Chapter 8
An Update and Overview of the Empirical Evidence for Transference-Focused Psychotherapy and Other Psychotherapies for Borderline Personality Disorder

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Keywords Borderline personality disorder • Dialectical behavior therapy • Empirically supported treatment • Evidence-based treatment • Personality disorder • Psychoanalysis • Psychodynamic psychotherapy • Psychotherapy outcome • Psychotherapy research • Schema-focused psychotherapy • Transference-focused psychotherapy • Mentalization-Based Treatment

Psychodynamic Psychotherapy for Borderline Personality Disorder

It is generally believed that psychoanalytically or dynamically oriented clinicians are not interested in research for a host of reasons ranging from the challenges of designing a randomized controlled trial that would demonstrate the efficacy of a psychoanalytic approach to epistemological and philosophical disagreements about the nature of science (see [1–3] debates for an illustration). Although many in the psychoanalytic community have in the past been cautious regarding the value of research, some of the earliest psychotherapy research was performed by psychoanalysts [4–12]. Additionally, psychoanalyst and psychodynamic clinicians are increasingly becoming interested in testing psychodynamic hypotheses and establishing a stronger evidence base for treatments based on psychodynamic ideas [2, 3, 13–20]. This increased interest in psychotherapy outcome research has been particularly fruitful with regard to the study of borderline personality disorder. Severe personality disorders such as borderline personality disorder are increasingly seen as the mainstay of psychoanalytic clinical work.

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R.A. Levy et al. (eds.), *Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence*, Current Clinical Psychiatry, DOI 10.1007/978-1-60761-792-1_8,

A number of these psychodynamic treatments may be quite effective in treating patients with borderline personality disorder; however, for the purpose of this chapter, we focus primarily on Otto Kernberg's [21, 22] Transference-Focused Psychotherapy (TFP) but consider other evidence-based treatments. Before examining the empirical evidence for the efficacy and effectiveness of TFP, we will discuss the three other major treatments for BPD that have shown their efficacy in randomized controlled trials (RCT): Dialectical Behavior Therapy [23], Mentalization-Based Therapy [24], and Schema-Focused Therapy [25]. We will then consider the empirical support in light of the recommendation by the American Psychological Association Division 12, which has concluded that "TFP is designated as having controversial research support because of mixed findings. TFP performed favorably in one randomized controlled trial [26], but did not perform well in another [27]. Thus, more research is needed before TFP can be considered to have modest or strong research support." We will discuss recent findings from an RCT of TFP by Doering et al. [28] that directly address this need for greater empirical support for TFP and further establish it as an efficacious treatment. We will then use a clinical case vignette to illustrate key principles of working clinically from a TFP perspective and contrast this to how a therapist might approach the same clinical issues from the perspective of Mentalization-Based Therapy. We will finish with a summary of conclusions that can be drawn from the literature.

What Constitutes Empirical Evidence?

Although randomized controlled trials (RCTs) are generally considered the gold standard and have important methodological strengths [29], they also suffer from a number of important limitations [19, 29–34]. The focus on RCTs has had the unintended consequence of overlooking other evidence that is relevant for assessing the empirical support of treatments. The numerous limitations of efficacy studies have led many investigators to recommend searching for empirically supported principles (ESPs) of treatment, or evidence-based explanations of treatment, rather than credentialed, trademarked, brand-name, or evidence-based treatment packages [30, 35–37].

Gabbard et al. [34, 38–40] have discussed a stage model, or hierarchy, of treatment evidence as a function of considering both internal and external validity. They have suggested that evidence from multiple sources within this model is necessary in order to build an empirically grounded framework for specific forms of psychotherapy. In ascending levels of internal validity and descending levels of external validity, the hierarchy of treatment evidence starts with the provision of an argument or the articulation of clinical innovation and proceeds through clinical case studies, clinical case series, pre–post designs without comparison groups, quasi-experimental designs that include comparisons but without randomization, and then RCTs. Within the RCT category there is a hierarchy with regard to the control group employed ranging from the use of wait-list controls through treatment as usual groups, placebos, and finally comparison with established, well-delivered alternative treatments. Levy and Scott [34] suggested that this hierarchy, in combination with the examination of evidence for specific techniques and mechanisms of action [41, 42], provides better breadth of evidence and better validity than focusing on RCTs alone. Others have noted that naturalistic studies may be necessary to help bridge the gap between practice and research [43, 44]. Limiting research, practice, and training exclusively to treatments that have been validated in RCTs could impede reasonable avenues of study in the treatment of BPD and obstruct access to treatments that might be better suited to specific patient subgroups (Table 8.1).

