict AXIS I disorders (e.g. depression, anxiety) in young adults (Westen, 2006; Bernstein et al, 1993)
- Personality pathology related to history of depression and suicide attempts (Clarkin et al, 1984; McManus et al, 1984; Marton et al, 1989)
- Adolescents with BPD were found to have significant work-related problems, increased contact with police, and depressive symptoms (Bernstein et al 1993)
- Detection of BPD characteristics is relevant to treatment of violence and suicidality (Westen, 2006)
AIMS OF AIT

• **Basic premise of treatment:**
  - Clearing blockages to normal identity development
  - “Planting Seeds”

• **Duel Treatment Focus:**
  - Long-term (Structural Change) Goals
    - Clear blockages to normal identity development
    - Integrated and differentiated identity vs identity diffusion
  - Acute and Focal Goals
    - Immediate presenting complaints
      - Differential diagnosis of comorbid diagnoses
      - Multiple presentations...dysfunction
    - Manifestations of identity diffusion
      - Behavioral - SIBs
      - Interpersonal – chaotic relationships
      - Affective – disproportionate (dysregulated)

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AIMS OF AIT (2)

- Basic premise of treatment:
  - Clearing blockages to normal identity development
  - “Planting Seeds”

- Duel Treatment Focus:
  - Long-term (Structural Change) Goals
    - Clear blockages to normal identity development
    - Integrated and differentiated identity vs identity diffusion
  - Acute and Focal Goals
    - Immediate present complaints
      - Differential diagnosis of comorbid diagnoses
      - Multiple presentations...dysfunction
    - Manifestations of identity diffusion
      - Behavioral - SIBs
      - Interpersonal – chaotic relationships
      - Affective – disproportionate (dysregulated)

All the benefits are not immediately observed, but blossom over time

“Primary seeds” the work of identity development in the various areas

“Additional seed” the recognition of a helping relationship which allows for appropriate help seeking in the future as needed

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BASIC ASSUMPTIONS

• Normal Developmental trajectories can be derailed at any point based on:
  • Initial biological limitations/deficits
  • Environmental limitations/deficits (which impact further biological developments)
  • Life Events at critical periods of development
  • Weaknesses in specific areas, necessary for other areas

• Therefore, AIT attends to all levels of derailment from the normal trajectory
  • Biological – particularly self regulation
  • Environmental – particularly differentiation of self from other, accurate assessment of reality (cognitive & affective)

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AIT TREATMENT APPROACH

• Provides a road map for the therapist, but does not dictate the journey
• Provide a systematic way to approach the adolescent’s difficulties by providing integrated treatment interventions and a rationale for choosing them in each moment.
  • Integration of techniques from Family Systems, Attachment, Developmental, and Cognitive Behavioral
  • to address family, school, behaviors & symptoms, and
• Object Relations to target Identity integration –
  • the therapist focuses on contradictions within the adolescent, between one image/experience (affects & cognitions) of him or herself; and the discrepancy with the view/experience of others, working initially with experiences outside the session with others and then within the present moment (“here & now”) with the therapist

• Adolescent’s material drives the sessions, but the therapist guides the destination
AIT TREATMENT GOALS

Short-Term Goals

- Symptom reduction
- Improved behavioral functioning
  - Love: reduction in promiscuity (or complete inhibition)
  - School/work: regular attendance; performing at level
  - Family: decrease in conflict related to improvement in familial/role boundaries and support of the separation and individuation phase of adolescence
  - Peers: increase continuity of friendships, improving relationships

Long-Term Goals

- Changes in personality structure
  - by age appropriate consolidation of identity through integration and differentiation of self and other representations.
  - Superego integration (improvement in moral values, capacity to feel shame)
  - Utilization of higher-level defenses and reduction of immature defenses (e.g. splitting, omnipotent control, denial, projective identification)
  - Improved ego functions:
    - Love / relations:
      - intimacy, mutuality and reciprocity
      - integration of love and sex
    - stability of sexual orientation
AIT TREATMENT GOALS (2)

**Short-Term Goals**
- Symptom reduction
  - e.g. suicidality, self-harm, (negative) mood, anxiety, behavior (aggressive), etc.
- School/work: regular attendance; performing at level
- Family: decrease in conflict related to improvement in familial/role boundaries and support of the separation and individuation phase of adolescence
- Peers: increase continuity of friendships, improving relationships

**Long-Term Goals**
- Changes in personality structure
  - by age appropriate consolidation of identity through integration and differentiation of self and other representations.
- Autonomy
- impulse control
- affect regulation
- delay of gratification
- frustration tolerance
- capacity to be alone
- empathy
- reflective functioning
- Improved ego functions:
- Love / relations:
  - intimacy, mutuality and reciprocity
  - integration of love and sex
  - stability of sexual orientation

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LENGTH OF TREATMENT

• Open-ended yet limited
  • There is no “preset” length
  • Structured initial time (e.g. 6 months minimum)

• Factors that determine length of treatment
  • Presenting pathology
  • Identified treatment goals
  • Observed progress

• Renegotiation of Contract
  • Continue with initial goals
  • Identify new (additional) goals
DEVELOPMENT OF PERSONALITY IMPAIRMENT

