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Case Report

Affective-Cognitive Storms in Severe Personality Disorders and Transference–Focused Psychotherapy–Extended

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Abstract

Any current explanatory approach to understanding self and the interpersonal functioning requires a conceptual integration of the neurobiologically-determined dimensions of the personality and the mediating psychostructural organization of behavior. Hence, the need for hybrid models that integrate, not only the phenomenology of the categorical and the psychostructural, but also the levels of personality organization and their corresponding specificity of meanings; in other words, the nature of motivations, defenses, and conflicts specific to each level underlying manifest behaviors. Contemporary hybrid diagnostic models are a valuable frame in our efforts to understand the subjective experience of the protean manifestations of patients with a borderline personality organization, particularly during their frequent affective storms, which constitutes a strenuous challenge that often culminates in bewilderment and paralysis, if there is a no preconceived plan. Transference-Focused Psychotherapy-Extended (TFP–E) is currently considered a supraordinate and integrative framework between neurobiology and the psychostructural organization of the personality, derived from empirical evidence that provides the overarching theoretical-clinical principles that could guide an effective approach in the containment of affective storms of patients with severe personality disorders, towards their potential transformation to a therapeutic experience.

Keywords: borderline personality organization; affective storms in borderline personality disorder; transference-focused psychotherapy–extended.

I. Contemporary Diagnosis of Severe Personality Disorders and Transference-Focused Psychotherapy—E

The contemporary diagnosis of Severe Personality Disorders (SPD) is located at the interface between neurobiology and affective-cognitive neurosciences of the interpersonal and the psychostructural organization of personality [1-4]. Any current explanatory approach to understanding self and interpersonal functioning requires the conceptual integration of neurobiologically-mediated personality dimensions (e.g., negative affectivity, fear, attachment, anger, sexual arousal) and psychostructural personality organization (e.g., identity, defenses, reality testing, quality of object relations, moral functioning, and control of aggression). The current systematization of schemes and models of nosology and diagnosis requires the articulation of two unavoidable levels in the organization and understanding of mental processes: The neurobiologically contributed, on the one hand, and the mediating psychostructural organization of the mental and symbolically represented, on the other [1,2,4-6].

Personality functioning could only be conceived as a complex emergent property, a specific psychological structure unique to each individual and irreducible to any of its co-determining or mediating components. Hence the need for supraordaining theoretical frameworks with overarching principles that integrate the neurobiology of self and interpersonal functioning, with the character structure mediating personality functioning [1-4,6-8]. Regardless of advances in information and research, the focus of clinical applications of psychiatry, psychology, and psychoanalysis will always be the exploration and understanding of mental disorders and alterations, particularly in their inherently human aspects: the specificity and singularity of the subjective experience of each individual [9,10]. Hence the need for hybrid models that integrate not only the phenomenology of the categorical and the psychostructural, but also the level of personality organization and its corresponding specificity of meanings, i.e., the nature of motivations, defenses, and conflicts, specific to each level, and underlying manifest behavior.

And trying to understand the subjective experience of the protean manifestations of patients with a Borderline Personality Organization (BPO), particularly during their repetitive temperamental overflows and Affective-Cognitive Storms (ACS), toward their containment and a potential therapeutic experience, constitutes an exhausting daily challenge for mental health clinicians and staff [2,4,6,11].

In this paper, a brief description of the characteristics of the (ACS) in Severe Personality Disorders (SPD) and their frequent complications will be followed by an exposition of a new psychotherapeutic approach, Transference-Focused Psy-

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chotherapy-Extended (TFP–E), for the efficient management of ACS in BPO. Finally, a clinical vignette illustrates the theoretical-clinical applications of TFP-E in a patient hospitalized in a psychiatric service with an ACS; particularly the contrast of TFP–E with Cognitive-Behavioral Therapy (CBT), Mentalization Techniques (MT), and Dialectical Behavioral Therapy (DBT), in terms of their differences in tactics and technique, and specifically, regarding its strategic scope and goals.