Additionally, the numerous limitations of efficacy studies have led many investigators to recommend that the field would be better served if research were directed at examining the mechanisms or processes that lead to sustained change [30, 31, 36, 37, 41, 42, 45, 46]. Likewise, Borkovec and

Table 8.1 Hierarchy or stage model of treatment evidence (as a function of controls and generalizability)

- Randomized controlled trials
  - Well-established, well-delivered, alternative treatment
  - Placebo
  - Treatment as usual
  - Wait-list
- Quasi-experimental designs
- Pre–post designs
- Case series
- Clinical case study

Provision of argument and/or the articulation of clinical innovation

Based on data from Gabbard et al. [38] and Clarke and Oxman [39]

Castonguay [29] and Connor-Smith and Weisz [47] recommend conducting well-controlled therapy trials in more naturalistic settings. Such hybrids of efficacy and effectiveness research may help to bridge the gap between science and practice [48]. At the same time, however, there seem to be considerable data already in existence at multiple levels of scientific evidence that could be combined to form increasingly well-rounded inferences about the treatment of BPD. Thus, a broader definition of evidence may be necessary when evaluating the effects of psychotherapy for this complex disorder.

The Rise of Dialectical Behavior Therapy: Benefits and Risks

Psychotherapy research on long-term treatments is difficult to perform, and in the past, many in the field believed that such research was so difficult as to render it unfeasible. As a result, many psychological treatments were developed to conform to a short-term model employed in medication trials. However, in 1991, Linehan [49] published the results of her year-long RCT for BPD in which she examined an integrative CBT treatment called Dialectical Behavior Therapy (DBT) as compared to treatment as usual (TAU). This seminal study has been highly influential on current training and treatment trends. However, one of the most important aspects of this study was that it showed that randomized controlled trials of a long-term treatment could be accomplished and thus stimulated a revival in the rigorous study of long-term psychodynamic treatments for BPD; we say revival because psychodynamic investigators had a history of engaging in long-term psychotherapy research such as the Menninger Foundation Psychotherapy Research Project initiated in the 1950s [50, 51].

In that seminal study, Linehan et al. [49] found that patients treated in DBT as compared to treatment as usual dropped out of treatment less often and had significant reductions in the number and severity of suicide attempts and length of inpatient admissions. Linehan et al. [52] also found that DBT for drug-dependent women with BPD, as compared to treatment as usual, were found to have significantly greater reductions in drug abuse. Despite these impressive outcomes, there was a significant limitation to these and other studies of DBT [52–54] – comparisons were made against control groups in which the patients received less treatment than the patients in DBT. For example, in Linehan's initial study, half the control patients were not receiving treatment at any given time. In Verheul's study, 73% of the patients drop out of the TAU group. Westen et al. [55, 56] have raised objections to the meaningfulness of data demonstrating the efficacy of a treatment when compared to what they call "intent-to-fail" conditions. Given the lack of treatment provided by TAU groups, Levy et al. [34, 57] suggest that TAU groups could be better conceptualized as non-treatment as usual groups. Additionally, these TAU groups not only fail to control for attention, but also fail to control for credibility (an often neglected aspect of a comparison group; see [58, 59]).

