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COMMENTARY

Isn't Criterion A Rather Than B the Language of Psychotherapy?: Comment on Sauer-Zavala et al. (2022)

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No one can deny that these are exciting times for researchers and practitioners in the field of personality disorders. We are in the midst of a paradigm shift, where our familiar categorical thinking is giving way to dimensional approaches. Moreover, this paradigm shift is also part of a much larger paradigm shift in which the boundaries between diagnostic categories are blurring, comorbidity appears to be an artifact, and personality problems are in fact the underpinnings of many diverse forms of mental disorders (Kotov et al., 2017). But what will this mean for the practitioner? The dust has yet to settle, but the Sauer-Zavala article may present some of the contours of a new treatment practice.

The authors use Criterion A—and thus severity of personality pathology—to differentiate between different doses of treatment. Such an approach has face validity: As personality problems become more severe, more treatment is needed to achieve change. They use Criterion B to identify targets for treatment. In the case of individuals with a borderline personality disorder (BPD)—the authors do not completely move away from a categorical approach—these will typically be the areas of negative affectivity, antagonism, and disinhibition. One could easily imagine that such an approach may be expanded to other trait domains for the other traditional types of PDs. Moreover, the authors argue that many traditional psychotherapeutic interventions—in their case cognitive behavioral therapy—may be suitable to target these maladaptive traits.

There are many reasons to get excited about this approach. To my knowledge, this is one of the first attempts to streamline treatment according to the contours of the alternative model. Sauer-Zavala and colleagues show how information from the alternative model can be used to design a treatment plan and to shape the content of psychotherapeutic modules. In doing so, they draw a straight line between the way we conceptualize personality pathology, the formulation of a treatment plan, and the content of treatment modules. This can only enhance consistency in treatment and help patients to understand how treatment interventions are linked to the core of their personality problems. Nowadays, we are not treating BPD anymore, we are treating emotional instability or separation insecurity. This allows for more coherence between our diagnostic approach and our treatment approach. In addition, I was also enthusiastic about their pragmatic approach: a short, theoretically simple, easy-to-learn approach that links up with interventions and techniques that most psychologists receive in their basic training. Such an approach offers the prospect of providing quality treatment to many more clients than is possible based on the availability of highly specialized treatments alone. In short, our field is probably evolving toward flexible, personalized, and modular treatment variants (Herpertz, 2020), and BPD Compass may be exemplary of this future approach.

However, I do have some reservations. I will leave aside my reservations on the brevity of treatment (What kind of changes are feasible in 8–12 sessions?) and I will focus on the core of their approach: the relevance of Criteria A and B in psychotherapy.

The authors focus the design of their treatment program primarily on Criterion B. Now I increasingly think that the distinction is partly artificial and only conceptually somewhat possible (see also Widiger et al., 2019, for a similar discussion), but still: Doesn't Criterion A preeminently constitute the fabric from which psychotherapy is built? Isn't Criterion A the language of therapy more than Criterion B? Of course, I would agree that most treatments are aimed at changing problem clusters related to negative affectivity or impulsivity. The issue however is as follows: How do you get these trait domains to become less maladaptive? What is the change process that needs to occur for a person to experience less negative affectivity? Can you capture that change process without referring to Criterion A? Doesn't Criterion A underpin much more the nature of the change we are aiming for in treatment than Criterion B? Doesn't reducing negative affectivity indeed presuppose access to a range of emotional experiences while at the same time being able to regulate—if you reconnect with these affects—the subjectively felt emotions? And isn't this exactly the process described under Criterion A?

Let us take this line of reasoning one step further. I would argue that the mechanisms of change involved in most evidence-based treatments directly refer to changes in Criterion A functioning. Psychotherapy for BPD is effective because it enables a patient to