II. Affective-Cognitive Storms in Borderline Personality Organization

Disruptive crises that alter the affective, cognitive, and behavioral functioning of patients, secondary to situations of delirium, epileptiform dysfunction, or metabolic or infectious complications (among a large number of causes), occur relatively frequently in the general hospital and are usually treated with the conventional measures of the traditional medical model: immediate risk assessment, guaranteeing the support of personnel who protect the safety of the patient and those who assist him, restraint techniques and physical containment, in addition to pharmacological sedation. The same occurs with acute psychotic decompensations in patients with schizophreniform or bipolar spectrum disorders.

On the other hand, there are temperamental overflows and ACS in the general hospital, as well as in psychiatric services (in patients' units, outpatient clinics, liaison psychiatry, or emergency rooms) that should be differentiated because their management could benefit from a different specifically psychiatric and psychodynamic intervention model [12].

1. The ACS of patients with BPO are characterized by:

a) Patients' preservation of their reality testing, but with ostensible alterations in their subjective experience of reality and social criteria: still in a relative control of their person and their circumstances, but on the verge of a total derailment, with threats of hurting themselves and others, and which they judge as entirely understandable and justified.

b) Usually manifested by intense irascibility and the expression of rage and physical and verbal violence, in a context in which patients habitually feel offended and see themselves as victims of families or the hospital staff, which they describe as sadistically oppressive, insensitive, and authoritarian. Even if they may have idealized in the past those they now perceive as their persecutors, at the moment of crisis, that experience no longer counts (i.e., primitive defenses such as the splitting of the emotional continuity of their experience lead to the absolute denial of those previously idealized (i.e., they suffer from affective, not cognitive, amnesia).

c) Patients with BPO, although they may present with a very protean range of affective-cognitive contents in the interpersonal dimension, their internal working model of relating to others is frequently reduced to a paranoid, victim-oppressor model; or an idealizing model, that induces them to situate in or long for a state of plenitud and satisfaction, perfectly cared for by others [11].

d) The strident explosion of rage and resentment immediately evokes and raises a halo of negative affectivity throughout their immediate surroundings, which not only confuses the staff and prevents them from reflecting, but also encourages them to act viscerally to stop and modulate the insufferable. Unfortunately, when one cannot even think with a minimum of serenity and objectivity, reflectivity ceases, which often aggravates the situation [6,12].

e)The ominous nature of ACS intuitively leads to immediate action, which often only makes the situation worse, for example: the temptation to fully validate the patients demands; the futility of an excessive tolerance, apparently empathetic; or even worse and in the opposite direction, coercive measures, isolation, and over sedation. All this culminates in the two most frequent complications in the control of ACS: polypharmacy, and repeated inefficient hospitalizations.

Nevertheless, and despite serious difficulties, the first step in an attempt to contain and transform a disturbing ACS into a therapeutic experience is to try to understand and help the patient to express in words, from his own subjective experience and in relation to others, the experienced totality of their current interactional moment —without rejecting or necessarily accepting the patient's initial perception [1,11,13].

It is at this complicated crossroads that results from the management of ACS in SPD that TFP–E, as a supraordaining theoretical-clinical framework recently proposed for the control of clinical crises in SPD, by Hersh, Caligor and Yeomans (2016) [5], has been found as a very useful and valuable approach.

III. Transference-Focused Psychotherapy–Extended and Affective-Cognitive Storms in Severe Personality Disorders

TFP–E is currently considered a higher order and integrative framework between neurobiology and the psychostructural organization of personality [1,3,4], applicable not only in a psychotherapeutic situation, but also in different settings: emergency room, liaison psychiatry, inpatient hospital services, and outpatient clinics. Although initially informed by psychoanalytic Object Relations theory, TFP-E currently integrates quantitative and qualitative differentiating modifications based on empirical evidence, and derived from the contemporary investigation of its psychotherapeutic properties in the diagnosis and treatment of self and interpersonal functioning in character pathology [1-3,5,14]. Besides, PFT–E in its conception and current clinical applications is "aligned" with the categorical and dimensional models of the DSM-5 (2013) [15] and the nosology and taxonomy of the World Health Organization (2018) [16].