Genetic Predisposition + Pre-/perinatal influences

Effortful Control

Developmental Tasks

Temperament

impaired neurobiological / psychological STRUCTURE

Attachment

inflexible and dysfunctional coping strategies

Life Events

traumatic experiences „type-II trauma“

„invalidating“ psychosocial environment

Psychosocial Problems

Interpersonal Crises

impairment in identity and interpersonal functioning

PERSONALITY DISORDER

Psychosocial Problems

Temperament

Effortful Control

Developmental Tasks

Attachment

Life Events

traumatic experiences „type-II trauma“

„invalidating“ psychosocial environment

impairment in identity and interpersonal functioning

PERSONALITY DISORDER
ASSESSMENT PROCESS IN AIT

DIFFERENTIAL DIAGNOSIS
AIT ASSESSMENT

Initial Contact

Family

Individual

Assessment

Rules of "Communication Pathways"

Primary Pathology; Parental Transference Predispositions; Locus of Power; Family Norms

Family Rules
House Rules
Secrets

Standard Psychiatric Interview "Plus"

Describe self & other

Collateral Sources

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Treatment (contra-)indications for AIT

1. Patient suffers from severe personality impairment? 
   - yes: No treatment / Other treatment
   - no: Acute threat to self or others?

2. Acute threat to self or others? 
   - yes: Unsafe environment?
   - no: Treatment (contra-)indications for AIT

3. Unsafe environment? 
   - yes: Find a safe place
   - no: Severe AXIS I Pathology?

4. Severe AXIS I Pathology? 
   - yes: specific treatment
   - no: Significant cognitive impairment or PDD spectrum?

5. Significant cognitive impairment or PDD spectrum? 
   - yes: ? further research needed
   - no: Malignant narcissism, callous/unemotional traits, severe antisocial beh.?

6. Malignant narcissism, callous/unemotional traits, severe antisocial beh.? 
   - yes: ? further research needed
   - no: Constant treatment refusal?

7. Constant treatment refusal? 
   - yes: Enhance motivation
   - no: Treatment (contra-)indications for AIT

Crisis intervention

Intervention successful?

Treat AXIS I

Intervention successful?

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WORKING WITH FAMILIES IN AIT

Reasons Why...

• **Differentiate the locus of pathology**
  • Primary pathology with the adolescent (contaminating the family system)
  • or with a family member (adolescent manifests the pathology)

• **Avoid premature drop-out**...support the adolescent’s individual therapy
  • Prepare/predict family changes
  • Contain enactments which sabotage the treatment

• **Help parents promote optimal adolescent development**
  • Maintain appropriate boundaries (role/relationships)
  • Tolerate/contain/modulate affect dysregulations
  • Promote differentiation from the family of origin

• **Manage treatment boundaries**...in order to provide space for the therapist to think
  • Contain parents (expectations, affect, acting-out/enactments)
  • manage countertransference reactions to parents

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CONTRACTING IN AIT

BUILDING THE CONTAINING FRAME

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THE PRIMARY THERAPEUTIC REASON FOR THE CONTRACT

• To create a clear frame within which deviations can be observed, clarified, confronted and ultimately interpreted
  • Creates an agreed upon objective reality
  • Establishes goals...providing a target to move towards collaboratively
  • Defines the boundaries by clarifying behavioral expectations and personal responsibility for all parties.
CONTRACTING GOALS

• Slow down the chaos
  • Manage the sense of “urgency” that the patient and family bring to the consultation
  • Maintain the “systematic” approach

• Find and foster Motivation
  • the “one square millimeter of desire to change”

• Create a “safe” place
  • Contain destructive behaviors
  • Establish a space within which reflection can occur

• Identify and prioritize treatment goals
  • Select the target behaviors and symptoms
  • Prioritize the targets
  • Develop consensus

• Clarify responsibilities
  • Individual’s
  • Therapist’s
  • Family’s

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INDIVIDUAL CONTRACT

• Patient’s Responsibilities
• Therapist’s Responsibilities
• Threats to Treatment

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PATIENT RESPONSIBILITIES

• Universal Patient Responsibilities (modified from Clarkin, et al 1999, 2006):
  
  • **Attendance and participation** — adolescents are expected to come on time and stay for the duration of each session.
  
  • **Fees** — the adolescent should be aware of the parent’s support of their treatment, though the parents are generally responsible for knowing the amount, method, and payment terms.
  
  • **Speaking Freely** — reporting thoughts and feelings without censoring, focused first on areas of difficulty then other areas that come to mind

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THERAPIST RESPONSIBILITIES

- **Attending to the schedule** — the therapist conveys that he or she will make sessions a priority and the cancellation policy is discussed.

- **Treatment** — the therapist will describe the method of treatment, including that they will not provide advice or “solutions”, but rather will be helping the adolescent with the process of coming to decisions on her own.

- **Clarification of the limits** of therapist involvement (particularly for patients with earlier experiences of challenging boundaries or a history of different treatment approaches).

- A review of the standard **confidentiality agreement**, and with the addition of the “Pathways of Communication” regarding how information is shared with parents (and contracted with them also).

- **Pledge** to make every effort to understand and to comment when useful, but will also ask a lot of question to better understand everything (i.e. Clarification).