Despite the limitations of Linehan's initial studies and the small number of participants treated (41 patients in three studies), by the year 2000, DBT had quickly gained popular acceptance. A number of managed care companies defined special benefits for DBT. Several state departments of mental health (Illinois, Connecticut, Massachusetts, New Hampshire, North Carolina, and Maine) enthusiastically endorsed and subsidized DBT as the treatment of choice for BPD and had mandated DBT training for state employees working with seriously disturbed patients. In Western Massachusetts, former DBT patients are able to be reimbursed for coaching current DBT patients. Hundreds of marketing initiatives, seminars, and training programs in DBT are provided for inpatient and outpatient clinics, correctional institutes, and community treatment centers – the majority offered by Behavioral Tech, the corporate entity that teaches DBT. Certainly, Linehan's efforts to develop, examine, and given the seriousness of BPD, to disseminate DBT are laudable. In the United Kingdom, the NICE guidelines mention only DBT by name and as the treatment of choice for parasuicidal women with BPD. However, concerns have been raised that the dissemination of DBT has exceeded the evidence base particularly with regard to state legislation and insurance reimbursements [46, 60–63].

In an effort to test DBT against a more stringent control, Linehan et al. [64] compared patients treated in DBT to Treatment by Experts in the Community (CTBE). In this study, 101 participants were randomized to either DBT or CTBE. The CTBE therapists were nominated by heads of mental health providing agencies as "expert" in working with "difficult clients." Out of the hundreds of therapist nominated, 94 were selected of which only 25 agreed to participate. These therapists were of diverse theoretical orientations although about half were identified as psychodynamic. Both groups were offered supervision; 100% of the DBT therapists attended supervision while only 50% of the CTBE therapists attended supervision. The supervision was designed to be carried out at prestigious institutions: for DBT, at the department of psychology at the University of Washington, and for the CTBE, at a psychoanalytic institute in Seattle. While 75% of the DBT therapists had a Ph.D. or M.D., <50% of the CTBE had that level of training. This study has been heralded in the DBT community and highlighted on the National Institute of Mental Health's website. The main findings that were publicized was that DBT had significantly less drop-out (19.2% in DBT vs. 46.9% in CTBE) and that in the intent-to-treat analyses (ITT), DBT demonstrated better outcomes than CTBE in terms of reductions in the severity of parasuicidal behaviors. Also, highly publicized was that the percentage of individuals who attempted suicide was significantly lower in the DBT group when the treatment year data were combined with the follow-up year data. However, not generally known is that there were no differences in the percent of patients using the emergency room, who were hospitalized, who were on medication, in global functioning, social adjustment, or who engaged in parasuicidal or suicidal behaviors in the ITT analyses. Additionally, completer analyses showed no significant differences between groups on any of these variables [65]. At 1-year follow-up, there were also no differences between the DBT and CTBE groups on any of the variables. In addition, although patients in DBT were less likely to make a suicide attempt as patients in the CTBE group, if the treatment year and follow-up period are combined, this difference disappeared when examining either the treatment year or the follow-up period alone [46]. Taken together, this suggests few differences between treatment groups despite the relative advantages in the DBT group (experienced and well-supervised therapists executing a treatment manual with a particular and relevant patient population) and the relative disadvantages in the CTBE group (less credentialed and less supervised therapists who were less likely to have training in a specific BPD treatment or with BPD patients in general, and of which only half the patients were in treatment). Further, differences between groups disappear when controlling for attention or dose, and differences disappear after a 1-year follow-up.

Other findings have called into question the durability of the initial gains made in DBT. For example, Linehan [66] found no between-group differences in the number of days hospitalized at a 6-month follow-up or in self-destructive acts at the end of a 1-year follow-up (despite the fact that the patients in the DBT group were still receiving DBT therapy, whereas about half the TAU group were not in any therapy). Additionally, a 6-month follow-up from the Verheul et al. [54] study found

no differences between DBT and the TAU control on impulsive behavior, parasuicidality, or alcohol and both soft and hard drug use [67, 68]. Thus, while the overall results of Linehan's studies of DBT are suggestive of its value, naturalistic follow-up of patients in DBT show variable maintenance of treatment effects, and ongoing impairment in functioning persists in patients who initially experienced symptom relief.

Most relevant to thinking about the relationship between DBT and psychodynamic psychotherapy is a recent RCT by McMain et al. [69], which found that General Psychiatric Management based on the American Psychiatric Treatment Guidelines which combined a psychodynamic individual psychotherapy (based on Gunderson's [70] model of treatment) with pharmacotherapy, and case management performed equally well to DBT. Patients with BPD evidenced no between-condition differences in rates of change across 1 year of treatment in terms of suicidality, self-injury, psychiatric service use, BPD symptoms, depression, anger, and social functioning.