Contemporary TFP–E is neither classical nor standard psychoanalysis, nor is it another psychodynamic psychotherapy that predates the empirical research of present psychotherapies. Although it has its origin in traditional Object Relations Theory and its clinical applications in SPD, it currently constitutes an independent theoretical framework derived from idiographic and nomothetic research; manualized and operationalized, and specifically designed for the categorical and dimensional evaluation of personality organization and the treatment of alterations in self and the interpersonal functioning: the two contemporary operative criteria of the DSM-5 for defining personality disorders [1-4,5,11,14].

The supraordaining and integrative theoretical frameworks that guide TFP–E allow the articulation of the two organismic levels mentioned above in the organization and understanding of mental processes: a) The neurobiologically mediated and co-determined; and, b) the psychostructural organization of the symbolic and reflectively processed and represented. TFP–E constitutes a manualized and systematized treatment model, based on empirical evidence derived from comparative studies with other intervention models for severe personality disorders. Its operationalized nature has allowed its replicability and multicenter research in different countries [17-20].

Tactical and Technical Aspects of TFP–E of Relevance in the Management of Affective-Cognitive Storms

a) Exposure to a crisis only under conditions of a minimum of security for all those present; tolerating the usual confusion and chaos typical of these circumstances, and the urgency of acting hastily, without a minimum understanding of the present moment. Empathetically request respect for conventional norms of communication, that might allow patients and staff to reflect on the nature of the problem (e.g., to not yell or threaten with objects in hands while speaking).

b) The first step to understand ACS is to simultaneously observe the three channels of communication in the patient and staff: the verbal content of what the patient or staff expresses; the non-verbal or attitudinal aspects of their communication; and the countertransference impact of all this information in oneself [12].

c) Becoming aware of "what I am thinking and feeling" in the three channels of communication and trying to put it into words (initially, only silently), allows the cognitive reflection and containment of our own affective hyperreactivity, thus reducing anguish. To be able to contain an overwhelmed patient, one must try firstly to remain self-contained and reflective [6].

d) With the experience derived from the three communication channels, try to identify the dominant internal object relationship and the reversal of roles that organizes the patient's affective experience between himself and the staff; by virtue of projective identification mechanisms that maintain him in a self-validating and self-perpetuating circle of pathological interactions [12]. Empathically clarifying and anchoring, as well as confronting inconsistencies that impede communication avoids the immediate pseudo-understanding of a problem (pretending that the problem has been clarified, without facing the inconsistencies) that has not yet been understood, thus potentially closing the door to a joint reflection.

Contrary to the confusion of the term confrontation with its colloquial adversarial connotations, if not aggressive, from the perspective of the process of interpretative activity in TFP–E, confrontation refers to the affective-cognitive emotional support that is provided to patients, when assisted to reflectively observe a conflict or contradiction between two parts of themselves —the confrontation is not between the patient and the therapist, or between the patient and the staff, but between two partially split off or dissociated aspects of the patient [4,11].

e) Attempting to put into words the global understanding of what the patient might be thinking and feeling from their own perspective, including precipitating elements of their environment, and in terms of the activated object relationship, transitorily validating their experience of feeling mistreated (without rejecting, nor accepting), allows the cognitive containment of their affective experience and provides a starting point of reciprocity, that may help to reflect on other alternatives, that could also explain the same problem [12].

IV. Theoretical and Clinical Articulation of TFP–E: Vignette on the Management of an Affective-Cognitive Storm

In what follows a brief clinical vignette illustrates the application and the theoretical and clinical articulation of basic concepts of TFP-E (i.e., as a supraordaining theoretical-clinical framework in general, not as a psychotherapeutic modality), in the management of an ACS in a patient with BPD hospitalized in an inpatient psychiatric unit.

