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Contemporary Inpatient Treatment for Severe Personality Disorders: The Reversal of The Perspective

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Abstract

The contemporary proposal of an alternative model for personality disorders (DSM-5, Section III-AMPD), toward a psychiatric nosology in terms of levels of severity of impairment in self and the interpersonal functioning, has allowed the alignment between descriptive psychiatry and psychodynamic clinical and theoretical frameworks that use the same dimensions for the diagnostic evaluation and the empirical research of the treatment of severe personality disorders (SPD). In this work, starting from the proposition that the true therapeutic potential of a current authentic inpatient program lies in the interactional presence of the staff and the patients; and from a perspective of Transference-Focused Psychotherapy—Extended (TFP-E), as a transdiagnostic and a superordinate theoretical and clinical framework that integrates all the modalities of staff intervention, with the therapeutic mechanisms of action guided to specifically overcome the psychostructural alterations of patients with SPD; likewise, the configuration of a hospital care program is described. In congruency with the specific objectives of this program, the organizational and administrative structure, as well as the principles that govern its instrumentation, are explicited. In addition, the precepts that guide the strategic, tactical and technical therapeutic interventions, along with the requirements that guarantee and preserve a stable functioning of the same, are explained.

Keywords: Severe personality disorders; characterological suicidality; inpatient treatment; reversal of the perspective.

Introduction: The Reversal of the Perspective

Five to four decades ago, the lack of information and evidence-based empirical research on the diagnosis, treatment, and prognosis of severe personality disorders (SPD) had imposed on this field an unattractive and unpromising perspective (Lenzenweger & Clarkin, 1996; Oldham et al, 2014; Garza-Guerrero, 2017). In those days, in contrast, advances in neurobiology and psychopharmacology offered a fascinating and promising future, particularly for major psychiatric disorders, such as schizophrenia and bipolar spectrum pathology, as well as to some phenotypic variants of depressive manifestations. In the nineties, there were even talks about the "decade of the brain" (e.g., Rosenberg & Rowland, 1990). However, toward the end of that decade, already Kandel (1998) prudently warned about the need to promote a new intellectual framework for the future of psychiatry, that would preserve an adequate integration and balance between psychodynamic contributions and contemporaneous developments in neurosciences and the neurobiology of the interpersonal (Kandel, 1998).

A current re-evaluation of our situation regarding new drug developments looks different from what was anticipated in the nineties. In fact, and as H. Christian Fibiger advanced some years ago (2012), despite the last four decades of research and investments of billions of dollars, the pharmaceutical industry related to psychiatry is in crisis; there is no significant novelty in any of the major dimensions of our pharmacological armamentarium (i.e., antidepressants, antipsychotics, and emotional stabilizers). In addition, if we consider the present day truism in pharmacological research and development in psychiatry, that establishes that our drugs should be divided into two classes: symptomatic and modifiers of the causality of disorders that cause symptoms, we would need to conclude that a major impediment of current drugs lies in the fact that they are predominantly symptomatic, but not transformative of underlying etiopathogenic substrates (Garza-Guerrero, 2017; Garza-Guerrero, 2019; Garza-Guerrero, 2023; Ghaemi, 2022; Kernberg, 2022).

At this time, and as described by S. Nassir Ghaemi, "a major limitation of our psychiatric drugs is that they are like having many variations of aspirin, each with a different name" (Ghaemi, 2022; Lenzenweger & Clarkin, 1996; Oldham et al, 2014; Garza-Guerrero, 2017; Rosenberg & Rowland, 1990; Kandel, 1998; Garza-Guerrero, 2019; Garza-Guerrero, 2023).

The restricted activity of available drugs, only for symptomatic dimensions, is not negligible. The use of these drugs allows for containing, reducing, controlling, and reestablishing altered mental functioning, making patients' accessibility to a diverse range of non-pharmacological therapeutic modalities possible. Nevertheless, it must be recognized that this therapeutic approximation, derived from merely symptomatic taxonomic groupings, has not contributed to advances in generating knowledge on the etiopathogenesis of psychiatric disorders (Fibiger, 2012; Garza-Guerrero, 2017; Ghaemi, 2022).

On the contrary, a current reevaluation of the SPD field regarding diagnosis, treatment, and prognosis reveals an ostensibly different situation from that of four decades ago: a truly informative explosion derived from empirical evidence has revolutionized the current horizon of personality psychopathology, such that, if in the nineties we spoke of the "brain decade," today we speak of a reversal of the perspective, at least in SPD— hence, the subtitle of this work. Our present crossroad take us back to the ancestral dictum: i.e., nor a professional discipline of the brain, without including the intersubjectivity of the mental, nor a psychiatry of the mental, without a brain (Lipowski, 1977; Morey & Bender, 2014; Oldham et al, 2014; Skodol et al, 2014; Garza Guerrero, 2017, Garza-Guerrero, 2019, Garza-Guerrero, 2022a; Garza-Guerrero, 2022b; Kernberg, 2022).

Besides, we must consider that the exploration of the subjective experience reflected in self and the interpersonal functioning (i.e., criterion A, for the evaluation of levels of personality organization in the alternative dimensional model of the DSM-5 for personality disorders), must integrate a double plane of organismic consolidation: one of a neurobiological order, and the other of a symbolic and representational nature. Accordingly, the intentionality expressed in issues of identity, empathy, and intimacy —among other experiences— must definitely be considered emergent properties, that are irreducible to any particular neural system. In other words, no linear relationship exists between highly complex, symbolic, and reflexively represented experiences, or specific character traits, and specific underlying neurobiological mechanisms (Kernberg et al, 2018; Kernberg, 2022; Garza Guerrero, 2022a; Garza-Guerrero, 2022b).

In this regard, the current proposal of an alternative model for SPD (DSM-5, 2013), toward a psychiatric nosology in terms of levels of severity of the self and the interpersonal functioning has allowed (Skodol et al., 2014), not only an alignment between descriptive psychiatry and psychodynamic theoretical and clinical frameworks that use the same dimensions for the diagnostic evaluation and empirical research of the treatment of SPD (Caligor & Stern, 2020; Clarkin et al., 2020); but also the conceptual articulation between neurobiologically mediated dimensions of personality (e.g., negative affectivity, affiliation, sexual arousal, fear); and the psychostructural organization of the personality (e.g., identity, defenses, and reality testing) (Garza Guerrero, 2022a; Garza Guerrero, 2022b; Kernberg, 2018: Kernberg 2022).

In summary, if we start from the idea that both, normal and pathological self and the interpersonal functioning are emergent properties mediated by the psychostructural organization of the personality; to propose as strategic objectives: to transform psychostructural alterations in SPD, such as diffuse identity syndrome, quality of object relations, primitive defenses and dysfunctions in reality and social testing, among others (independently if their etiology is constitutionally given, or acquired and internalized), could represent the variable that differentiates (in comparison to the distinction described above, between symptomatic drugs, and those that could modify or transform etiopathogenic substrates); between merely symptomatic psychotherapies (dialectical behavioral therapy, DBT; dynamic deconstructive psychotherapy, DDP; metallization techniques, MT; schema-focused therapy, SFT; systems training for emotional predictability and problem solving, STEPPS) and psychotherapies and hospital care programs for SPD that aim to specifically modify multifactorial and organismically co-determined psychostructural alterations, responsible for the psychopathology of SPD —such as those derived from the line of empirical research on, transference-focused psychotherapy-extended, TFP-E (e.g., Yeomans et al, 2015; Hersh et al., 2016; Caligor et al., 2018; Leichsenring et al., 2019; Kraus et al., 2020; Normandin et al, 2021; Diamond et al, 2022).

In this study, a succinct historical review of contemporaneous comprehensive inpatient psychiatric care programs, relevant to SPD, introduces to the explicitation of etiopathogenic conceptions and a superordinate theoretical and clinical framework that permits the articulation of all the modalities of intervention of the different disciplines that participate in hospital care programs.

In what follows, an outline of a comprehensive inpatient program for SPD is described, especially: It's organizational and administrative structure; the precepts that guide its implementation; the principles that orient its strategic, tactical, and technical aspects of therapeutic interventions and mechanism of changes; as well as the requirements that guarantee and preserve its healthy operation. Concepts related to self and the interpersonal functioning, as well as those connected to the intrapsychic representativeness of self and others (Caligor et al, 2018; Kernberg, 2018; Kernberg, 2022), constitute the integrating axes of this work.