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THREATS TO TREATMENT

- suicidal and self-destructive behaviors;
- homicidal impulses or actions if present (including behaviors that are a threat to the therapist);
- lying or withholding information;
- substance abuse (including coming to sessions under the influence);
- an uncontrolled eating disorder;
- poor attendance;
- excessive phone calls or intrusions into the therapist’s life;
- things that put continued participation in treatment at risk, e.g., creating (external) situations that interfere with coming to sessions (i.e. scheduling activities that conflict with session times);
- not paying fees, or arranging a situation which interferes with the ability to pay.
CRISIS – CONTRACTING

• Crisis Management example
PSYCHOEDUCATION

• Geared toward adolescents and parents/families
  • Provide normative adolescent development information
  • Clarify expectations and limitations of treatment

• Some parent-focused education
  • Specific parenting strategies around various hot topic areas

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PROVIDE SPECIFIC PARENT STRATEGIES

- Communication & Relationship Building
- Safety/Rescue Judgment/Autonomy
- Affect Tolerance
- Limit Setting

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PROVIDE NORMATIVE ADOLESCENT DEVELOPMENT INFORMATION

- Reinforce Tasks of Adolescence
  - Establishing Identity
  - Developing Autonomy/Independence
  - Establishing Intimacy
  - Development of Self Esteem
  - Establishing a Stable Body Image
  - Achievement
  - Changes in Parent-Child Relationships
- Discuss case relevant statistics re: alcohol and substance experimentation, sexual activity, etc...
  - Clarify when an intervention is warranted
PROVIDE NORMATIVE ADOLESCENT DEVELOPMENT INFORMATION (2)

• Reinforce Tasks of Adolescence
  • Establishing Identity
  • Developing Autonomy/Independence
  • Establishing Intimacy
  • Development of Self Esteem
  • Establishing a Stable Body Image
  • Achievement
  • Changes in Parent-Child Relationships
• Discuss case relevant statistics re: alcohol and substance experimentation, sexual activity, etc...
  • Clarify when an intervention is warranted

Review with parents the areas in which their child is having difficulties... and how these will be targeted in the treatment

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CLARIFY EXPECTATIONS AND THE LIMITATIONS OF TREATMENT

- Limitations are discussed best in the dialog with parents about their treatment expectations as well as the pathology (and level of severity) of their adolescent
  - Often there is an expectation that is unrealistic about how quickly treatment can “stop the problems”
- Treatment is a collaboration between therapist and adolescent, in the context of parental support for the treatment
- Treatment success is related to
  - effort and investment in the process (treatment compliance)
  - the severity & co-morbidity of pathology
  - the level of secondary gain (adolescent’s &/or parents)

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PARENTING STRATEGIES: COMMUNICATION/RELATIONSHIP

- Listen, Listen and Listen
- Communicate openly
- Be empathic and nonjudgmental
- Talk early and often
- Be ready to hear opinions with which you don’t agree!
- Be a good role model
- Educate yourself and them
- Know their friends
- Ask questions
- Check in regularly
- Remind them that they can call you for WHATEVER and WHENEVER and you will be there

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PARENTING STRATEGIES: SAFETY

- Facilitate adolescents to use good judgment and maintain their safety
  - Prepare them to “Make the call” to get out of a bad situation
- Discuss the advantages of having a plan
- Make a plan...together
- Arrange a signal ahead of time
  - “Stomach flu” avoids the driving problem
- Agree to NOT discuss anything (unless they have questions/concerns they want to share) at the time you pick them up

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PARENT STRATEGIES: MANAGING AFFECT

• Listen, non-judgmentally (without “expectation’’)
• State clearly your position and what behavior you expect
  • Differentiate what’s “ideal” from “real”
• If it gets “hot”, step back, but DON’T disappear
• Make it clear that you are/will be there to listen when they/you are ready

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PARENT STRATEGIES: LIMIT SETTING

- Build mutual trust and respect
  - Maintain a positive attitude that they can succeed in fulfilling the expectation
  - Humiliation never works
- Set clear (reasonable) expectations
- Clarify consequences
  - Immediate
  - Commensurate with the misbehavior
  - Short duration
- Allow for a way to “repair”

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# Home Plan for Subject 006

**Name:** 006  
**Date:** Created May 19, 2008  
**Prepared By:** Carrie Christensen, LCSW

## Overview & Purpose
A plan to facilitate the rebuilding of trust and respect within the family, with gradual implementation of increasing privileges commensurate with demonstration of increased responsibility and self care.

## Issues Addressed
Harmful behaviors, self-care, academics

<table>
<thead>
<tr>
<th>Harmful Behaviors</th>
<th>006</th>
<th>Mom &amp; Boyfriend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No engaging in harmful</strong></td>
<td><strong>Safe and non-harmful behavior is expected at all times.</strong></td>
<td><strong>Any violation of the expectation in red results in immediate loss of all privileges for one full day and communication with Carrie.</strong></td>
</tr>
<tr>
<td>behavior:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>cutting</em></td>
<td></td>
<td></td>
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<tr>
<td><em>screaming</em></td>
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<tr>
<td><em>vomiting</em></td>
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<tr>
<td><em>sniffing</em></td>
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<tr>
<td><em>hair pulling</em></td>
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<td></td>
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<tr>
<td><em>head banging</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>ALL other harmful behaviors</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Self-Care
*Good sleeping habits  
*Good hygiene  
*No lying  
*Good eating habits  
*Appropriate exercise  
*Attend all therapy appointments

Self care is expected at all times. These are the minimum expectations of self-care.