Since Linehan's [49] seminal study, many different treatments have shown efficacy in comparison to TAU or a more stringent control, and while DBT has garnered the most evidence to date, the data are far from conclusive. Studies that have compared DBT to well-delivered bonafide treatments generally find few differences between these treatments, and there is not one study in which DBT is compared with an active treatment that it shows clear superiority. Clearly, DBT is an efficacious treatment when compared with TAU. However, given the heterogeneity of BPD, it is unlikely that any one treatment will be useful for all patients [71]. Future research will be needed to examine more fully the interaction between treatment and patient characteristics in order to determine "what treatment, by whom, is most effective with this individual, with that specific problem, under which set of circumstances?"

Mentalization-Based Therapy

Bateman and Fonagy [72] developed Mentalization-Based Therapy (MBT) based on the developmental theory of mentalization, which integrates philosophy (theory of mind), ego psychology, Kleinian theory, and attachment theory. Fonagy and Bateman [73] posit that the mechanism of change in all effective treatments for BPD involves the capacity for mentalization – the capacity to think about mental states in oneself and in others in terms of wishes, desires, and intentions. This involves inviting patients become curious about their thoughts, beliefs, and especially an awareness of manifest affects about themselves and others; a capacity that is challenged by the activation of the attachment system in affectively charged interpersonal situations. The concept of mentalization has been operationalized in the reflective function (RF) scale [74].

In a randomized clinical trial, Bateman and Fonagy [75] compared the effectiveness of 18 months of a psychoanalytically oriented day hospitalization program compared to routine general psychiatric care for patients with BPD. Patients randomly assigned to the psychoanalytic day hospital program, now called Mentalization-Based Therapy (MBT; [24]), showed statistically significant improvement in depressive symptoms and better social and interpersonal functioning, as well as significant decreases in suicidal and parasuicidal behavior and number of days in inpatient treatment.

Patients were re-assessed every 3 months for up to 18-month post-discharge [76]. Follow-up results indicate that patients who completed the MBT not only maintained their substantial gains, but also showed continued steady and statistically significant improvement on most measures, suggesting that BPD patients can continue to demonstrate gains in functioning long after treatment has ended. At 18-month post-discharge follow-up, 59.1% of patients treated with MBT were below the BPD diagnostic threshold, compared to only 12.5% of those treated in routine general psychiatric care.

An 8-year follow-up post randomization of MBT has recently been completed, and the results show an impressive long-term maintenance of treatment gains [77]. At follow-up, 87% of patients

treated with MBT no longer met criteria for BPD, compared to only 13% of those treated in routine general psychiatric care. Further, patients treated with MBT continued to show maintenance of gains in terms of decreased suicidality, psychiatric service use, medication use, and improved vocational functioning, though social functioning remained impaired. These findings showing the long-term maintenance of treatment gains for BPD patients are particularly important because whereas for MBT not only is there continued improvement, but there seems to be a sleeper effect with increased improvement over time. However, given that this long-term follow-up data are based on comparison to a treatment as usual cohort, more research will be needed to more fully evaluate the long-term efficacy of MBT.

While MBT has demonstrated its efficacy as a part-time hospitalization program, a recent RCT by Bateman and Fonagy [78] compared the effectiveness of 18 months of outpatient MBT to Structured Clinical Management (SCM) for patients with BPD. This study is important for understanding the benefits of MBT because SCM is a more stringent control. SCM controlled for attention in that it was a structured treatment, consisting of similar dose in terms of time in treatment and in which therapists received comparable level of supervision and had comparable levels of experience to those therapists in MBT. In fact, one outstanding aspect of this study is that therapists were randomly assigned to treatment condition most likely controlling for any therapist effects. Findings suggested that while patients benefited from both treatments, larger effect sizes were reported in MBT than in SCM in terms of reduced suicidal and self-harm behavior, number and length of inpatient hospitalizations, as well as statistically significant improvement in depressive symptoms and better social and interpersonal functioning. One of the strengths of this study was that both MBT and SCM were delivered by nonspecialist mental health practitioners, suggesting that MBT can be delivered with minimal training and supervision and does not require advanced psychoanalytic training.