The traditional medical model and contemporary inpatient psychiatric models for severe personality disorders

In the context of a traditional medical model (i.e., even if it is inserted in a psychiatric division of a hospital), the patient passively submits to being cared for, and consequently expects too, that those who care for him take the responsibility for improving the nature of their symptoms and the difficulties that led them to the hospital. In this model patients don´t consider themselves co-responsible for the outcome and consequences of their treatment. On the contrary, in the context of a current psychiatric model, the patient is encouraged to actively co-participate and co-determine a potentially therapeutic

relationship with the staff. In summary, they are considered co-responsible for the results of their stay and for jointly planning a reorganization in their life thereafter (Hersh et al, 2016; Garza-Guerrero, 2019; Garza-Guerrero, 2023; Lohmer, 2022; Kernberg, 2022).

The true therapeutic potential of an authentic contemporary inpatient program lies in the interactional presence between the staff and patients (Rösch, 2022). However, this complex task requires an organizational and administrative structure, which collectively and individually, allows the utilization of the different social subsystems of the hospital at the service of therapeutic objectives (Garza-Guerrero, 1975; Garza-Guerrero, 2019; Garza-Guerrero, 2023; Kernberg, 1984; Kernberg, 2022). Nevertheless, despite enormous advances, both in the organizational structure and different modalities of psychotherapeutic interventions (e.g., Dulz et al., 2022; Dammann et al., 2016; Kernberg, 2022; Kramer et al., 2024), with few exceptions, most psychiatric hospital programs nowadays, still function under the precepts of a traditional medical model as: a) "Therapeutic Communities," which bring together a disjointed miscellany of diverse psychotherapeutic supports, custodial containment, pharmacological control, and occupational therapies; or as, b) mixed models of psychotherapeutic support, cognitive-behavioral techniques, mentalization based interventions, DBT, symptomatic pharmacological approaches, exercise and entertainment. Unfortunately, most traditional medical models of psychiatric hospital care, suffer universally from frequent limitations in both, adult psychiatric programs and in child and adolescent psychiatry, among others:

- In general, they lack a superordinating theoretical and clinical framework that articulates the distinct therapeutic modalities of intervention to the specific mechanisms of therapeutic change, and to an understanding of the total interactions between patients and staff (Kramer et al., 2024).
- They frequently do not have an operationalized manual of principles that may guide and define the clarifications to patients, families, and staff, about the nature, limitations, and realistic expectations of hospitalization.
- Usually, psychiatric disorders comorbid to SPD (e.g., panic attacks, depression, post-traumatic stress syndrome, complex trauma, substance related and addictive disorders) are commonly mentioned, but the nature and characteristics of the overwhelming nature of their severe personality disorder and its corresponding level of underlying characterological organization mediating the symptomatology (i.e., their true primary diagnosis) are not explained to the patients and family members, in terms that they might be able to understand.
- Symptomatic diagnoses, along with solely symptomatic treatments (i.e., drugs and non-transformative psychotherapies of etiopathogenic substrates) result in patients stuck in a future revolving door of admissions, discharges, and readmissions (Hersh et al., 2016; Caligor et al.,2018; Kernberg, 2018; Kernberg, 2022; Blüml & Doering, 2021, Weinberg & Ronningstam, 2020; Garza Guerrero, 2022a; Garza Guerrero, 2022b; Garza Guerrero, 2023).

On the contrary, if the capitalization of the therapeutic interaction between staff and patients (as well as between patients themselves), as a co-participatory agent of change is taken as a conceptual referent, (Rösch, 2022), the origin of hospital programs properly instituted for SPD ("borderline states" at that time) could be traced in the pioneering contributions of psychoanalysts and psychiatrists in Germany, England, and subsequently, the United States (Klein, 1946; Sutherland, 1952; Fairbairn, 1954; Jones, 1953; Sullivan, 1953; Main, 1957; Bion, 1961). During the sixties and seventies, psychiatric institutions with a psychodynamic orientation prevailed in the United States, e.g., the Chestnut Lodge Clinic in Rockville, Maryland; the Austen Riggs Psychiatric Clinic in Stockbridge, Massachusetts; the Sheppard and Enoch Pratt Clinic in Baltimore, Maryland; and the Menninger Clinic in Topeka, Kansas.

A historical and systematized review of the development of programs of this nature for SPD is beyond the focus of this study; however, due to its direct relationship with the conceptual axis of this exposition, it is imperative to highlight the diligent efforts of Dr. Otto F. Kernberg as director of the C. F. Menninger Memorial Hospital (1969-1973), in the enormous impulse to develop an authentic inpatient program, from the perspective of an object relations theories (individual and group), systems theory, and the psychology of small and large groups, as well as institutional organizational theory (Kernberg, 1984; Kernberg, 2022).

It is important to underline that the instrumentation of this ambitious inpatient program, coincided simultaneously with the launching of his pioneering and seminal major research axis on borderline personality organization, or severe personality disorders in general (Kernberg, 1975; Kernberg, 1980; Kernberg, 1984). This program and line of research was extended posteriorly and continued in the Westchester Division of The New York Hospital, and culminated with the foundation of the Personality Disorders Institute in the same division in 1996.

The elevated cost of operation and the demand of highly specialized training for professional and para-professional disciplines, in programs that intended to capitalize the interactional co-participation between patients and staff; at a time when operational manuals nor theoretical and clinical superordinate frameworks that might have facilitated and simplified their greater dissemination, did not exist, reduced its subsequent deployment in the United States. These facts, along with the oversold promise of a future pharmacological progress in the "brain decade," the impact of the "Community Psychiatry" movement of the seventies and eighties in the United States, as well as the advent of managed care and the advancement of various brief psychotherapies, slowed the development —in the United States— of extended hospitalization programs for severe personality disorders.

Nevertheless, a more propitious environment in Europe contemporaneously, related to greater coverage of public social security programs; academic support for the interdisciplinary training of human resources; and significant incentives for massive longitudinal research, has made it possible to preserve and reinvigorate the continuity of these programs in Basel, Switzerland; Hamburg and Munich in Germany; Holland, and Austria (Dammann et. al., 2016; Sollberger et al., 2015; Dulz et. al., 2022; Kernberg, 2022). And, it is precisely from the evidence derived from the empirical research in these European centers (i.e., regarding hospital care), as well as that from the intense and uninterrupted research work of the Kernberg group and collaborators at Cornell and Columbia, since the seventies and eighties (e.g., Yeomans et al, 2015; Hersh et al., 2016; Caligor et al., 2018; Normandin et al., 2021; Diamond et al., 2022); that their contributions have permited the development of operational manuals and a superordinating theoretical and clinical framework, which could jointly contribute to the more widespread, simplified, and less expensive development of inpatient programs for SPD —both in private and public practice, especially in an academic or university setting.

Etiopathogenesis in SPD: transdiagnostic and superordinate theoretical and clinical frameworks, and therapeutic mechanisms of action

Causality

Mental processes underlying the subjective intentionality of interpersonal experience, as all ready mentioned, integrate organismically, two levels of functioning: one, mediated neurobiologically —as negative affectivity, sexual excitement and aggression— and another psychologically determined and symbolically represented in mental structures, such as identity and representations of the self and others (i.e., object relationships).

In this regard, although of proteiform expression, a common denominator of dysfunctional attachments (DA) in SPD is excessive negative affectivity in interpersonal relations. However, the clinical and phenomenological manifestations of DA, in general, are only emergent properties that could have originated in, or derived from:

- genetic or temperamentally determined vulnerabilities, which predispose to a negative affective states of hyper reactivity;
- adverse traumatic developmental vicissitudes; or,
- interpersonal or constitutionally determined distortions derived from primitive defenses and conflicts, even in the context of positive and affiliative interpersonal relationships. In synthesis, DA are symptomatic predispositions, not a cause.

A corollary of these mentioned premises is that regardless of whether they are genetically and constitutionally determined or derived from adverse developmental vicissitudes, the impact of all etiopathogenic variables will be reflected as emergent properties in psychostructural alterations of the self and interpersonal functioning (i.e., diffuse identity syndrome and pathological interpersonal relationships). And problems of identity and interpersonal dysfunction are not only the operational dimension of diagnostic manuals (i.e., DSM-5-AM; CIE-11, 2018) for SPD; but they are also, precisely, the focus of TFP-E, in individual and group treatments, and in ambulatory as well as in inpatient programs (Caligor et al., 2018; Kernberg, 2018; Kernberg, 2022; Garza-Guerrero, 2017; Garza-Guerrero 2022a; Garza-Guerrero 2022b; Garza-Guerrero, 2023; Kraus et al., 2020; Dulz et al., 2021; Lohmer, 2022).