Three weeks after being introduced to Jose (i.e., a patient hospitalized in a Therapeutic Community (TC); while on his way to the nurses' station to attend a temperamental derailment, during a midday of his TC rotation, Dr. LM would recall the exaggerated considerations with which the patient had received him: "You have an intelligent face... … you really will help me... not like the poor imitation of a doctor that I was assigned in the last rotation". His always artificially kind and courteous treatment toward him, contrasted with his subtly contemptuous and arrogant attitude towards other patients in the therapeutic team meetings, as well as his occasional harassment towards nurses, and his disdainful opposition to colleagues' proposals in the weekly meetings of the TC.

A venial error in handling a modification to his eating plan, had seemingly triggered an escalation of his manifestation, of verbal and physical violence. When Dr. LM went to the patient's room, accompanied by two nurses and a guard, he found the patient walking from one side to the other, still vociferous about the ineptitude of the "fucking nurses". "It's human to err... I know" —he shouted with overflowing rage, "but for them to fuck up just for the pleasure of screwing me...and trampling on me, I'm not going to allow it". Scattered on the floor were sheets, pillows, and various half-destroyed objects that Jose had thrown on the walls of his room.

His accelerated gait, while threateningly holding a book in one hand and an inverted pack of brushes in the other, made the situation somewhat ominous, which increased the pressure on Dr. LM to say or do something. Semi-paralyzed by his anguish and bewilderment, he barely managed to stammer, "Did you do all this, Jose?" To which he angrily replied: "Well ...it must not have been your fucking mother". Dr. LM's insufferable feeling of humiliation was aggravated by his thinking that the head nurse, should certainly ridicule him internally, given her silent rivalry with him on the TC teams, from the first day he started his rotation.

Dr. LM avoided the intuitive, but futile inertia, of trying to make Jose "come to his senses". He thought that he should not talk, just to talk; much less, do something, just to do something, without a plan that would help him to a more orderly approach, such as the TFP-E, which he had recently read in one of his seminars in the first semester of his residency. He tried to remember the sequence (the SOIP acronym) that he had memorized:

1) Suggest acceptable standards of communication and security;

2) Observe the three communication channels (verbal, nonverbal or attitudinal, and countertransference).

3) Identify the dominant internal object relation (DIOR), including its reversal of roles, and

4) Put into words the global understanding of the interactional moment, towards a joint reflection of the situation in discord, which would allow the search for alternatives.

Dr. LM recognized the error in the nurse's request for his food and explained to Jose that he wanted to help him. However, he would have to stop yelling and hand over the threatening objects in his hand, to continue the dialogue. In addition, he added that, although he admitted how frustrating it meant for him to be the focus of an error, which was repeated for a second time, this did not justify his violence, much less his mention of his mother. Jose, defiant and strident, warned that to hand over the objects, they needed to assure him that they would not inject him with something to "drug" him and put him in the "insane cage".

Dr. LM asked if he had seen anything like this happen in this

division since he arrived. Jose answered no, but he knew that his cousin had been "caged" in this or another hospital. Dr. LM warned him that, on the contrary, the best way to avoid more restrictive measures was by respecting the usual rules for a conversation. He also made it clear that he did not consider him a schizophrenic or bipolar patient; or someone with a brain tumor or something out of his control. He only thought, as he had expressed when admitted, that he had difficulty "cooling emotions". And learning to control negative emotions, without the need to act violently; had been one of the reasons for his hospitalization. In short, Dr. LM was convinced that Jose, with an evident severe personality disorder, could control himself and willingly decide to continue, or discontinue his overwhelming, although gratifying, emotional storm.