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deal better with overwhelming emotions (identity), for example, by approaching emotions in a more mindful way (dialectical behavior therapy; Linehan, 1993). It is effective because it increases flexibility in thinking (self-direction), for example, by increasing the capacity to mentalize (mentalization-based treatment [MBT]; Bateman & Fonagy, 2004). Psychotherapy works because it helps to integrate different parts of self (identity) and other (intimacy) representations (transference-focused psychotherapy; Yeomans et al., 2015). Psychotherapy works because it changes Criterion A functioning. One may even argue that several common factors in psychotherapy are related to Criterion A functioning: a genuine and real relationship (Gelso et al., 2018) and a strong therapist alliance (Flückiger et al., 2018) including the capacity to repair ruptures (Eubanks et al., 2018; intimacy and empathy), the ability to help a patient to approach and express emotions (Peluso & Freund, 2018; identity), or the ability to foster autonomous motivation to change in a patient (Zuroff et al., 2007; self-direction). In short, Criterion A is the fabric of which therapy consists, it refers to the main working mechanisms in treatment and indicates the direction in which a person's psychological capacities must develop so that maladaptive variants of Criterion B might mitigate. Mitigating Criterion B is in my opinion the outcome of treatment that alters Criterion A. And just because Criterion A is an overarching dimension, it may not matter as much where exactly that process of change starts. The authors argue that existing proven effective treatments would not adequately address all trait domains. Dialectical behavior therapy would too exclusively address negative affectivity and impulsivity, whereas MBT and transference-focused psychotherapy would exclusively address antagonism. Apart from the question whether this is the case, outcome studies do not seem to support this assumption. I am not aware of any study that would suggest that specific approaches result in only specific gains. On the contrary, the process of change initiated by these treatments influences various domains of functioning (as shown in the broad range of outcomes that change during these treatments, e.g., Storebø et al., 2020). This seems to be more in line with the idea of an overall dimension of severity changing. Nevertheless, it may be relevant that the access to these changes is sought in addressing specific symptoms, which may sort more under one or more of these trait domains, but the process of change is clearly not limited to just these trait domains.

Moreover, Criterion A does not only inform us on length and dosage but also on the kind of process that may be expected in treatment. If a patient is functioning at lower levels, a different therapy process will take place and a different treatment approach may be warranted. To give an example: If identity (unique sense of self) of a BPD patient is impaired at Level 2, treatment goals may be focused at helping a patient to overcome fear for not meeting expectations and helping a patient to be "him-/herself" when with others: "How can you learn to express yourself, your needs, and opinions, even if they may be different from others?" On a Level 3, however, a patient should be helped to develop some basic sense of self by helping him or her to *identify* basic emotions, needs, ideas, opinions, and so on. The "self" needs to be shaped, discovered, whereas at Level 2, the "self" needs to be "freed" from assumed expectations from others. Criterion A is not only about longer therapy but also basically about different therapy.

I think the lack of a clear embedding of BPD Compass in a Criterion A framework touches on one of my most fundamental reservations. In particular, the authors have put a great deal of energy into defining the content of the sessions, making it a protocolized treatment with a step-by-step plan that must be followed session by session to ensure that the various skills are addressed. But is it the *content* of a treatment that determines the *quality* of a treatment? In the Guideline-Informed Treatment for Personality Disorders (Hutsebaut et al., 2020), we take a different approach by prioritizing form to content: *How* interventions are delivered is often more important in clients with personality disorders than exactly *what* interventions are delivered. "How" then refers to the embedding of interventions in an emotionally close, supportive, authentic, and genuine relationship, with a focus on motivation, collaboration, and strengthening autonomy and with a focus on repairing ruptures where necessary. Moreover, it refers to the embedding of treatment interventions within the context of a well-functioning team, a clear clinical process, and a supportive and stable organization. We assume that these common factors are much more decisive than the content of the treatment. This is because these common factors respond to the limitations contained in Criterion A. In this sense, Criterion A also forms, as far as I am concerned, a clearer framework for what is needed in the treatment of people with personality disorders than Criterion B. Criterion A is what glues the interventions together, what makes separate interventions effective. It tells the practitioner what the central focus in contact with the client should be regardless of the content of the module. Indeed, we believe that most psychotherapeutic interventions—whether they are cognitive behavioral therapy or otherwise oriented—address Criterion B problems and could therefore be used as an access gate to achieve what is really needed in treatment: improving Criterion A.

Finally, approaching therapy from the framework of Criterion A may also help to understand the impact of one of the most undervalued determinants in psychotherapy research: the context in which an intervention is delivered. The efficacy of specialist treatments is not unconditional: We found that MBT was three times less effective when delivered in a context of major instability in team and organizational functioning (Bales et al., 2017). An interesting side-finding of the Cristea meta-analysis was that a control condition that was designed and delivered by the study team seemed to outperform standard treatment as usual (Cristea et al., 2017). Could it be that such a team may have provided the context in which practitioners feel guided, supervised, coached, and supported by experienced experts, which may have helped them to remain reflective, understand their own emotional reactions, and stay in touch with severe patients despite high levels of arousal and imminent crises and ruptures? In other words, to keep a healthy Criterion A functioning themselves that may be needed to assist in improving Criterion A in their patients.

In short, Sauer-Zavala and colleagues have written a stimulating article that challenges fixed beliefs about the treatment of personality disorders and that offers the first attempt to design a treatment according to the heuristic framework of the alternative model of personality disorders. This article presents several elements of the direction our field is developing to but may have underrated the importance of Criterion A in designing good-quality generic PD treatment.

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