Taken together, these studies indicate that MBT is an efficacious treatment when compared with treatment as usual or a more stringent control. As previously discussed, in order to build an empirically grounded framework for this psychotherapy, the next step in the hierarchy of treatment evidence would be to compare MBT to a well-established, well-delivered alternative treatment (such as DBT, TFP, or SFT), but the evidence for the efficacy of MBT is impressive thus far. However, it is important to understand that the aims of MBT are admittedly more modest in that it is not "aiming to achieve structural or personality change or alter cognitions and schemas; its aim is to enhance embryonic capacities of mentalization so that the individual is more able to solve problems and to manage emotional states particularly with interpersonal relationships or at least feels more confident in their ability to do so" ([79], p. 200).

Further, as previously discussed, treatment efficacy should be evaluated in combination with the examination of evidence for specific techniques and mechanisms of action [34, 41, 42]. To date, MBT has yet to demonstrate that change operates through its putative mechanism of action, reflective function (RF). While it is the case that many treatments have not shown specific effects on theory-driven mechanisms of change, it is nonetheless important for MBT to demonstrate that it works in theoretically predicted ways.

Schema-Focused Therapy

Schema-Focused Therapy (SFT [25]) is an integrative approach that "draws on insights and techniques from the cognitive-behavioral, attachment, psychodynamic, and emotion-focused traditions…" [80]. This approach draws roughly on concepts from object relations theory in that the schemas at its center are internal representations of self in relation to other, but it does not include a sense of the dynamic unconscious. Its approach to the internal schemas is rather that patients can be helped to learn them without a focus on the motivations of their being out of the patient's awareness.

The four core mechanisms used in SFT are (1) "limited reparenting," (2) experiential imagery and dialog work, (3) cognitive restructuring and education, and (4) behavioral pattern breaking. Limited reparenting has been described as the heart of SFT. It is based on the assumption that BPD patients' core emotional needs were not met by their parents and that the therapist should provide the experience of having these needs met. Limited reparenting welcomes and encourages dependency on the therapist and ranges from providing warmth and nurturance, which could include hugging the patient, to self-disclosure to firmness and limit setting. From a psychodynamic point of view, this technique – which encourages patients to emphasize their parents' mistreatment of them – might be seen as helping the patient stabilize the externalization of negative characteristics and the identification with a victimized self at the expense of achieving an integrated sense of positive and negative aspects of the self.

In a study in the Netherlands, Giesen-Bloo et al. [27] compared SFT to Transference-Focused Psychotherapy (TFP). Their study is unique in that it examined two active treatments over 3 years. Patients benefited from both treatments, but larger effect sizes were reported in SFT than in TFP after 3 years in terms of reduced BPD symptoms, improved quality of life, and gains on measures of general psychopathology and personality factors. Further, the TFP group revealed a significantly higher drop-out rate (51.2% vs. 26.7%) over the 3 years of treatment.

Though at first glance, these findings seem to suggest that SFT is more efficacious than TFP, a number of serious limitations argue against this conclusion. First, despite randomization, the TFP condition included twice as many recently suicidal patients (76% vs. 38%; there was also a trend ($p = .09$) for the TFP condition having more patients with recent self-injury behavior). Previous research has demonstrated that suicidality significantly influences treatment outcome [81].

Second, the differences between the two groups were only apparent in the intent-to-treat analyses but not in the completer analyses. A major factor in this difference appears to have been that patients in the TFP condition were significantly more likely to prematurely drop out of their treatment. Whereas intent-to-treat analyses speak to the external validity (e.g., generalizability), completer analyses speak to the issue of sufficient dose and thus the internal validity or integrity of the study. Differences in outcome between completer analyses and ITT suggest loss of validity due to nonrandom drop-out. This can negate the control provided by randomization [33]. Completer analyses did not show any statistically significant advantage for SFT [80, 82].