Calmer now, Jose continued to complain of feeling exasperated by the staff, due to a series of impositions and restrictions (conventional rules in a TC program), which only made him feel oppressed and powerless in the face of an "arrogant" and "authoritarian" staff. While listening, Dr. LM, also more serene, tried to attend to the three channels of communication with Jose and order his own emotional maelstrom activated in a few minutes, and whose affective-cognitive horizon covered, among other dimensions: feeling like an "imbecile", in contrast to the intelligent person that Jose had seen in him three weeks before. He was distressed by the expectation that in his role as a doctor and the authority that came with his position, he alone had the responsibility to resolve the crisis. Worse still, it bothered him to think that instead of feeling supported by the staff, the mere presence of the head nurse induced the inner conviction that they watched over him as a newly arrived resident, "foolish and innocent". Likewise, in the opposite direction, to his astonishment and confusion, Dr. LM experienced at times the infiltration of gratifying fantasies of an absolute control of the situation by sedating and confining Jose if he did not calm down. Commanding and authoritarian, he visualized himself making fun of Jose, already locked up in the "quiet room": "Maybe my fucking mother did this too?" In addition, he fantasized that, with this stroke of authority, he would, in passing, send a signal of power to the head nurse and all the staff, so they do not see him as a "foolish and cowardly newcomer".

Already repositioned in a more reflective dimension, the polarization of the activated and Dominant Internal Object Representations (DIOR), including the reversal of roles, now it would seem to gradually become more comprehensible to Dr. LM. From the perspective of Jose's verbal and conscious communication (i.e., presenting himself as a powerless victim, in front of an intimidating staff), and from a concordant identification with Jose, he saw himself exactly like him, humiliated, powerless, and despised. However, from the perspective of Jose's attitudinal and unconscious communication (i.e., his offensive vociferations and gesticulations of anger and hatred); and the projection of a dissociated and non-tolerated object representation of him placed on Dr. LM; in a complementary identification with Jose, Dr. LM countertransferentially imagined himself as someone tyrannical and despotic, with the desire to subdue and humiliate him, besides eager to take revenge on Jose and the head nurse.

With all this affective-cognitive experience now reflected on, Dr. LM felt more serene and prepared to put it into words and share it with Jose and the staff. He began by partially validating him (i.e., the precipitating factor, not his behavior): "I understand, Jose, how frustrating and obnoxious it must have seemed to you, as well as intimidating, if you thought the staff was intentionally trying to subdue you into submission, just for the pleasure of doing it. However, we acknowledge the error in the food request, even if it happened a couple of times. As for the rest that you perceive as arbitrary impositions, they are just the common norms of any TC program and established for all patients. Breaking them would be equivalent to giving you special status, which would not help you.

On the other hand, although with your words you present yourself as the victim of an arrogant and authoritarian staff, with your violent behavior and hateful and threatening gestures, you seem not to be aware that it is you who intimidates, paralyzes, and victimizes the staff and me. It is as if an aggressive and violent part of you that you do not tolerate, by attributing it to others, you not only persecute yourself with us; but, in addition, you run the risk of inducing us to transform ourselves into precisely what you fear most: that we behave like tyrants and authoritarians (i.e., the typical end result of projective identification mechanisms). You solve nothing with shouts and insults. It only prevents us from helping you to consider other alternatives. ¿What do you think if you request to be present at the nursing nutritional planning meeting with the food coordinator when your case is presented?

More understanding, Jose managed to calm down and was grateful that he had been heard. The explanatory reflection about the entire crisis made sense to him, and he compared it with many others at home and work, before his hospitalization. He recognized that he should continue working with these experiences in the therapeutic teams and with his hospital therapist.

TFP–E and Other Treatment Modalities

This clinical vignette attempts to contribute to understanding and illustrating, among other theoretical and clinical aspects of TFP–E, the following considerations:

a) The containment and frontal management (in its therapeutic, non-adversarial sense) of the currently emerging phenomenology of ACS in patients with SPD, without having to heed apostolic admonitions from the past, such as: "Don't touch the borderline pathology for now"… "Leave the psychodynamics for later"… "Avoid the interpretation of the negative transference, to develop a working alliance"… "TFP is contraindicated in aggressive patients with BPD and complex trauma; or very concrete and non-reflective".

b) The centrality of the concept of Internal Object Representations (IOR) in personality functioning, from an Object Relations perspective, overlaps with other theoretical models such as cognitive-behavioral, interpersonal, and attachment theories. But congruently with contemporary neurocognitive developments and the current understanding of the psychostructural alterations typical of patients with BPO, TFP–E integrates a conception of IOR which marks a significant difference in the approach to patients with SPD. TFP–E is a contemporary psychodynamic model derived from empirical research and which it is no considered as merely a developmentalist perspective. IOR are not simply and linearly conceptualized as the historically valid representation of early experiences [1,2,4].