Superordinate theoretical frameworks

Identity and interpersonal functioning are bridge concepts between descriptive psychiatry and psychodynamic perspectives; likewise, between neurobiologically mediated dimensions and the psychostructural organization of personality (Diamond & Hersh, 2020; Caligor et al., 2018; Kernberg, 2022; Garza Guerrero, 2022a; Garza Guerrero, 2022b; Diamond et al., 2022).The endopsychic representation of the self and others is a concept common to different interpersonal theoretical models, to psychodynamic personologies, attachment and mentalization theories, as well as to superordinating models, such as the one developed by (Mischel & Shoda, 2008) —Cognitive-Affective Processing Systems— and TFP-E (Caligor et al.,2018, Diamond, & Hersh, 2020; Diamond et al., 2022; Kernberg, 2018; Kernberg 2022).

Nevertheless, TFP-E should not be categorized only as a purely developmental model that aims to validate past experiences. In addition, unlike other frames, it does not conceive external and internal reality as equivalents; it integrates a psychodynamic model of intrapsychic defenses and conflicts; and it takes into considerations the extreme oscillation in role reversal in the interpersonal functioning of patients with SPD. Likewise, in contrast to DBT it doesn´t aim solely to regulate emotions; and different to mentalization techniques (MT), it does not only seek to correct distortions.

The interpretative activity of TFP-E overlaps with the preliminary phases of clarifications and confrontations of MT; nevertheless, it subsequently integrates into its interpretative process the role reversal derived from split dyads, as well as its defensive aspects, toward a more integrated concept of the self and others that allows the recontextualization of the past and present (Caligor et al., 2018; Kernberg, 2022; Garza Guerrero, 2022a; Garza Guerrero, 2022b).

TFP-E could be combined with other treatment modalities in outpatient and hospital settings; however, it would be imperative to know and specify the objectives and mechanisms of action and, above all, the superordinating principles of tactics, technique and strategy, which guide potential synergies between them, or that may signal inconsistencies that could exclude each other; as well as the timing of introduction and pertinence of each modality (e.g., DBT, CBT, MT).

TFP-E is not psychoanalysis, although initially, it derived from object relations theories. TFP-E is currently considered a major theoretical and clinical framework between interpersonal neurobiology and psychostructural personality organization,

that integrates quantitative and qualitative modifications derived from empirical research on the diagnosis and treatment of SPD (Dammann et al., 2016; Krauss et al., 2020; Dulz et al., 2021; Lohmer, 2022; Kernberg, 2018; Kernberg, 2022).

In conclusion, TFP-E, currently constitutes a superordinating theoretical and clinical framework that could integrate and guide all interventions from the different disciplines of inpatient programs for SPD. At the same time, its manualization and operationalization in guiding principles, permits not only it´s teaching, but also its multicentric research, which in turn facilitates replicability. Finally, TFP-E counts with assessment and follow-up clinimetric instruments for the self and the interpersonal functioning which allow constant supervision and observation of the efficacy of inpatient programs for treating SPD, as well as scales that quantify the degree of adhesion to the intervention modalities under study (Kraus et al., 2020; Lohmer, 2022; Dammann et al., 2016; Dulz et al., 2022).

Therapeutic Mechanisms of Action

At present time, a consensus prevails on the possibility of multiple potentially mutative processes for therapeutic interventions in different treatment situations for SPD (Gabbard & Westen, 2003). A large number of these are of a non-specific nature, mediated by implicit relational knowledge, common to different modalities of intervention, and congruent with the anaclitic aspects of the interpersonal, e.g., an attitude of tolerance and acceptance, a presence that provides empathic validation and understanding of the other, or that give protection, containment, and security.

However, in the case of SPD, the strategic, tactical, and technical aspects of treatment programs must go beyond mere patient containment and stabilization, towards the beginning, at least, of a gradual process of integration of representations of the self and others, affectively and cognitively split-off, which contribute to a diffuse identity syndrome, affective-cognitive dysregulation, and poor reflective thinking. Hence, a common task, and always present for all the staff of an inpatient program, is the observation of the three communication channels in their interaction with patients (i.e., the verbal aspects of communication, the non-verbal attitudinal elements of expression, and their countertransference reaction), as well as observation of the total interaction between them.

The experience derived from all these interactions is the starting point towards a gradual process of clarifications, confrontations, and the interpretative explicitation of predominant models of relating, including when entirely feasible and indicated the interpretation of the reversal of relational roles, or the defensive aspects of split-off or conflictive dyads (Sollberger et al., 2015, Caligor et al., 2018; Kraus et al., 2020; Kernberg, 2022). This common task for all the various disciplines that integrate the hospital care teams, complement the corresponding specific aspects of each discipline (i.e., nursing, social work, psychology, psychiatrists, and residents). Besides, this objective and action of observing here and now, all interaction between patients and staff, should be extended towards its maximum capitalization in all the different subsystems and activities of the inpatient program (Garza-Guerrero, 1975; Garza-Guerrero, 2017; Garza-Guerrero, 2022a: Garza-Guerrero, 2022b; Kernberg, 2018; Kernberg, 2022; Caligor et al., 2018; Lohmer, 2022).

Finally, and regarding mechanisms of therapeutic change, the primary objective of hospitalization for SPD must contemplate not only the stabilization of the patient and their preparation for a gradual process of subsequent outpatient treatment, which leads to a more integrated concept of the self and others; but also, to provoke an emotionally ego-dystonic shaking of their status quo, that might initiate a reorganization towards long-term goals that incorporate good quality to their lifes, in dimensions such as work, education, or professional aspects; intimate, sexual, and family life, as well as creative and recreational aspects (Caligor et al., 2018; Garza-Guerrero, 2022a; Garza-Guerrero, 2022b; Kernberg, 2022).

Towards a comprehensive inpatient program for SPD: regressive and reorganizational group tendencies

While it is true that the interaction between patients and staff is consubstantial to a program that aims to diagnose, understand, and overcome psychostructural alterations in SPD, its instrumentation and monitoring entails an arduous and complex task. Among other aspects, it requires strict monitoring of group and institutional variables that jointly co-determine regressive and reorganizational tendencies, well known and typical of every collective social system (Stanton & Schwartz, 1954; Main, 1957; Bion, 1961; Garza-Guerrero, 1975; Garza- Guerrero, 2006; Cesar, 2017; Garza-Guerrero, 2022a; Garza-Guerrero, 2022b; Kernberg, 1984; Haslam, 2009; Haslam, 2009; Kernberg, 1998; 2012, Kernberg, 2022).

These include:

- A clear definition of the objectives and tasks to be developed;
- The nature of leadership;
- The clarification of lines of authority and the hierarchy of responsibilities; as well as,
- A clearly delineated and generalized information on the mechanisms and forms of decision-making.

The greater the clarity, explanation, and control of all these variables, the greater the possibility of remaining as a stable task group, adhered to its functions and objectives. However, ignorance of all these variables, to the contrary, leads to a chaotic functioning, regressive and exhaustingly unproductive (Dulz et al., 2022; Kernberg, 2022; Garza-Guerrero, 2022a; Garza-Guerrero, 2022b; Garza-Guerrero, 2023).

With the purpose of conceptually illustrating, the specific description of the organizational structure of a comprehensive inpatient program of eight to twelve weeks for SPD will be exposed (for patients with complex mental situations, where the diagnosis of SPD coexist with diverse comorbidities and multiple complications, such as addictive disorders, PTSD, complex-trauma, an eating disorder, or characterological suicidality); which could be reduced to six, to eight weeks in

patients with more favorable circunstances.

* The following are emphasized:

- The organizing principles that guide the program operation;
- The administrative structure that supports its instrumentation,
- The phases and objectives corresponding to the hospitalization period, and
- The institutional requirements that guarantee its viability and an optimal program functioning.

From an actual proposal of the author to a University Hospital.

Organizing Principles

Focus: the starting point for all staff lies in observing in the here and now of their interactions, the totality of their self and interpersonal functioning, SIF (i.e., transference and countertransference, in both: patients and staff); relying on the continuous monitoring of the three communication channels, TCC (verbal, non-verbal or attitudinal, and countertransference reactions).