Mom & boyfriend are responsible for making monthly doctor’s appointments for 006. They are also responsible for making regular dentist appointments and/or any other appointments appropriate necessary for 006’s care.

## Academics
006 is expected to attend the whole school day and complete all school assignments.

Mom & boyfriend will be in communication with 006’s school on an as needed basis. Mom & boyfriend agree to “back off” of 006 in regards to school work completion.

## Privilege Goals:
**One month goals:**
- Have iPod fixed
- Day In NYC with Mom & Boyfriend
  - Three month goals:
    - class or workshop of 006’s choice
    - Six month goal:
      - Complete application for eersion program in Paris

## Consequences:
For each mess up, one day will be lost and therefore added to the “month” required to earn a privilege. A mess up results in a full days’ loss of privileges, beginning immediately, and carrying through the next complete day.

## Additional Notes
Also included in this plan, is the family’s verbal agreement to plan and execute regular, positive time together. Ideas suggested: tennis, sailing, beach trips.
PARENT/FAMILY CONTRACT

- Parent Responsibilities generally mirror patient responsibilities.
  - Attendance and participation — parents are expected to get the adolescent to sessions on time.
  - Fees — parents are expected to pay for services in a timely manner.
- Parents are also expected to allow the treatment time to unfold and to do their best to be supportive of their child’s therapy.
  - Be mindful of reviewed strategies and model expected behavior
  - Adjunctive treatments may be recommended
  - Home Plan

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**AIT TREATMENT STRUCTURE**

- **External Reality**
- **Home Plan**
- **Treatment Contract**
- **Frame**

**Alliance**
- **P/F**
- **Parents / Family Work**

**Extra-Transference Exploration**
- **P/F**

**Transference Exploration**
- **P/F**

**Reassessment or Termination**

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Techniques

What to do in a session...
EXPERIENCE DEPENDENT MATURATION: NATURE/NURTURE IN THE DYAD

Dyadic Regulation

Temperament

Neurophysiological Development

Attachment

Effortful Control

Growth

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DYADIC DEVELOPMENT (SELF REGULATION AND IDENTITY): RELATIONSHIP TO AIT TECHNIQUES

Therapy provides opportunity for reparative development and a return to normal growth trajectory.
PRIORITIZING INTERVENTIONS

① Safety First
- Suicidality and Homocidality
- Self-harm
- Abuse or neglect

② Threats to the continuation of the treatment
- Overt behaviors (e.g. missing sessions)
- Dishonesty (e.g. overt lies or motivated withholding of relevant information)
- Contract violations (i.e. both the adolescent’s and the family’s)

③ Identity Integration
- Extratransferential activation of object relations dyads
- Transference activation of object relations dyads
- Other affective content

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REGULATING AFFECT ACTIVATION

• There are **two sets of affects** that require regulating during the here and now therapy process,
  • those of the adolescent and
  • those of the therapist.

• The identification of this as a tactic helps the therapist to **attend to the maintenance of objectivity**, particularly in the face of the extreme affects that the adolescent brings into the session.

• It also facilitates awareness of **exploring systematically the affects**, associated with the activated dyads, by paying attention to not overwhelm the adolescent’s capacity to tolerate the process.

• The goal of regulating **the optimum level of affect in the session (not too much, not too little)** is usually accomplished through the thoughtful application of the interpretative techniques (clarification primarily).
CYCLE OF INTERPRETATION

- Exploring the underlying object relations dyad
  - the internalized mental representation of self and other and
  - associated affect
- manifest in the relationships
  - with others, as well as
  - in the “here and now” with therapist

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CLARIFICATION TARGETS

• Affects
  • Identification (naming)
  • Differentiating locus (mine, not mine)
  • Tolerating (understanding & managing, not acting)

• Perspective
  • Time (past, present, & future)
  • View (self & other)

• Object Relations
  • Differentiation of self and other (boundary)
  • Integration of the self-representation and other representations (“good-enough”)

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LOVE RELATIONS EXAMPLE: TOLERATING AND INTEGRATING

- Working toward integration: The case of the idiot frog
- (deleted video clip)
CONFRONTATION
“COLUMBO” TECHNIQUE

• After the initial toleration of the affect and preliminary clarification of the affects...and the frame has been reestablished

• Clarify whether the adolescent has observed the changes/contradiction in their behavior
  • If they have, move forward with the exploration;
  • If they haven’t, work to have them see what you have observed.
    • If they agree, move forward.
    • If they don’t, you may have to “agree to disagree”, but continue to explore then this discrepancy in views.

• Explain that you are looking for a way to understand this change/contradiction; what might it be attributed to?

• Ask the adolescent to help you understand/clarify what might be happening around this behavior.

• NOTE: Confrontations often return to Clarification, as this is part of a cycle. Likewise, a confrontation may lead to an interpretation as the adolescent is either open to this level of understanding or in a crisis, which requires quick movement from surface to depth.