Third, the findings suggest inadequate implementation of TFP as indicated by lack of adherence by the TFP therapists. The authors report that the median adherence level for TFP was 65.6. Given that a score of 60 is considered adherent, about 50% of TFP therapists were nonadherent. In contrast, the SFT group had a median score of 85.6 (again with 60 considered adherent), suggesting that 50% of the SFT were not just adherent but exceptionally so. Not only were adherence ratings relatively poor for TFP, but they also appear to be significantly lower than for SFT. Suffice it to say, the authors are reporting a study that compared an exceptionally well-delivered treatment with an inadequately delivered one. There should be no surprise that the exceptionally delivered treatment outperformed the poorly delivered treatment, but it is not a fair test, and this fact alone may explain the differential outcome between the two treatments. One of the most potent methodological choices that result in allegiance effects is the selection of therapists who differ in skillfulness that favor the allegiance of the researcher [83].

Fourth, treatment integrity includes having experienced treatment cell leaders, choosing experienced and adherent therapists with a proven track record, providing expert supervision, ongoing monitoring of adherence, and having plans for dealing with nonadherence [84]. Each of these issues was problematic in the current study. Supervision was carried out in the form of peer supervision, known as intervision [85]. Intervision may work well when carried out by exceptionally adherent therapists as was the case for the SFPT. However, such a model would not work well with nonadherent therapists and would be more akin to "the blind leading the blind." The authors indicate that treatment integrity was monitored by means of supervision; however, who was doing that monitoring?

Yeomans [85] reports the clinical observation that half the therapists were nonadherent, which is consistent with the authors' own independently rated adherence scores. Most disturbing, however, is that Yeomans [85] reports that he informed the study PIs of the nonadherence problem on numerous occasions, including by email and fax, and that no action was taken to deal with this problem.

Fifth, therapists and assessors were not blind to ongoing outcome. Partial results were presented prior to study completion [25, 82, 86, 87], creating another possible confound, which could have caused therapist demoralization in the TFP therapists or enhanced motivation SFT therapists [88]. Given these concerns, it would be premature and irresponsible to conclude that TFP is not as efficacious as SFT.

Despite concerns about the adequacy of training and supervision in the TFP group as well as the randomization process, SFT has evidenced impressive results regarding retention of patients, with only 7% of patients dropping out in the first year of treatment. Future research should examine the mechanism of treatment retention and its potential generalizability to other forms of treatment.

Transference-Focused Psychotherapy

Since the early 1980s, the Borderline Psychotherapy Research Project at New York Presbyterian Hospital-Weill Cornell Medical Center, headed by Drs. John Clarkin and Otto Kernberg, has been systematizing and investigating an object relations treatment of patients with BPD. This group has generated treatment manuals (e.g. [21, 22, 89]) that describe key strategies and techniques of a highly structured modified dynamic treatment of patients with borderline personality organization called Transference-Focused Psychotherapy (TFP).

Central to TFP are mental representations derived through the internalization of attachment relationships with caregivers. The degree of differentiation and integration of these representations of self and other, along with their affective valence, constitutes personality organization [90]. According to Kernberg, borderline personality can be thought of as a severely disturbed level of personality organization, characterized by unintegrated and undifferentiated representations of self and other (what Kernberg calls identity diffusion and is manifested in an inconsistent view of self and others), the use of immature defenses (e.g., splitting, projective identification, omnipotent control), and variable reality testing (e.g., poor conception of one's own social stimulus value). (See Chap. 29 for a lengthier description of these clinical manifestations of BPD.)

The major goals of TFP are to reduce suicidality and self-injurious behaviors and to facilitate better behavioral control, increased affect regulation, more gratifying relationships, and the ability to pursue life goals. This is believed to be accomplished through the development of integrated representations of self and others, the modification of primitive defensive operations, and the resolution of identity diffusion that perpetuate the fragmentation of the patient's internal representational world. In this treatment, the analysis of the transference is the primary vehicle for the transformation of primitive (e.g., split, polarized) to advanced (e.g., complex, differentiated and integrated) object relations. Thus, in contrast to therapies that focus on the short-term treatment of symptoms, TFP has the ambitious goal of not just changing symptoms, but changing the personality organization, which is the context of the symptoms. In contrast to most manuals for CBT or short-term treatments, the TFP manual could be described as principle based rather than sequentially based, which requires the clinician to be flexible and use clinical judgment. Using video-taped sessions and supervisor ratings, Kernberg and his colleagues have been able to train both senior clinicians and junior trainees at multiple sites to adherence and competence in applying the principles of TFP.