Objectives: the exploration and understanding of all disruptive factors (i.e., not only those that the patient and family members described, but also those which both could have been unaware of), that caused the hospitalization, towards a reorganization and preparation for an outpatient follow-up.

Interdisciplinarity: a genuine interdisciplinary practice, in contest to a multidisciplinary one, tries to integrate the wealth of the entire functions of the different disciplines, at the service of the common objectives of the program (and in contrast to, homogenizing, or denying their differences). The fundamental objective lies in the treatment of psychiatric dysfunctions or psychostructural alterations, not the imposition of a pseudo-egalitarian ideology. The pseudo-democratization of professional disciplines in an institution blurs roles and culminates in administrative chaos (Sollberger et al., 2015; Garza-Guerrero, 1975; Garza-Guerrero, 2017; Garza-Guerrero, 2022a; Guerrero, 2022b; Lohmer, 2022; Kraus et al., 2020; Kernberg, 2022).

Leadership: authentic leadership must be anchored in co-participatory decisions based on functional criteria (i.e., congruent with the tasks in question), not by democratic consensus: everyone's responsibility, no one's responsibility. Authority can be delegated. Responsibility no. For example, in the decision to allow a specific patient to go out on the weekend, all team members could co-participate. However, it is up to the resident or team psychiatrist assigned to that patient, to make the decision based on his functional hierarchy, experience, and information, not on the consensus derived from the votes of the entire team (i.e., patients and staff).

Authority and responsibility: a clear definition of general objectives, common to all, and individual tasks; coupled with the explicitness –known to everyone– of the levels of hierarchy and lines of authority and responsibilities; it prevents regressive group phenomena and avoids the generalized derailment of the specific program objectives (Sollberger et al., 2015; Garza-Guerrero, 1975; Garza-Guerrero, 2017; Garza-Guerrero, 2022a; Lohmer, 2022; Kraus et al., 2020; Kernberg, 2022).

Administrative Structure

This subject involves the organization of all the administrative meetings of staff and patients, as well as those of the social systems and subsystems that integrate the hospital program. From the observation of the TCC, these meetings and gatherings constitute the psychosocial intercommunicating context common to all the staff´s interventions: the strategies to meet the objectives (i.e., the actions that will lead to the goals of the program through hospitalization); the tactical aspects (i.e., the terms and conditions of coexistence, rules and framing of the program); as well as their technical modalities (i.e., the articulation from meeting to meeting, and day to day, of the basic aspects of TFP-E); within a superordinate theoretical framework applicable to the self and interpersonal functioning observed between staff and patients, e.g., clarifications, confrontations, the identification of affectively dominant object relations, and role reversals.

Task groups or Teams (TG)

Comprised by six to eight staff members (i.e., psychiatry residents, psychiatrists, psychologists, nurses, or social workers) and eight to ten patients, the two TG represents the basic axes of the inpatient program. These task groups have a leader, that meet for one hour three times a week, and their objective is to explore the reasons for the admission of each patient, the restoration of their functioning, and the planning of a subsequent outpatient follow-up program, which may contribute to a reorganization in their lives. Considering that patients reproduce within the hospital their usual model of relating to others, the work of the TG begins with exploratory questions, such as: Why are you here? What did you do, or you didn´t do it, that warranted hospitalization? How do you understand everything related to your hospitalization? How could you have avoided it?

The exploratory and evocative nature of these questions psychoeducationally seeks to help the patients position themselves as a co-participatory agent in their diagnostic evaluation and treatment plan, in contrast to the usual position of seeing themselves as an individual who passively submits and waits for others to do something to them, or for them.

Likewise, the open and exploratory nature of these questions raises the level of anxiety and immediately causes the primitive defenses of patients with SPD to be externalized; as well as their split-off or polarized paradigmatic models of relating to others, e.g., an aggressive and paranoidized model from which they perceive themselves as potential victims, of an insensitive, authoritarian and indolent staff; or else, an idealized model of oneself, as someone pusillanimous, weak, and timorous, in search of someone benevolently, empathetic, and unconditionally protective.

Other common questions in TG, which complement those mentioned above, are: how do you think we could help you overcome your situation, not only with an urgent stabilization, but with a reorganization of your life, from which you might be able to avoid future rehospitalizations? What have you done

during your stay with us so far, and what could you do during the time you have left here in the hospital, so that you could lead yourself to meet the goals of your hospitalization?

Although the stated questions apply individually to each TG patient, listening to the responses of other patients during the meetings represents a positive emotional multiplication impact, which literally begins to question and shake the mental status quo of all participants. However, it is also necessary to be alert to the regressive effect in some patients, the result of negative contagiousness phenomena (Garza-Guerrero, 1975; Garza-Guerrero, 2022a; Kernberg, 2022).

Another common activity in TG is the exploration of disruptive behaviors that could negatively affect the implementation of the program and the fulfillment of its objectives. In this regard, the information that patients and TG staff may have about the affectively dominant object relationships (ADOR) of patients in other places or meetings, of relevance to the tasks and functions of the TG, could also be integrated into these meetings, unless the group leader considers it as contraindicated.

TG reflection meetings with each of the patients

These are meetings of the members of the TG, in the presence of each patient, for a joint reflection on the current state and evolution of each person's respective treatment, with their setbacks and progress, as well as the planning of their future follow-up in the community. The content of these meetings is confidential, and each patient must be informed previously. This is the opportunity to expose absolutely confidential topics. Here, the patients could contribute with greater disinhibition too, with their most critical observations of the program, and their corresponding rationale.

Transference-focused psychotherapy-individual, TFP-I (two sessions per week)

A psychotherapist is assigned to each patient, starting from the second week of hospitalization, for a working plan of two 45-minute sessions per week. Although some trivial information could infiltrate the session material, the exploration of the totality of the patient's interactions, in the immediacy of the transference here and now, is privileged, including those outside of the individual treatment. The TCC are observed, and the basic concepts of TFP-E are followed in terms of strategic, tactical, and technical considerations, as well as those related to clarifications, confrontations, and interpretive activity (Yeomans et al., 2015; Hersh et al., 2016; Caligor et al., 2018; Kernberg, 2018; Kernberg, 2022).

By the third week of admission, individual psychotherapists could participate in meetings where their assigned patients are centrally discussed. There, they can be informed of the interactions observed by other staff members and, in turn, share their own considerations about dominant paradigmatic relations DPR observed by them and their defensive or conflictive aspects. All this information must be known by all staff members involved in the patient's treatment. Likewise, all this material must be processed and worked on throughout the patient's interactions within the hospital (Kernberg, 2022; Lohmer, 2022).

Transference-focused psychotherapy-group TFP-G (one to two sessions per week for 60 to 90 minutes)

The strength of a inpatient program like this/one, comes not only from the possibility of offering different combinations of methodologies and modalities of intervention by interdisciplinary teams, but also, and above all, from the fact that each patient has the simultaneous presence of other patients in similar situations (Lohmer, 2022).

There are three traditional theoretical approaches to the analysis of the functioning of psychotherapy groups: that of Foulkes and Anthony (1957), where the way in which each individual relates to the group is observed and analyzed; that of Bion (1961), who takes into account the response of each group member to the group's regressive themes, or collective basic assumptions. Where as, Ezriel (1950) and Sutherland (1952) combine the analysis of predominant group themes, with the analysis of the position that each member of the group adopts in relation to the conflicts activated in the corresponding basic assumptions (Kernberg, 2022).

However, regardless of the theoretical approach, what must predominate is the understanding of their objectives in relation to TFP-I. The purpose is to avoid polarizations where the different modalities exclude each other, or where TFP-G replaces TFP-I. In other words, the centralizing and integrating impact of TFP-I is privileged in order to articulate all the information of each patient.

TFP-G is a complex development derived from psychoanalytic group therapy (Bion, 1946; Ezriel, 1950; Sutherland, 1952). Generally, TFP-G has two leaders who help each other in the complex analysis of the psychodynamics of the group. The essence of TFP-G, particularly in inpatient programs, lies in the observation of transference reactions that occur between members, or between individuals and the group as a whole. TFP-G combines two models in the approach to ADOR exploration (Rufat et al., 2023). In one model, the focus is in each patient's expression of their internalized, affectively dominant object relations (ADOR), toward other patients in the group; and, in turn, the exploration of the mutual interactions between members as an expression of the interaction of their corresponding (ADOR). The second observation model derives from the analysis of total group regression towards the basic group assumptions of Bion's approach to group analysis (i.e., the basic assumptions of dependence, flight and/or fight, and pairing).