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INTERPRETATION

• Interpretations are offered as “hypotheses” to the adolescent for their consideration
  • Made when the repetitive patterns have been acknowledged & understood by the adolescent

• Designed to help them organize and develop meaning for their thoughts and actions

• Interpretations focus on
  • the conflicted affects and behaviors that are manifestations of the split-off intrapsychic internalized objects
  • “linking” material that has been elucidated through the clarification and confrontation process
  • Articulating the relationship between the adolescent’s conscious material and the inferred unconscious material that is exerting an influence on the adolescent’s motivation and functioning
  • Emphasis is on the links between the verbal, non-verbal, countertransference (observed through projective identification and the experience of omnipotent control)

• Generally made first in the context of relationships with family and peers, then with the therapist, but in an affect storm, brought directly into the transference

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THERAPY PROCESS IN AIT: STRUCTURE, CONTRIBUTIONS, AND OUTCOMES

Therapist

- Sets frame via contract
- Observes (all communication levels); Tries to identify underlying object relations & associated affects using:
  - Clarification
  - Confrontation
  - Interpretation

Adolescent

- Experiences safe haven to reflect on affects that arise
- Expression of affects includes interactions based on implicit object relations

Techniques

- Increases reflection
- Improved Interpersonal Functioning
- Increases Affect Regulation

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RESEARCH TEAM

• **Principle Investigator:** Anna Odom, Ph.D.

• **Co-Investigators:**
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  - Jeanne Dietrich, Ph.D.
  - Steve Hurt, Ph.D.
  - Archna Bassau, Ph.D.
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  - Jessica Siegel
  - Ingi Soliman, Ph.D.
  - Rachel Sneif
  - Numerous PDI Fellows

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EMPIRICAL SUPPORT FOR CORE MECHANISM OF AIT

Transference Focused Psychotherapy

• **TFP Efficacy Study** - Clarkin JF, Foelsch PA, Levy KN, Hull JW, Delaney JC, Kernberg OF, 2001
  • N=23 female patients with borderline personality disorder
  • TFP for one year
  • **Findings:**
    • Fewer suicide attempts
    • Reduction in the lethality of self-injurious behavior
    • Fewer hospitalizations and number of days in the hospital

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Randomized Clinical Trials of TFP

- **Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF**, 2007
  - N=90 patients: Treatment Conditions: TFP, Dialectical Behavior Therapy (DBT), or psychodynamic supportive therapy
    - **All Groups**
      - Decrease in depression and anxiety
      - Increased in global and social functioning
    - **TFP and DBT Groups**
      - Reduction in suicidality.
    - **TFP and Supportive Group**
      - Improvement in impulsivity
    - **TFP**
      - Improvement in anger, irritability, and verbal and physical assaults
      - Improvement in their reflective functioning and attachment style

  - TFP versus therapy administered by experienced community therapists; N=104 female patients
  - Treated for 1 year
    - **TFP Group**
      - Fewer than five DSM-IV borderline personality disorder criteria,
      - Improved psychosocial functioning and improved personality organization
      - Fewer suicide attempts compared to the community therapist group,
      - Fewer inpatient hospitalization

  - TFP to Schema-Focused Therapy (SFT)
  - N=88 with borderline personality disorder
  - **Findings:**
    - Both treatments were effective in reducing symptoms of borderline personality disorder a
    - Improved quality of life
    - Treatment effect of TFP were smaller in comparison to SFT
TREATMENT MODIFICATIONS FOR ADOLESCENTS

• Modifications of Adult Treatment for Adolescents
  • Modifying adult treatments for BPD is effective for adolescents that exhibit similar pathology
  • Developmentally appropriate modifications to adult treatments are also effective (Rathus & Miller, 2002; Rossouw & Fonagy, 2012)

• DBT
  • Manualized the modifications of DBT for adolescents (DBT-A) (Miller et al., 2007)
  • Non-randomized study of DBT-A and TAU (Rathus & Miller, 2002)
    • Findings:
      • DBT-A had significantly fewer psychiatric hospitalizations
      • Higher rates of treatment completion

• Mentalization-Based Treatment for Adolescents (MBT-A)
  • Modified from an adult treatment (Bleiberg, Roussow, & Fonagy, 2012)
  • Randomized clinical trial of 80 adolescents, comparing MBT-A to TAU for adolescents who self-harm (Rossouw & Fonagy, 2012)
    • Findings:
      • MBT-A more effective in reducing self-harm and depression

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CHART REVIEW STUDY

- **AIT and Treatment as Usual (TAU) with Experienced Clinicians**
  - **Sites:**
    - **AIT N=12**
      - New York, USA
        - NYPH/Cornell-4 Cases
        - Private Practice-4 Cases
    - Santiago, Chile
      - Schilkrut Institute-4 Cases
    - **TAU N=11**
      - Frankfurt, Germany
        - Practice for Child and Adolescent Psychiatry and Psychotherapy-8 Cases
      - New York, USA
        - NYPH/Cornell-3 Cases
  
- **Measures:**
  - Structured Clinical Interview (SCID-II)
  - Borderline Personality Disorder Dimensional Interview (BPDDI)
  - Global Assessment of Functioning (GAF)
  - Clinical Global Impression (CGI)
  - School Functioning Rating

- **Assessments:**
  - Baseline (less than 2 months of treatment)
  - 6 months
  - 12 months

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# AIT CHART REVIEW STUDY SAMPLE