TFP begins with explicit contract setting that clarifies the conditions of therapy, the method of treatment, and the respective roles of patient and therapist. The primary focus of TFP is on the dominant affect-laden themes that emerge in the relationship between borderline patients and their therapists in the here-and-now of the transference. This is supplemented by ongoing monitoring of the patient's life

outside of sessions. During the first year of treatment, TFP focuses on a hierarchy of goals: containing suicidal and self-destructive behaviors, addressing ways the patient might undermine the treatment since it challenges the patient's fragile and dysfunctional homeostasis, and identifying and recapitulating dominant object relational patterns, as they are experienced and expressed in the here-and-now of the transference relationship.

Within psychoanalysis, TFP is closest to the Kleinian school [91], which also emphasizes a focus on the analysis of the transference. However, TFP can be distinguished from Kleinian psychoanalysis in that TFP is practiced twice per week and that TFP includes a more highly structured treatment frame by emphasizing the treatment contract and a pre-established set of priorities to focus (e.g., suicidality, treatment-interfering behaviors). The role of the treatment contract and the treatment priorities both go beyond that found in more typical psychoanalytic psychotherapy or psychoanalysis, including Kleinian psychoanalysis. In addition, transference interpretations are consistently linked with both extra-transference material and, importantly, long-term treatment goals (e.g., better behavioral control). In contrast to Kleinian approaches, the TFP approach is a highly engaged, more talkative, and an interactive one. Additionally, technical neutrality is modified to the extent required to maintain structure. TFP also differs from other expressive psychodynamic approaches with a persistent focus on the here-and-now and an empathy with the total internal experience of the patient. By the latter, we mean the patient's identifications with both the persecutory as well as the persecuted object and also the idealized as well as idealizing object. This is achieved through a focus on the immediate interpretation of the negative transference, and the emphasis on interpretation of the defensive function of idealization, as well as a focus on the patients' aggression and hostility.

In relation to Dialectic Behavioral Therapy (DBT), some of the most salient differences between the two treatments concern the frame. To avoid the secondary gain that can be experienced by extra contact with the therapist and to encourage the development of autonomy [92], the TFP therapist is considered unavailable between sessions except in the case of emergencies, whereas in DBT, the patient is encouraged to phone the individual therapist between sessions. Another difference is the emphasis in TFP on technical neutrality (not siding with any part of the patient's internal conflicts but rather helping the patient see and resolve the conflicting parts within himself) vs. strategies used in DBT including validation, coaching, and cheerleading that may temporarily suppress, but not integrate negative internal forces. Despite these differences, both TFP and DBT have in common a firm, explicit contract, a focus on a hierarchy of acting out behaviors, a highly engaged therapeutic relationship, a structured disciplined approach, and utilization of supervision groups as essential for therapists.

In TFP, hypothesized mechanisms of change derive from Kernberg's [90] developmentally based theory of BPD, which conceptualizes the disorder in terms of undifferentiated and unintegrated affects and representations (or concepts) of self and other. Partial representations of self and other are paired and linked by an intense affect in mental units called "object relations dyads." These dyads are representational elements of psychological structure. In BPD, the lack of integration of the internal object relations dyads corresponds to a "split" psychological structure in which totally negative dyads are split off or segregated from idealized positive dyads of self and other. The putative global mechanism of change in patients treated with TFP is the integration of these polarized affect states and representations of self and other into a more coherent whole. Through the exploration and integration of these "split-off" cognitive-affective units of self- and other representations, Kernberg postulates that the patient's awareness and experience in life become more enriched and modulated as the patient develops more nuanced internal representations that correspond better to the complexity of life and thereby develops the capacity to think more flexibly, realistically, and benevolently. The integration of the split and polarized concepts of self and others leads to a more complex, differentiated, and realistic sense of self and others that allows for better modulation of affects and in turn clearer thinking. Therefore, as split-off representations become integrated, patients tend to experience an increased coherence of identity, relationships that are balanced and constant over time and therefore not at risk of being overwhelmed by aggressive affect, a greater capacity for intimacy, a reduction in self-destructive behaviors, and general improvement in functioning.