Collective meeting (once a week)

I use the term collective meeting, instead of the coloquial "community meeting" for two reasons: one to avoid the risk of confusing the program proposed here, with Maxwell Jones' (1953) concept of a therapeutic community with a specific sociopolitical orientation that aspires to an idealized democracy (Garza-Guerrero, 1975; Garza-Guerrero, 2017;

Kernberg, 2022); the other, to prevent the risk that the proposal of an inpatient program like the one hereby exposed may be equated or placed at the same level as the banalized versions of pseudotherapeutic communities that combine, and commercially exploit, a miscellany of different treatment modalities; without a superordinate theoretical and clinical framework that might articulate them to explicit objectives of mechanisms of therapeutic change, and without precising specifically, for which patients, with which categorical diagnoses, and at what level of personality organization (Hersh et al., 2016; Yeomans et al., 2015; Caligor et al., 2018; Dulz et al., 2021; Garza-Guerrero, 2022a; Garza-Guerrero, 2022b; Kernberg, 2022).

Collective meetings are held once a week and include all the staff and patient available at the time of the reunion. They require an assigned leader, responsible for: 1) explaining how to gather and structure the thematic and permissible content of the agenda; 2) the mechanisms of discussion and co-participation in decisions by functional consensus, typical of this level of deliberation; and 3) preserving the congruity of the content and decisions of the agenda, with the specific treatment objectives of the program.

The usual topics of collective meetings are related to the quality of the environmental setting in the daily life of the unit, planning activities, exploring problems of coexistence and functionality, and, of course, welcoming or expressing farewell to a patient at his departure, among others (Kernberg, 1984; Kernberg, 2022).

Nursing Functions and Meetings

If the observation and the use of the therapeutic interactions between patients and staff is the essential activity that distinguishes between a merely custodial program and an authentic inpatient psychiatric program: nursing, due to the large number of hours of presence in the hospital environment, is a discipline with a very significant potential impact to achieve objectives. For example, in addition to their specific functions (i.e., drug delivery, monitoring vital signs and report sleep patterns, etc.) and by virtue of paying attention to TCC with patients, nursing must also integrate their observation of the activation of ADOR, including role reversal, as part of their own contribution to the common collective functions of the entire program: the comprehensive capitalization of staff-patient interactions.

In an authentic contemporary psychiatric inpatient program, due to their ubiquitous presence, nursing fulfills, not only the liaison between different nursing shifts but also other fundamental functions: such as the intercommunication with all disciplines and members who participate in the program, as well as planning collective activities for patients and/or family members. Finally, due to their constant presence, nursing is also more frequently responsible for being the first line of intervention in temperamental outbursts or the containment and therapeutic management of affective-cognitive storms in patients with SPD, using the principles of TFP-E, applicable to situations outside the context of individual psychotherapy (Hersh et al., 2016; Garza-Guerrero, 2022a; Garza-Guerrero, 2022b; Garza-Guerrero, 2023).

Regarding the importance of the central nursing functions, it would not be idle to emphasize that if one wants to quickly assess and know the true quality of an inpatient program, it is only necessary to review some of the nursing notes (along with those of residents, psychiatrists, and other professionals disciplines), in different shifts, and in a few medical charts, so that their content, in an expeditious manner, permits us to perceive the difference between a traditional custodial medical model (limited only to the reporting of vital signs, sleep patterns, and eating habits of patients, or the impersonal account of observable behaviors); and an authentic personalized and humanized contemporary inpatient psychiatric program.

Weekly meeting of the two teams (TG)

This meeting allows not only sharing the experience of both teams, with their respective patients, but also reflecting on the impact of one team on the other, as well as exploring shared information that should be integrated into their corresponding agendas.

Collective activities (gastronomy, outings to recreation and cultural centers, diverse projects)

The planning, conformation, instrumentation, and organization of these collaborative activities for patients and staff must adhere to the specific objectives of the inpatient program: the stabilization of patients towards a reorganization of their outpatient life after hospitalization. The most frequent error lies in reducing the general objective to merely entertainment (even if, secondarily, they entail some of this experience).

Occupational therapy (arts and crafts: music, painting, theater, journalism, knitting.)

Ideally, these activities should requires therapists to be familiar with some of the basic concepts of TFP-E, thus allowing them to integrate the process of their occupational approach in to their respective tasks, with the observation of patients' ADOR at the service of therapeutic objectives.

Exercise and Good Eating Habits

A sedentary and poor lifestyle, overweight, and bad eating habits are the product of self-destructive and even parasuicidal complications, commonly observed in a high percentage of patients with SPD. Measures to prevent serious harm from these should be part of the terms, conditions, and framework at the time of admission to the hospital. In some medically evaluated cases, the recommendation to lose half a kilo of weight per week, could be not only an objective, but a precondition for continuing in the program, especially in situations of obvious self-destructiveness (Hersh et al., 2016; Garza-Guerrero, 2017; Garza-Guerrero, 2022a; Garza-Guerrero, 2022b). This approach is only congruent and similar to the expectation in patient discharge planning, regarding the need to study or work on something, as a precondition for treatment continuity as an outpatient (Yeomans et al., 2015; Caligor et al., 2018; Garza-Guerrero, 2017; Garza-Guerrero, 2023).

Description of Phases and Objectives

The phases of hospitalization, with their corresponding objectives, in relation to an eight to twelve-week program for SPD; and six to eight for less severe patients, and without comorbid conditions that could complicate their evolution

- The preliminary phase during the first week covers the orientation period, comprehensive diagnosis, and the application of clinimetric scales and questionnaires (e.g., PICED, IPO, STIPO, FIAD 60, LPFS).
- During the second week, a comprehensive explanation of the diagnostic conceptualization is carried out (i.e., the categorical diagnoses of the DSM-5 and the ICD-18, as well as the psychostructural evaluation and the level of personality organization); in words that everybody could understand. Special attention is given too to a clarification of the expectations, terms, and conditions of the treatment to patients and staff (if they had not been mentioned before admission).

Regarding the terms and conditions of hospitalization, the approach to characterological suicidality (CS) requires some specific considerations, because it is one of the most frequent causes of hospital admissions, but it entails a common determinant of errors in its management. Unlike depressive suicidality (DS) (i.e., as a component of a major depressive disorder, or as a manifestation of a bipolar spectrum pathology), CS is not episodic. It is stable within its instability and often turns into a stormy modus vivendi. SC is ostensibly linked to specifically significant interpersonal contexts and has an oscillating, capricious and volatile course (Caligor, et. al., 2018; Garza-Guerrero, 2019; Garza-Guerrero, 2023).

Because SC occurs in a clinical context where the patient preserves volitional control of their life and circumstances, they alone are responsible for safeguarding their physical and mental integrity. The patient decides to perpetrate it or not, and how, when, and who to hurt and affect. For the same reason, it cannot be prevented or predicted. This predicament must be made explicit to couples and family members. Therefore, it must be made clear to them, that the reason of hospitalization is not to guarantee the preservation of a patient's life. Patients with SC end their lives even in the best hospitals in the world. The purpose of hospitalization is to collaboratively try to explore, contain, and resolve underlying psychostructural alterations, mediators of suicidal behaviors. During a hospitalization, if the volitional nature of SC and the locus of responsibility in the patient himself is not made explicit to patients, partners, and family members, the secondary gain and the risk of acting out increases. Furthermore, some family members take for granted that the hospital assumes full responsibility.

Characterological suicidality (CS) is used as a sadistic instrument of omnipotent control over others, at the service of forcing others to behave in the direction convenient to them. CS does not derive from properly expressed depressive motivations, but from psychodynamics instigated by the desire to punish, torture, hurt, or take revenge on others. Poor CS management has a highly contagious and disruptive impact on divisions with SPD, hence the importance of anticipating proactively complications and crises.