<table>
<thead>
<tr>
<th></th>
<th>Total Sample (N=23)</th>
<th>AIT (n=12)</th>
<th>TAU (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>16.43 ± 1.88</td>
<td>17.00 ± 2.22</td>
<td>15.82 ± 1.25</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>20 Female</td>
<td>9 Female</td>
<td>11 Female</td>
</tr>
<tr>
<td></td>
<td>3 Male</td>
<td>3 Male</td>
<td></td>
</tr>
</tbody>
</table>

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## DIFFERENTIAL TREATMENT EFFECTS

### Repeated Measures ANOVA Comparing TAU and AIT at 12 Months

<table>
<thead>
<tr>
<th>Between Subjects Effects</th>
<th>Mean ± SD</th>
<th>DF</th>
<th>Type III SS</th>
<th>Mean Square</th>
<th>F Value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAU</td>
<td>46.11±13.54</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIT</td>
<td>66.00±7.91</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Treatment</td>
<td>1</td>
<td>116.82</td>
<td>116.82</td>
<td>22.31</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>56</td>
<td>293.23</td>
<td>5.24</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*For GAF, SFR, & each BPDDI criteria*

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FINDINGS

Repeated Measures ANOVA Comparing TAU and AIT across time

<table>
<thead>
<tr>
<th>Within Subjects Effects</th>
<th>DF</th>
<th>Type III SS</th>
<th>Mean Square</th>
<th>F Value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>10</td>
<td>5022.41</td>
<td>502.24</td>
<td>27.71</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Time x Treatment</td>
<td>10</td>
<td>1157.23</td>
<td>18.123</td>
<td>6.39</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Treatment</td>
<td>37</td>
<td>18.123</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>560</td>
<td>10149.60</td>
<td>18.124</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For GAF, SFR, & each BPDDI criteria
HYPOTHESIS

• **Hypothesis:**
  • Adolescents with identity problems as seen in interpersonal, school, and/or family difficulties in the AIT group will reduce these problem behaviors and improve management of their feelings and moods compared to adolescents with identity problems in the treatment as usual control group (TAU).

• **Primary Aim:**
  • To evaluate the efficaciousness of AIT in adolescents with identity pathology.

• **Secondary Aims:**
  • To validate modified adult measures of identity pathology for adolescents.
  • To assess therapist’s adherence and competence to AIT treatment.
**Inclusion Criteria**
- Female Adolescents, ages 14-21
- A score of five out of nine critical items on the Borderline Personality Disorder Dimension Interview Scale.
- Have interpersonal difficulties in school, family, and/or peer functioning.
- Live at home with family.
- Willingness to attend evaluation sessions and weekly, individual therapy.

**Exclusion Criteria**
- The presence of psychosis, substance dependence, non-verbal learning disability, significant antisocial behavior, and/or primary diagnoses of eating disorder, bipolar disorder, and obsessive-compulsive disorder.
- The need for hospitalization for symptom management.
- Significant cognitive impairment (Full Scale IQ <85).
- The presence of a life-threatening medical illness.
Study Design

Baseline Assessment (T0)

Randomized

**AIT**
Duration
- 6 months active treatment
- 6 month naturalistic follow up

**TAU**
Duration
- 6 months active treatment
- 6 month naturalistic follow up

Time 2 Assessment
Time 4 Assessment
Time 6 Assessment
Time 8 Assessment
Time 10 Assessment
Time 12 Assessment

Weekly Assessment

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Assessment Instruments

**Diagnostic**
- **Structured Clinical Interviews**
  - Structured Clinical Interview for the DSM-IV – TR (SCID)
  - Structured Clinical Interview for the DSM-IV Axis II Personality Disorders (SCID-P)
  - DSM-IV-TR Criteria for Identity Disturbance Questionnaire (IDDQ)
  - Interview for Borderline Personality Disorder Dimensional Scores
- **Self-Report**
  - Millon Adolescent Clinical Inventory (MACI)

**Symptoms**
- **General**
  - The Brief Symptom Inventory (BSI)
  - Child Behavior Checklist for Ages 6-18 (CBCL)
  - Youth Self Report for Ages 11-18 (YSR)
  - Teacher’s Report Form for Ages 6-18 (TRF)
  - Global Assessment Scale (GAS)
- **Depression**
  - Beck Depression Inventory, II (BDI-II)
  - Children’s Depression Inventory (CDI)
  - Reynolds Adolescent Depression Scale – 2 (RAD-2)
  - The Reasons for Living Inventory for Adolescents (RFL-A)
  - Children’s Depression Inventory-Parent Version (CDI-Parent)
- **Anxiety**
  - The State-Trait Anxiety Inventory (STAI)
- **Anger**
  - The State-Trait Anger Expression Inventory (STAXI)
- **Substance Abuse**
  - Personal Experience Questionnaire (PEQ)

**Functioning**
- Target Complaints Questionnaire
- Parasuicidal History Inventory (PHI)
- Social History Inventory (SHI)
- Treatment History Inventory (THI)

**Interpersonal**
- Cornell Interview of Peers and Friends
- Attachment Style Inventory (ASI)
- Bell Object Relations and Reality Testing Inventory (BORI)