The primitive nature of defenses and conflicts in SPDs leads patients to distort their perception of reality in the here and now; and even more, their reconstruction and narrative of interactional realities with others, in their past. Furthermore, the lack of a cohesive and integrated identity, coupled with primitive defenses and conflicts, predisposes them, not only to significant distortions of their early attachments, but to the epi-

genetic resignification, and capriciously changing narration of the same. In addition, their persistent fear of abandonment frequently leads them to the pathological acting out of defensive dysfunctional detachments, with a punitive and vengeful intention, which allows reversing the roles of the one who abandons: i.e., now they are the ones who abandon others, including their pychotherapists [1-4,6,11,14,21,22].

Similarly, the IOR are not innocently conceived as the direct or linear representation of external reality, but rather as constructions that result from the interaction between constitutionally given predispositions and the developing psychostructural organization, from early experiences that integrate defenses, conflicts, desires, needs, and fantasies. The IOR constitute a bridge between past and present: They reflect a condensation of genetic and temperamental factors (i.e., innate predispositions), developmental experiences, and the conflicts and defenses derived from them; i.e., the psychostructural organization of the current personality [1,2,4,20].

c) Unlike other treatment modalities such as (e.g., CBT, DBT, and MT), TFP–E does not seek to alleviate or merely normalize affect-cognitive dysregulation by solely correcting distortions, reflecting or mentalizing on the mental state of the current interactional moment, or through emotional regulation techniques. In the context of a mutually established and safe framework, TFP–E allows the patient to experience the totality of the current interactional moment, sufficiently to render it ego-dystonic, and in preparation for its clarification and confrontation (in the therapeutic, not the adversative sense). But unlike CBT, MT, DBT, and other overly simplified modalities derived from attachment theories, TFP–E also includes the exploration of the potential for the defensive reversal of roles, stemming from IOR that oscillate capriciously in SPD, from a relational context, in which the patient presents himself in the role of "victim", to another interpersonal context, in which he dissociatedly assumes the role of the "tyrant who victimizes others" [1-3,11,14].

For example, even though Jose continued to cognitively present himself as the victim of a cruel and intimidating staff, he did not realize that it was now him, whom through a reversal of roles, furiously intimidated and mistreated the staff. Primitive defenses based on splitting (such as projective identification, omnipotent control, devaluation, and primitive denial), allowed Jose to project his aggression onto the staff, and justify his acting in a dissociated manner, the role of the one who cantankerously intimidates everyone.

d) In TFP–E, it is assumed that the clarification and confrontation of the current interactional moment, and the exploration of the reversal of roles in IOR, is only the first step of the interpretative process. Clarification and confrontation are exploratory activities that are very similar to mentalization techniques. In TFP–E, they are considered phases one and two of a long-term interpretative process; which includes later on, phases three and four: The interpretative activity properly said, which takes into consideration the re-elaboration an integration of IOR, affectively opposed (i.e., idealized, and aggressivized, or paranoid), including their respective defenses and conflicts, as well as their epigenetic resignifications, towards a more cohesive concept of self and others. For example, in Jose's case, it is possible that later in a specifically psychotherapeutic setting, it may be concluded that the predominant mental representation of himself as a "victim" of others, who are perceived as sadistic and cruel, only serves as a character defense that protects him from exactly the opposite: his desire that the other be someone idealized to protect him, take care of him, and provide him security. But faced with the potential anguish of being hurt and disappointed if something like this does not happen, defensively he positions himself in what he is accustomed to anticipate: "people are mean, cruel and arrogant...if you let them, they trample on you". This explains why it is said, that "The TFP–E starts, where MT ends".