- From the second to the eighth week, multisystemic and interdisciplinary monitoring of specific treatment objectives is implemented for the primary diagnosis of the personality disorder and for comorbidities (i.e., these same actions could be applied in the phases of both, adult and adolescent programs).
- The last four weeks (for both versions of the program: short and extended) are oriented towards termination planning, pertinent educational, and/or work recommendations as a condition sine qua non of admission to outpatient treatment, as well as the corresponding subsequent follow-up (Sollberger et al., 2015; Garza-Guerrero, 1975; Garza-Guerrero, 2017; Garza-Guerrero, 2022a; Garza-Guerrero, 2022b; Lohmer, 2022; Kraus et al., 2020; Kernberg, 1984; Kernberg, 2022).

Institutional prerequisites for an authentic comprehensive psychiatric inpatient program for SPD

- The absolute preservation of the locus of internal authority and responsibility (chairman of the department and the coordinator of hospital services) in the management and control of the entire program, combined with respect for the lines of decisions-making and hierarchies in the different subsystems, avoids common disputes over available beds, the potential for the corrupt usufruct of them, or the commercial banalization, of the program.
- Training, updating, and continuous supervision of all staff.
- Functional co-participation of the entire multidisciplinary staff in decisions that concern the integrity and operation of the program.
- The same program for all patients (both "private" and "non-private") in contrast to "first" and "second class" programs implemented by residents and faculty members authorized by the Department of Psychiatry and with operating costs and fees, planned in such a way that the most economically privileged compensate for those with fewer economic resources (only such a measure would delimit between the "renting of rooms and beds", from an authentic contemporary first level, functional, and genuinely professional university-based inpatient program).
- Monthly investigative supervision of therapeutic results and economic monitoring, through a written record of progress and complications, as well as complaints and grievances (Sollberger et al., 2015; Garza-Guerrero, 1975; Garza-Guerrero, 2017; Garza-Guerrero, 2022a; Garza-Guerrero, 2022b; Garza-Guerrero, 2023; Lohmer, 2022; Kraus et al., 2020; Haslam, 2009; Haslam, 2009; Kernberg, 1984; Kernberg, 1998; Kernberg, 2022).

Final Considerations

As a corollary of the advances and limitations so far indicated in the psychotherapeutic and pharmacological approach to SPD, below are three debatable and controversial situations related to: the extended inpatient treatment of SPD; "special programs" for addictive and eating disorders, and the training of human resources in contemporary psychiatry.

Extended hospital Treatment for SPD

About 40 percent of patients with SPD were diagnosed in the past as bipolar I or II, rapid cycle, atypical, subsyndromatic, or as patients with "depression refractory to treatment". The majority overmedicated for 2-3, to 5-7 years or more, only with symptomatic medications (probably except for lamotrigine and lithium for a minority of phenotypic variants of the bipolar spectrum, as expressed by Ghaemi (2022), but not with medications specifically modifiers of etiopathogenic substrates of bipolarity or disabling depression. The majority of patients with SPD (80-95 percent) were, in turn, overdiagnosed with different comorbid disorders (e.g., panic attacks, major depression, post-traumatic stress syndrome, generalized anxiety disorder, complex trauma, etc.). And a large number of them are usually overmedicated, too, with symptomatic drugs that do not modify any etiopathogenic substrate. Furthermore, a large number of these patients are also subjected to some non-specific and only symptomatic variant of psychotherapies (e.g., DBT, mentalization techniques, CBT, dynamic deconstructive psychotherapy, training systems for emotional predictability and problem-solving, schema-focused psychotherapy), although it is exceptional that they receive an specific psychotherapy for borderline personality organization (BPO). Additionally, for the majority of patients with SPD (80-95 percent), their diagnosis of a severe personality disorder has rarely been specifically revealed and explained to them. It is also exceptional that they would have been warned about the limited, transitory, and only adjuvant nature of their pharmacological plan. Yet, the vast majority are "maintained" for years and even decades in a kaleidoscopic salad –due to the extraordinary and frequent variability– of medications.

Considering that (with the exception of some countries such as Switzerland, Germany, Holland, and Austria) for many of these patients with SPD, the lack of extended inpatient programs (i.e., 6-8 weeks, to 10 weeks) forces them to reiterative hospitalizations (i.e., some with histories of up to 10, 20 or more brief recurrent admissions) that, far from adding progress, create complications inherent to the chronic deterioration of the poor quality of their lives (i.e., in dimensions such as work, studies, intimate and family life, without omitting recreational and creative aspects); currently, a pressing situation is to question whether an inpatient program of 6-8 to 8-12 weeks, followed by TFP twice a week for 12 to 18 months, would provide a more effective and promising, even more economical result. Recent studies lead us to think that this could be the path to follow, for what nowadays represents a major worldwide social problem (Kraus et al., 2020; Leichsenring et al., 2019; Sollberger et al., 2015; Kernberg, 2022; Garza-Guerrero, 2022a; Garza-Guerrero, 2022b; Garza-Guerrero, 2023).

"Special programs" for patients with addictive and eating disorders

All large scale longitudinal studies point out how the presence of SPD is a negative prognostic factor for most other psychiatric disorders (Gunderson et al., 2000; Cohen et al., 2005; Zanarini et al., 2003). If one have an inpatient whose objectives are focused on the effective approach to the personality structure that mediates symptoms, one is in a better position to comprehensively care for the majority of psychiatric disorders associated or comorbid with SPD, which require hospitalization (depressive or anxiety disorders, PTSD, complex trauma, etc.) only with the complementary addition of what the best current empirical evidence suggests for them (i.e., pharmacological and/or psychotherapeutic interventions). In this regard, the proliferation of clinics with "special programs" for patients with problems related to substance use or addictions is striking; as well as for patients with eating disorders (most with underlying SPD); but without a superordinate theoretical and clinical framework that addresses the personality structure and its corresponding level of organization, mediating global functioning. Similar to what was mentioned in relation to the treatment of SPD being only symptomatic, the history of recurrent admissions to these clinics is very high. Contrary to the trend in the past of "special programs", with the complement of some specific adaptations for disorders related to substance addiction and eating disorders, it would seem that these disorders should be treated more efficiently and comprehensively in an authentic inpatient program, which addresses the totality of their personality functioning and prevents subsequent hospitalizations. An approach of this order would also avoid the risk of contagiousness that comes with agglomerating patients with the same disorder (addictions or anorexia-bulimia) in a single program. Contrary to coexistence with a heterogeneity of patients that encourages differentiation and individuation, overexposure to other patients with the same disorder frequently leads to the homologation of their virulence levels.

On the other hand, patients with acute psychotic decompensations (e.g., associated with schizophrenia, bipolar spectrum pathology, metabolic disorders, and substance abuse) require care in specialized divisions for the containment and stabilization of their functioning. After recovery however, some of these patients might benefit, partially or entirely, from the same inpatient program, depending on the evaluation of their overall functioning after their stabilization.

Human resources Training

Finally, another debatable situation is related to the formation and training of human resources. In relation to the importance of the preparation of psychiatric staff, a small bronze plaque comes to mind, with the emblematic phrase: First the brains, then the bricks —which, in the seventies, stood at the entrance to the main building of the C.F. Menninger Memorial Hospital in Topeka, Kansas— . Contemporary advances in personality disorders and hospital psychiatry demand the urgent preparation of competent staff duly qualified in psychiatry.

In this regard, our experience in a university setting, with a four-year resident program in psychiatry, with seminars in: a) Fundamentals of TFP-E, during the first semester of residency (Hersh et al., 2016); b) TFP for Borderline Personality Organization, during the second semester (Yeomans et al., 2015); and, c) TFP-E, for low, intermediate, and high levels of personality, during the third semester (Caligor et al., 2018), has allowed us to integrate to them, not only psychiatrists interested in learning about TFP (as a treatment modality and

as a superordinating theoretical and clinical framework applied to inpatient programs), but also psychologists, social workers and nurses who work in our Department of Psychiatry.

Likewise, the enormous didactic value of these operationalized text manuals, added to their interdisciplinary and research orientation, has also enriched the training of residents and staff in general. These seminars, combined with a group supervision workshop for TFP-E; as well as the exposure to videos of the text manuals mentioned, and the individual supervision of assigned cases, have allowed us to form a growing team of collaborators in this program.

Finally, as it was mentioned at the beginning, the extraordinary advances in the psychopathology of personality disorders have reversed the gloomy perspective of a few decades ago. However, like everything that evolves, this situation has confronted us too, with enormous challenges to solve and continue exploring. It is from current and ongoing research, as well as from long-term and multicenter studies, that validated information and lines of argument must be derived that allow us to preserve a healthy balance between awareness of the complexities we face, and the risk of expectations without foundation.

