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COMMENTARY

BPD Compass Is an Accessible Alignment of Dimensional Assessment and Treatment

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BPD Compass is a short-term (18-session) intervention for borderline personality disorder (BPD) that was designed to address the higher-order dimensions of personality implicated in this condition in the Alternative Model of Personality Disorders (AMPD): Negative affectivity, Antagonism, and Disinhibition. We received three commentaries on our manuscript describing the conceptual background for BPD Compass; the purpose of this rejoinder is to respond to that feedback. In our rejoinder, we challenge researchers and clinicians to stretch their assumptions about what treatment for BPD should look like, describe the utility of a cognitive-behavioral approach for subsequent dissemination, and discuss how information Criterion A of the AMPD can also be used to personalize course of treatment with BPD Compass.

With the transition to a dimensional model of personality disorders in the *International Classification of Diseases, Eleventh Revision* (*ICD-11*; WHO, 2019), along with the looming 10-year anniversary of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM–5*)'s alternative model of personality disorders (AMPD; American Psychiatric Association, 2013), the time has come to reimagine treatment for personality disorders. BPD Compass is a novel treatment package for borderline personality disorder (BPD) with delivery decisions based on Criteria A and B of the AMPDs (Sauer-Zavala et al., this issue). As BPD Compass is in the early stages of development and efficacy testing ($N = 74$ and counting for our initial trial), it is incredibly valuable to receive and have the chance to engage with feedback on this treatment's conceptual background from experts in the classification and treatment of BPD.

First, Crowell et al. (2022) summarize the advantages BPD Compass may have over existing, longer term treatments. They mention its (relatively) brief duration and its use of well-known cognitive–behavioral therapy (CBT) skills as strengths that may increase BPD Compass' adoption in generalist settings, ultimately making high-quality care more accessible to patients. Indeed, as Crowell et al. note, BPD Compass was designed to be a less intensive alternative that complements, rather than replaces, existing evidence-based treatments. Crowell et al. emphasize this point and go on to describe the contexts in which they believe BPD Compass will have the most utility (i.e., for patients with subthreshold presentations or fewer comorbid diagnoses).

However, the suitability of BPD Compass for particular patients and settings is an open empirical question, and we challenge researchers and clinicians to stretch their assumptions about what treatment for BPD should look like. For example, recent data from an intensive outpatient setting suggest that 50% of patients with BPD do not endorse the self-injurious behavior diagnostic criterion (Zimmerman & Becker, 2022), and 80% have not engaged in suicidal behavior in the past year (Grilo & Udo, 2021; Yen et al., 2021). In contrast, the original dialectical behavior therapy (DBT) studies (Linehan, 1987) recruited the most severe patients, perhaps skewing the field's perception of this condition. As Crowell and colleagues suggest, BPD is a dimensional construct and, perhaps, a greater proportion of individuals with this condition could respond to short-term treatment. Preliminary data from our efficacy trial suggests that 18 weeks of treatment with BPD Compass is associated with significant reductions in BPD symptoms, with effects of comparable magnitude to more intensive treatments (and with comparable levels of dropout; Sauer-Zavala et al., 2021). All patients in our trial met *DSM–5* criteria for BPD, most endorsed substantial comorbidity, and exclusion criteria were minimal (uncontrolled psychotic or manic symptoms). Although we expected that severity would moderate the outcome, our preliminary data suggest otherwise. Of course, there will always be individuals with BPD who require intensive longer term care (e.g., DBT); however, if we can address the needs of more patients with shorter term care, specialist providers will have more bandwidth to dedicate to the patients who require their services.

Unlike Crowell and colleagues, Livesley (this issue) views the use of CBT strategies exclusively as a "major limitation." However, Livesley also acknowledges that these approaches are equally

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effective to other methods—so why not use them! As noted in the article by Sauer-Zavala et al. (2022), we chose to focus on CBT because this approach is most commonly taught in training programs and would not require additional specialist training. Although practitioners who specialize in BPD may have the time, investment, and/or availability to receive training in specialist treatments for BPD such as transference-focused psychotherapy, mentalization-based therapy, or DBT, most generalist clinicians do not. Also, it is worth noting that treatment orientations are not completely orthogonal. A strong relationship with one's CBT therapist can be restorative for problems with attachment. Cognitive restructuring can be used to help patients mentalize. Designing an exposure to have a tough conversation with another person can target both emotion tolerance and attachment security. Given the shortage of mental health providers, we argue that well-known, evidence-based treatment components best balance training accessibility with clinical efficacy.

Livesley (this issue) also asserts that the intervention strategies included in BPD Compass are not based on a comprehensive theory of psychopathology. Livesley contends that the AMPD, although important, is not sufficient to capture deficits in BPD including impaired executive functions, interpersonal conflicts, metacognitive functioning, self-pathology, or impaired personality organization and dynamics. However, the BPD criteria in the AMPD include each of these deficits to varying degrees (American Psychiatric Association, 2022). The intervention strategies used to target these deficits in BPD Compass are based in part on decades of research supporting the models that underlie emotion regulation (i.e., DBT) and attachment-based treatments (e.g., mentalization-based therapy, transference-focused psychotherapy), as well as conceptual ideas for engaging disinhibition in treatment (Magidson et al., 2014). At the same time, we believe that it is a valid empirical question regarding the degree to which the intervention strategies included in BPD Compass efficaciously target the most impactful deficits in BPD. We believe that the modular nature of BPD Compass lends itself to test this question and iteratively refine the treatment so it can address the most impactful targets for patients while remaining user friendly to a range of providers.

Moreover, as Livesley (2022) also mentions, therapists do not necessarily consider the theoretical model when applying treatment ("appropriate interventions from diverse therapies are used without assuming the theory behind them"), so articulation of a novel theory may not be necessary to improve care for individuals with BPD.

Finally, Hutsebaut (2022) shares our excitement about a treatment directly informed by more modern dimensional conceptions of psychopathology while also posing some interesting questions about how dysfunction is captured in Criteria A and B of the AMPD. Specifically, Hutsebaut argues that Criterion A better captures the core of psychopathology and is better aligned with the holistic goals of psychotherapy (improving self and relationship functioning). Although we agree that information provided by assessing Criterion A may be largely overlapping with Criterion B (Widiger et al., 2019), we also (similar to Hutsebaut) see value in their differentiation as a treatment heuristic. Specifically, Criterion B can tell us "what" skills to provide, whereas as Criterion A provides guidance on "how" to provide them. Indeed, Hutsebaut describes a number of common factors inherent to quality treatment of all orientations that would likely promote self- and other-functioning that we plan to incorporate into more detailed descriptions of BPD Compass. However, it is worth noting that in at least one dismantling study of DBT, skills training (perhaps akin Criterion B–focused skill selection) was necessary for reductions in self-injury, depression, and anxiety, whereas relationship-focused strategies in individual therapy (perhaps akin to Criterion A common factors) may be less important (Linehan et al., 2015).

In summary, treatment for personality disorders is likely to undergo changes as the field shifts to a dimensional understanding of these conditions. We are excited by the discussion BPD Compass, a novel intervention designed to align with *DSM–5*'s AMPD, has prompted. Ultimately, treatment development and refinement are iterative based on feedback from colleagues and informed by data. Our goal is to ease suffering for those with BPD, and we are grateful for these commentaries from leaders in our field.

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