It is necessary to clarify that being able to help mentalize and reflect on the possible meanings of a patient's current interactional moment, does not mean that the patient could contextualize these same meanings and modify them in the context of their past adverse interactions, under the impact of different affective conditions; even less, evoke and anticipate them autonoetically. This reflective capacity requires an entire re-elaborative process (working through) of defensively split off lOR toward a more integrated concept of self and others: phases three and four of the TFP–E process of interpretative activity [1-3,14].

e) From an TFP–E framework, it is considered that the most authentic way to support and contain the manifestations of aggressiveness of patients with SPD; as well as, to develop a genuine therapeutic alliance, it is necessary for patients to be allowed to experience their manifestations, within explicit limits; helping them to explore and put into words the totality of the current interactional moment, towards its clarification and therapeutic confrontation. When due to ignorance, timidity, or a misplaced concept of "alliance", one falls into postures of an artificial affability or "empathy" that avoids exploring aggression, not only a therapeutic opportunity with the patient is lost, but it allows to perpetuate it and escalate further on. In hospital services where several patients with BPO coexist, violence that is not clarified or confronted therapeutically, not only escalates but also infects and contaminates patients and staff [1-6,11,21,22].

f) In the case of our patient Jose, his clinical and narrative reconstruction could suggest symptomatic manifestations typical of dysfunctional attachments, mediated by IOR with excessive negative affectivity. But the phenomenological manifestations of his dysfunctional attachments, are just a complex emergent property, that could have originated from: 1) genetic or temperamental vulnerabilities that predispose him to overreact with negative affect; 2) traumatically adverse developmental vicissitudes; or 3) Constitutionally determined distortions of relational experiences, derived from primitive defenses and conflicts, even in the context of early benevolent and affiliative relational experiences. Any of these dimensions or combinations could have led to the same psychic reality in Jose. The characteristic phenomenology of dysfunctional attachments, as an emergent property, irreducible to any of its components, neurobiological or psychostructural, co-determining of mediating symptoms.

Dysfunctional attachments refer to a diverse and proteiform range of symptomatic manifestations, resulting from the organismic interactionality of multiple systems and dimensions; they are only a non-specific symptomatic consequence. A dysfunctional attachment is a symptom, not a cause. When in addition of confusing symptoms, with cause, the fallacy of confusing the whole with one of its parts is committed, the risk is of ending proposing overly simplified, linear, and monolithic pseudo-explanations, as observed in the following comment in a theoretical-clinical discussion: "There is enough evidence in the clinical history of this patient, as well as in the psychological tests, to speak of dysfunctional traumatic attachments in the

causology of the pathology of this patient with a BPD".
g) Finally, the management of affective storms, like that of Jose in the TC, could have been implemented by any member of the conventional interdisciplinary teams in the mental health area (i.e., medical residents, social workers, nurses, psychologists) with a thoughtful mind and moderately familiar with the fundamental aspects of TFP–E [5] for example: exposed to 10 sessions of a seminar on the fundamental aspects of TFP–E, and after observing two to three video recordings, and at least one supervised case.

V. Final Considerations

The responsibility that entails the effort to contain and control the affective-cognitive storms of patients with SPD, generates a level of anguish and puzzlement that often interferes with the ability to think objectively and preserve a minimum of a capacity for a reflective communication. Mental health clinicians and staff, often without a preconceived plan to attempt, to not only attenuate or dissipate a calamitous situation, but to potentially transform it into a therapeutic opportunity for the patient, suddenly feel disarmed, semi-paralyzed, and incompetent to decide on the best way to proceed [4-6,22].
TFP–E provides the conceptual tools and theoretical-clinical principles that guide an effective psychotherapeutic approach to affective-cognitive storms of patients with SPD during an uncontained temperamental overflow. TFP–E is accessible to be taught, supervised, and practiced by the different professional disciplines that usually compose the primary teams of in patient's psychiatric units or outpatient services. In addition, its implementation and applications could occur outside of strictly psychotherapeutic situations, without the person exercising it having had a previous relationship with the patient.

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