Reference

1. Lenzenweger, M. F., & Clarkin, J. F. (2005). The Personality Disorders: History, Classification, and Research Issues. In M. F. Lenzenweger, & J. F. Clarkin (Eds.), Major theories of personality disorder, (2nd ed., pp. 1–42). Guilford Press. https://psycnet.apa.org/record/2005-02797-001
2. Oldham, J. M. Skodol, A. E. & Bender, D. S. (2014). The American Psychiatric Association Publishing Text book of Personality disorders. In J. M. Oldham, A. E Skodol, & D. S. (Eds.), Bender Personality Disorders: Recent History and New Directions. (2nd ed., pp. 1-19). American Psychiatric Association Publishing. https://books.google.co.in/books/about/The_American_Psychiatric_Publishing_Text.html?id=bZuvBAAAQBAJ&redir_esc=y
3. Garza-Guerrero, C. (2017). Psychoanalytic education: between marginalization and irrelevance. In P. Zagermann (Eds.). The Future of Psychoanalysis: The Debate About the Training Analyst System (1st ed., pp. 31-378). Routledge. DOI: https://doi.org/10.4324/9780429481871
4. Rosenberg, R.N., & Rowland, L.P. (1990). The1990s-Decade of the Brain. The need for a national priority. *Neurology, 40*(2), 322. DOI: https://doi.org/10.1212/wnl.40.2.322
5. Kandel, E. R. (1998) A new intellectual framework for psychiatry. *American Journal of Psychiatry, 155*(4), 457-469. DOI: https://doi.org/10.1176/ajp.155.4.457
6. Garza-Guerrero, C. (2019). Differences between conventional and psychiatric hospitalization – Suicidality in severe personality disorders. *Medicina Universitaria, 21*(4), 138-144. DOI: https://doi.org/10.24875/RMU.19000092
7. Garza-Guerrero, C. (2023). Divergencies between a medical and a psychiatric hospitalization: Admissions, aggressiveness, and characterological suicidality in severe personality disorders. *In Analysis, 7*(3), DOI: https://awspntest.apa.org/doi/10.1016/j.inan.2023.100387
8. Ghaemi, S. N. (2022). Symptomatic versus disease-modifying effects of psychiatric drugs. *Acta Psychiatrica Scandinavica. 146*(3), 251-257. DOI: https://doi.org/10.1111/acps.13459
9. Kernberg, O. F. (2022). Hatred, Emptiness, and Hope–Transference-Focused Psychotherapy in Personality Disorders. *American Psychiatric Association Publishing*. https://www.amazon.in/Hatred-Emptiness-Hope-Transference-Focused-Psychotherapy/dp/1615374612
10. Fibiger, H. C. (2012). Psychiatry, the pharmaceutical industry, and the road to better therapeutics. *Schizophrenia Bulletin, 38*(4) 649–650. DOI: https://doi.org/10.1093/schbul/sbs073
11. Lipowski, Z. J. (1977). Psychosomatic medicine in the seventies: an overview. *American Journal of Psychiatry, 134*(3), 233–244. DOI: https://doi.org/10.1176/ajp.134.3.233
12. Morey, L. C., & Bender, D. S. (2014). Articulating a Core Dimension of personality Pathology. In J. M. Oldham, A. E. Skodol, & D. S. Bender, The American Psychiatric Publishing text book of personality disorders. (2nd ed., pp. 39-54). American Psychiatric Association Publishing. https://psycnet.apa.org/record/2014-23578-003
13. Skodol, A. E., Bender, D. S., & Oldham, J. M. (2014). An Alternative Model for Personality Disorders: DSM-5 section III and Beyond. In: Oldham, J. M, Skodol, A. E, Bender, D. S, (Eds.). American Psychiatric Press textbook of personality disorders. (2nd ed. pp. 511-544). American Psychiatric. https://psycnet.apa.org/record/2014-23578-025
14. Garza-Guerrero, C. (2022a). Affective-Cognitive Storms in Severe Personality Disorders and Transference–Focused Psychotherapy–Extended. *International Journal of Clinical Studies & Medical Case Reports, 21*(1), 1-6. DOI: https://dx.doi.org/10.46998/IJCMCR.2022.21.000505
15. Garza-Guerrero, C. (2022b). Twenty frequent errors and inaccuracies in the diagnostic evaluation of personality disorders. *In Analysis, 6*(2), 210-219. DOI: https://psycnet.apa.org/doi/10.1016/j.inan.2022.09.012
16. Caligor, E., Kernberg, O. F., Clarkin, J. F., & Yeomans, F. E. (2018). Psychodynamic therapy for personality pathology. Treating self and interpersonal functioning (1st eds). American Psychiatric Association Publishing. https://www.appi.org/Products/Psychotherapy/Psychodynamic-Therapy-for-Personality-Pathology
17. Caligor, E., & Stern, B.L. (2020). Diagnosis, classification, and assessment of narcissistic personality disorder within the framework of Object Relations Theory. *Journal of Personality Disorders, 34* (Suppl). 104-121. DOI: https://doi.org/10.1521/pedi.2020.34.supp.104

18. Clarkin, J. F., Caligor, E., & Sowislo, J. F. (2020). An object relations model perspective on the Alternative Model for personality disorders (DSM-5). *Psychopathology, 53*(3-4), 141-148. DOI: https://doi.org/10.1159/000508353
19. Yeomans, F. E., Clarkin, J. F., & Kernberg, O. F. (2015). Transference-focused psychotherapy for borderline personality disorder: A clinical guide. American Psychiatric Association Publishing. https://www.appi.org/transference-focused_psychotherapy_for_borderline_personality_disorder
20. Hersh, R. G., Caligor, E., & Yeomans, F. E. (2016). Fundamentals of transference-focused psychotherapy: Application in psychiatric and medical setting. *Springer*. DOI:https://psycnet.apa.org/doi/10.1007/978-3-319-44091-0
21. Leichsenring, F., Jaeger, U., Masuhr, O., Dally, A., Dümpelmann, M., Fricke-Neef, C., Steinert, C., & Spitzer, C. (2019). Changes in Personality Functioning After Inpatient Psychodynamic Therapy: A Dimensional Approach to Personality Disorders. *Psychodynamic Psychiatry, 47*(2) 183-196. DOI: https://doi.org/10.1521/pdps.2019.47.2.183
22. Kraus, B., Dammann, G., Rudaz, M., Sammet, I., Jeggle, D., & Grimmer, B. (2020). Changes in the level of personality functioning in inpatient psychotherapy. *Psychotherapy Research, 31*(1), 117-131. DOI: http://dx.doi.org/10.1080/10503307.2020.1763493
23. Normandin, L., Ensink, K., Weiner, A., & Kernberg, O. F. (2020). Transference-Focused Psychotherapy for Adolescents with Severe Personality Disorders (1st edition). *American Psychiatric Association Publishing*. https://www.researchgate.net/publication/352776628_Transference-Focused_Psychotherapy_for_Adolescents_With_Severe_Personality_Disorders
24. Diamond, D., Yeomans, F. E., Stern, B. L., & Kernberg, O. F. (2023). Treating pathological narcissism with transference-focused psychotherapy. Guilford Press, https://www.guilford.com/books/Treating-Pathological-Narcissism-with-Transference-Focused-Psychotherapy/Diamond-Yeomans-Stern-Kernberg/9781462552733?srsltid=AfmBOoqyC0QJiofaO1OtDBbBTVlpmH3dvf1-eZM-skRq-HLAUEYSk812
25. Lohmer, M. (2022). TFP Inpatient Psychotherapy, Innsbruck, Austria, online TFP Symposium, October 29th.
26. Rösch, Ch. (2022). TFP Inpatient Psychotherapy, Innsbruck, Austria, online TFP symposium, October 29th.
27. Garza-Guerrero, C. (1975). Theraputic use of social subsystems in a hospital setting. *Journal - National Association of Private Psychiatric Hospitals, 7*(1), 23-30. https://pubmed.ncbi.nlm.nih.gov/10238016/
28. Kernberg, O. F. (1984). The couch at sea: Psychoanalytic studies of group and organizational leadership. *International Journal of Group Psychotherapy, 34*(1), 5-23. DOI: https://doi.org/10.1080/00207284.1984.11491359
29. Dulz, B., Lohmer, M., Kernberg, O. F., Wlodarczyc, O., & Dammann, G. (2022). Borderline-Persönlichkeitsstörung: Stationäre Übertragungsfokussierte Psychotherapie. Hogrefe. https://elibrary.hogrefe.com/book/10.1026/02588-000
30. Dammann, G., Riemenschneider, A., Walter M., Sollberger, D., Küchenhoff, J., Gündel, H., Clarkin, J. F., & Gremaud-Heitz, D. J. (2016). Impact of interpersonal problems in borderline personality disorder in patients on treatment outcome and psychotherapy. *Psychopathology, 49*(3), 172-180. DOI: http://dx.doi.org/10.1159/000446661
31. Kramer, U., Levy, K. N., & McMain, S. (2024). Understanding Mechanisms of Change in Psychotherapies for Personality Disorders. *American Psychological Association*. DOI: https://awspntest.apa.org/doiLanding?doi=10.1037%2F0000388-000
32. Blüml, V., & Doering, S. (2021). ICD-11 personality disorders: a psychodynamic perspective on personality functioning. *Frontiers in Psychiatry*, 12. DOI: https://doi.org/10.3389/fpsyt.2021.654026
33. Weinberg, I., & Ronningstam, E. (2020). Dos and Don'ts in Treatments of Patients with Narcissistic Personality Disorder. *J Pers Disord, 34*(Suppl), 122-142. DOI: https://doi.org/10.1521/pedi.2020.34.supp.122
34. Klein, M. (1946). Notes on some schizoid mechanisms. *The International Journal of Psychoanalysis, 27*(Pt 3-4), 99–110. https://pubmed.ncbi.nlm.nih.gov/20261821/
35. Sutherland, J. D. (1952). Notes on psychoanalytic group therapy: I. *Therapy and training. Psychiatry, 15*(2), 111-117. DOI: https://doi.org/10.1080/00332747.1952.11022865
36. Fairbairn, W. D. (1954). An Object-Relations Theory of the Personality. Basic Books. https://www.amazon.com/object-relations-theory-personality-Ronald-Fairbairn/dp/B0007EA518
37. Jones, M. (1953). The therapeutic community: A new treatment method in psychiatry. Basic Books. https://www.amazon.com/therapeutic-community-treatment-method-psychiatry/dp/B0007DRAGM
38. Sullivan, H. S. (1953). The Interpersonal theory of psychiatry. Routledge. DOI: https://doi.org/10.4324/9781315014029
39. Main, T. F. (1957). The ailment. British Journal of Medical Psychology, 30(3), 129-145. DOI: https://doi.org/10.1111/j.2044-8341.1957.tb01193.x
40. Bion, W. R. (1961). Experiences in Groups and Other Papers. Basic Books. DOI: https://doi.org/10.4324/9780203359075
41. Kernberg, O. F. (1975). Borderline conditions and pathological narcissism. New York: Jason Aronson. https://www.scirp.org/reference/referencespapers?referenceid=1639868
42. Kernberg, O. F. (1980). Internal world and external reality-object relations theory applied. New York-London: Jason Aronson. https://archive.org/details/internalworldext0000kern