**Identity**
- The Inventory of Personality Organization for Adolescents (IPO-CH)
- Identity Consolidation Inventory for Children (IPO-CH)
- Ego Identity Scale for Children (EIC-CH)
- Separation-Individuation Process Inventory for Children (SIPI-CH)
- Offer Self-Image Questionnaire for Adolescents, Revised (OSIQ)
- Multidimensional Self-Concept Scale (MSCS)
INTENT TO TREAT

Assessed for Eligibility
N=26

Eligible
N=11

Control Group
N=4
- Completed Active Treatment
  N=1
- Did Not Complete Active Treatment
  N=3

AIT Group
N=5
- Completed Active Treatment
  N=4
- Did Not Complete Active Treatment
  N=1

Ineligible
N=15
- Met Exclusion Criteria
  N=12
- Chose Not to Participate
  N=3

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CHALLENGES OF COLLECTING DATA

Subject Assessment Completion

Assessments Completed

Screening | Time 0 | Time 2 | Time 4 | Time 6 | Time 8 | Time 10 | Time 12
---|---|---|---|---|---|---|---
AIT | TAU

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### SUBJECT CHARACTERISTICS

<table>
<thead>
<tr>
<th></th>
<th>AIT n=5</th>
<th>TAU n=4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>16.2</td>
<td>16</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>+/- 1.78</td>
<td>+/- 1.63</td>
</tr>
<tr>
<td><strong>Length of Time in Study (Months)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>3.8</td>
<td>2.28</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>+/-2.28</td>
<td>+/-2.22</td>
</tr>
<tr>
<td><strong>IQ Scores (Mean/SD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSIQ</td>
<td>101.5 (+/-4.43)</td>
<td>105 (+/-8.76)</td>
</tr>
<tr>
<td>VIQ</td>
<td>102.25 (+/-4.79)</td>
<td>112 (+/-12.41)</td>
</tr>
<tr>
<td>PIQ</td>
<td>100.25 (+/-4.57)</td>
<td>97.25 (+/-11.15)</td>
</tr>
</tbody>
</table>
# SUBJECT CHARACTERISTICS

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Axis I Disorder</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>43%</td>
<td>0.43</td>
<td>+/-0.53</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>71%</td>
<td>0.71</td>
<td>+/-0.48</td>
</tr>
<tr>
<td>More than 1 Anxiety Disorders</td>
<td>43%</td>
<td>0.43</td>
<td>+/-0.53</td>
</tr>
<tr>
<td><strong>Axis II Disorders</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDP</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passive Aggressive</td>
<td>50%</td>
<td>0.50</td>
<td>+/-0.55</td>
</tr>
<tr>
<td>Depressive</td>
<td>43%</td>
<td>0.43</td>
<td>+/-0.53</td>
</tr>
<tr>
<td>Paranoid</td>
<td>43%</td>
<td>0.43</td>
<td>+/-0.53</td>
</tr>
<tr>
<td>Avoidant</td>
<td>16%</td>
<td>0.17</td>
<td>+/-0.41</td>
</tr>
<tr>
<td>More than 1 PD</td>
<td>86%</td>
<td>0.86</td>
<td>+/-0.38</td>
</tr>
</tbody>
</table>

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TREATMENT

Treatment by Group

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HOSPITALIZATIONS

Days in Hospital from T0 to T6

* Did not complete 6 months

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FINDINGS: CHANGES IN SYMPTOMS
ANXIETY

Change in State Anxiety from T0 to T6

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FINDINGS: CHANGES IN SYMPTOMS

Symptoms of BPD on the BPDDS

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FINDINGS: CHANGES IN SYMPTOMS DEPRESSION

Change in Depression from T0 to T6

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FINDINGS: OVERALL FUNCTIONING

Changes in AIT GAF Scores

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FINDINGS: IDENTITY

• IPO-CH: Identity Diffusion Scale
  • Currently 21 items, rated on 5 point scale

• Example Items
  • I feel that what I like (prefer) and what I feel are not really my own, but I have taken them from other people.

  • I make friends that I don’t really like because it’s hard for me to say no to them.

  • When others see me as being successful, I am on top of the world, and when they see me failing, I feel crushed.
FINDINGS: IDENTITY

Change in Identity from T0 to T6 on IPO-CH/A
Identity Diffusion

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WHAT WE LEARNED

• Less is more...much more
  • Length of Assessment
  • Number of Assessments
  • Chaotic Nature of Patients and Families

• Core Battery
  • Diagnosis
  • Symptoms
  • Identity
  • Functioning

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Assessment of identity development and identity diffusion in adolescence - Theoretical basis and psychometric properties of the self-report questionnaire AIDA

Kirstin Goth¹*, Pamela Foelsch², Susanne Schlüter-Müller³, Marc Birkholzer⁴, Emanuel Jung¹, Oliver Pick¹ and Klaus Schmeck¹

Identity development in adolescents with mental problems

Emanuel Jung¹*, Oliver Pick¹, Susanne Schlüter-Müller²,³, Klaus Schmeck¹ and Kirstin Goth¹
# US ADAPTATION OF AIDA

## AIDA Assessment of Identity Development in Adolescence

On the following pages you will find statements people might use to describe their attitudes, opinions, interests, and other personal feelings. For each statement, please circle one of the following five answers based on how you feel in general. Please answer every statement, even if you are not completely sure of the answer.

Remember, there are no right or wrong answers – just select the choice which best describes how you generally feel. Some statements may seem similar to you; these items should be viewed as an opportunity to describe yourself more fully and accurately.

### For the following statements, please circle the response that best describes you.

<table>
<thead>
<tr>
<th>ID:</th>
<th>Age:</th>
<th>Birthdate:</th>
<th>Sex:</th>
<th>Ethnicity (check any/all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>African American</td>
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</tbody>
</table>

### Statements and Responses

<table>
<thead>
<tr>
<th>Statement</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 I’m often not sure whether I am doing the right thing for myself or not.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 My parents think that I’m no good.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Sometimes I have strong feelings without knowing where they come from.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 I often see my own behavior differently from how my friends see it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 People who know me in one situation (i.e. teachers, friends) hardly recognize me in a different situation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 I feel empty.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 I can imagine that I will find my place in the world.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34 I often can’t help feeling either inferior or superior to other people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 I am confused about what kind of person I really am.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36 If someone hurts my feelings, I usually stop talking to them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37 I often don’t know why I do the things I do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 When I’m criticized by others, I feel devastated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39 I feel comfortable in my body.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 I usually have on-again, off-again relationships.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41 I have had very good experiences with listening to my intuitions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 When I’m alone I feel helpless.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43 When I see myself in a mirror, I recognize myself immediately.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44 I’m afraid that my friends suddenly won’t like me anymore and exclude me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45 I often feel as if I could be several people rather than just one because I have so many different thoughts and feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46 Being alone is difficult for me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47 I have many different sides to me that don’t match well (e.g. I want to be healthy, but I eat junk food all the time).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48 If someone praises me or others see me succeeding, I feel on top of the world.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49 Many people are fake and do not behave the way they really are.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 I’m totally confused when my mood changes suddenly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51 I often have a block when I ask myself why I did things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52 I often feel deceived by others when they turn out to be very different from what I expected.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53 I need reassurance from others to not give up.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54 My friendships usually last only a few months.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55 I feel that I have a strong inner core no matter what happens.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56 Others often tell me that I contradict myself, but I don’t think I do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57 I often feel that I will find my place in the world.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
US AIDA: PILOT STUDY

• Demographics
  • N=24
  • Controls 18; Patients (Identity Diffusion) 6
  • Male 5 (20.8%), Female 19 (79.2%);
  • Age 12-18; Mean 15.8 (SD 2.1)
# RELIABILITY OF US AIDA

<table>
<thead>
<tr>
<th>Scale</th>
<th>Number of Items</th>
<th>Alpha N=24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diffusion Total Score</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td><strong>1. Discontinuity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Attributes</td>
<td>9</td>
<td>.70</td>
</tr>
<tr>
<td>1.2 Relationships</td>
<td>11</td>
<td>.76</td>
</tr>
<tr>
<td>1.3 Emotion/Self Reflection</td>
<td>7</td>
<td>.83</td>
</tr>
<tr>
<td><strong>2. Incoherence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Consistency</td>
<td>11</td>
<td>.90</td>
</tr>
<tr>
<td>2.2 Autonomy</td>
<td>12</td>
<td>.81</td>
</tr>
<tr>
<td>2.3 Cognitive Self Reflection</td>
<td>8</td>
<td>.79</td>
</tr>
</tbody>
</table>

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WHAT’S COMING?

THERAPY PROCESS, NEUROBIOLOGY

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Evaluation of AIT-Study

Basel
- Emanuel Jung
- Susanne Schlüter-Müller
- Klaus Schmeck
- Christian Schrobildgen
- Ronan Zimmermann

Heidelberg
- Romuald Brunner
- Michael Kaess
- Julian König

Santiago de Chile
- Andrés H. Borzutzky
- Pamela Foelsch
- Mariane Krause
- Yamil Quevedo
- Nelson Valdez

Mexico-City
- Moises Kassin
LINES OF RESEARCH

1. Basic bio-psycho-social structures and processes
2. Health promotion and psychosocial intervention
3. Psychotherapeutic interventions and change processes
4. Rehabilitation and reintegration

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Multidimensional approach to the study of depression

Genetics

Psychophysiology

Culture

Social context

Personality

Developmental perspective

Cognitions, emotions and behavior

Depression

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Depression and personality disorders across 8 years of follow-up

Risk factors
- Personality
  - Relatedness vs self definition
  - Structure
- Genetics
  - Prosocial polymorphism
- Cognition Emotion Behavior
  - Attributional styles
  - Reflexive function
  - Emotion regulation
  - Risk behaviors
- Developmental perspective
  - Attachment
  - Trauma
- Social context
  - Social support and networks
  - Stressors
  - Life events
- Culture
  - Self-construal
  - Sex role ideology
  - Social/family norms

Outcomes
- Depressive disorder
- Personality disorders

Sample size = 1800
Cohort: 0 yrs.
Cohort: 12 yrs.
Cohort: 60 yrs.
MIDAP’s networks emphasize scientific research, training of young researchers, conjoint scientific publications, training of mental health professionals, workshops, seminars, and conferences.
THANK YOU FOR YOUR ATTENTION

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drodom@yahoo.com
drfoelsch@profpsych.com

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