43. Sollberger, D., Gremaud-Heitz, D., Riemenschneider, A. Agarwalla, P., Benecke, C., Schwald, O., Küchenhoff, J., Walter, M., & Dammann, G. (2015). Change in identity diffusion and psychopathology in a specialized inpatient treatment for borderline personality disorder. Clin. Psychol. *Psychoter, 22*(6), 559-569. DOI: https://doi.org/10.1002/cpp.1915
44. Mischel, W., & Shoda, Y. (2008). Toward a unified theory of personality: Integrating disposition and processing dynamics within cognitive-affective processing system. In O. P. John, R. W. Robins, & L. A. Pervin (Eds.), Handbook of Personality: Theory and Research (3rd ed., pp. 208-241). Guilford Press. https://psycnet.apa.org/record/2008-11667-007
45. Gabbard, G. O., & Westen, D. (2003). Rethinking therapeutic action. *International Journal of Psychoanalysis, 84*(4), 823–841. DOI: https://doi.org/10.1516/002075703768284605
46. Stanton, A. M., & Schwartz, M. (1954). The Mental Hospital. New York, Basic Books. https://books.google.co.in/books/about/Mental_Hospital.html?id=mr1rAAAAMAAJ&redir_esc=y
47. Robles, M. T. A. (2006). Crisis organizacional y educación del psicoanálisis: Desafíos contemporáneos. *Journal of Psychoanalysis,* 22. https://dialnet.unirioja.es/servlet/articulo?codigo=6493551
48. Cesar, G. (2017). Trastornos de la personalidad: Avances y desafíos contemporáneos (en psiquiatría, psicología y psicoanálisis) (1st ed.). Psychiatry. https://www.laleo.com/trastornos-de-la-personalidad-avances-y-desafios-contemporaneos-en-psiquiatria-psicologia-y-psicoanalisis-p-22617.html?srsltid=AfmBOop25cvyukLrsspPnwILDMWY-zJXozz0pUBKFULBtK9aijT7fRBh
49. Haslam, J. (2009). The therapeutic community model of hospital treatment for severe psychopathology. In O. Kernberg (Eds.), Severe personality disorders: Psychotherapeutic strategies, 330-342. New Haven: Yale University Press. DOI: https://doi.org/10.12987/9780300159486-023
50. Haslam, J. (2009). Structural diagnosis. The Structural Interview. Problems in the classification of personality disorders (Chapter 1, 2, 3). In O. Kernberg (Eds.) Severe personality disorders: Psychotherapeutic strategies, 3-67. New Haven: Yale University Press. https://www.jstor.org/stable/j.ctt32bf53
51. Kernberg, O. F. (1998). Ideology, Conflict, and Leadership in Groups and Organizations. Yale University Press. https://books.google.co.in/books/about/Ideology_Conflict_and_Leadership_in_Grou.html?id=HxV0QgAACAAJ&redir_esc=y
52. (2011). Psychoanalytic individual and group psychotherapy: the transference-focused psychotherapy (TFP) model. In O. F. Kernberg & D. C. Washington (Eds.), The Inseparable Nature of Love and Aggression: Clinical and Theoretical Perspectives (pp 31-55). American Psychiatric Association Publishing. DOI: https://doi.org/10.1176/appi.books.9781615378296.lg02
53. Foulkes, S. H., & Anthony, E. J. (1957) Group Psychotherapy: The Psycho-analytic Approach (1st Edition). Penguin Books. https://www.amazon.com/Group-Psychotherapy-Psycho-Analytic-Anthony-Foulkes/dp/B000K6J852
54. Ezriel, H. (1950). A psycho-analytic approach to the treatment of patients in groups. *J. Ment Sci, 96*(404), 74-779. DOI: https://doi.org/10.1192/bjp.96.404.774
55. Rufat, M. J., Radcliffe, J., Lee, T., Martius, P., Fertuck, E., Arango, I., Lappe, H., Ripoll, E., & Yeomans, F. E. (2023). Developments in Group Transference-Focused Psychotherapy, *Psychodyn Psychiatry, 51*(3), 311-329. DOI: https://doi.org/10.1521/pdps.2023.51.3.311
56. Cohen, P., Crawford, T. N., Johnson, J. G. & Kasen, S. (2005). The children in the community study of developmental course of personality disorder. *J Pers Disord, 19*(5), 446-486. DOI: https://doi.org/10.1521/pedi.2005.19.5.466
57. Gunderson, J. G., Shea, M. T., Skodol, A. E. McGlashan, T. H., Morey, L. C., Stout, R. L., Zanarini, M. C., Grilo, C. M., Oldham, J. M., & Keller, M. B. (2000). The collaborative longitudinal personality disorders study: Development, aims, design, and sample characteristics. *J Pers Disord, 14* (4), 300-315. DOI: https://doi.org/10.1521/pedi.2000.14.4.300
58. Zanarini, M. C., Frankenburg. F. R., Hennen, J., & Silk, K. R. (2003). The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. *Am J Psychiatry, 160*(2), 274-283. DOI: https://doi.org/10.1176/appi.ajp.160.2.274
59. American Psychiatric Association (APA). (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington DC: American Psychiatric Association Publishing. DOI: https://psycnet.apa.org/doi/10.1176/appi.books.9780890425596
60. World Health Organization (WHO). (2018). International statistical classification of diseases and related health problem (11th Revision). https://www.who.int/standards/classifications/classification-of-diseases.