Using the techniques of clarification, confrontation, and interpretation, the TFP therapist provides the patient with the opportunity to integrate cognitions and affects that were previously split and disorganized. In addition, the engaged, interactive, and emotionally intense stance of the therapist is typically experienced by patients as emotionally holding (containing) because the therapist conveys that he or she can tolerate the patient's negative affective states without denying them or reacting in a retaliatory way to them. The therapist's expectation of the patient's eventual ability to have a thoughtful and disciplined approach to emotional states (i.e., that the patient is a fledgling version of a capable, responsible, and reflective adult) is thought to be experienced as supportive and cognitively holding. The therapist's timely, clear, and tactful interpretations of the dominant, affect-laden themes and patient enactments in the here-and-now of the transference frequently shed light on the reasons that representations remain split off and thus facilitate integrating polarized representations of self and others.

With regard to the flow of treatment, the structured frame of TFP facilitates the full activation of the patient's distorted internal representations of self and other in the ongoing relationship between patient and therapist: this activation of internal images in the present relationship constitutes the transference. The unintegrated representations of self and other are activated in the treatment setting as they are in every aspect of the patient's life where these partial representations play a role in determining the patient's perception of real life interactions and in motivating the patient's behavior. The difference in the therapy is that the therapist both experiences the patient's representation of the interaction and also nonjudgmentally observes and comments on it (within the psychoanalytic literature, this is known as the "third position"). This is facilitated by the therapist establishing a treatment frame and contract, which in addition to providing structure and holding for the patient and a consensual reality from which to examine acting out behavior, minimizes the therapist's potential for acting in ways that might cause iatrogenic harm. The therapist does not respond to the patient's fragmented partial representation, but helps the patient observe it and the implied other that is paired with it.

As these internal object relations unfold in relation with the therapist, the TFP therapist helps the patient become more cognizant of his internal state in the moment through clarification and reflection since patients often experience affect in a primary way without symbolic representation. This process of clarification helps the patient mentalize internal states. However, in most cases, this technique alone will not lead to integration because clarification does not address the conflicts that keep the partial representations separated. Confrontation – the technique of inquiring about the elements of the patient's verbal and nonverbal communications in contradiction with each other – and interpretation of obstacles to integration are needed to get the patient beyond the level of split organization. Interpretation includes helping the patient see that he or she identifies at different moments in time with each pole of the predominant object relation dyads within him or her. Increasing the patient's awareness of his or her range of identifications increases his or her ability to integrate the different parts.

On the practical level, the relationship with the therapist in TFP is structured to create controlled conditions that facilitate the patient's experiencing affects without being overwhelmed by them in a way that destroys communication. The negotiation of a treatment frame provides a safe setting for the reactivation of the internalized relation paradigms. The safety and stability of the therapeutic environment permit the patient to begin to reflect about what is going on in the present with another person, in light of these internalized paradigms. This is similar to what attachment theorists would describe as a safe haven, which along with the guidance of an attachment figure, allows for the exploration of the content of the mind. With guidance from the therapist, the patient becomes aware of the extent to which his perceptions are based on internalized representations in contrast to the current situation. The therapist's help to cognitively structure what at first seemed chaotic also provides a containing function for the patient's affects.

TFP fosters change by inhibiting the vicious circle of setting off reactions in others that often occurs when the patient behaves with emotion dysregulation in the "real" world (often eliciting the

very responses that the patient fears from others). The objective and nonjudgmental attitude of the therapist assists in the reactivation of the internalized experience patterns, their containment, and their exploration for new understandings. Instead of attempting to deter these behaviors by educative means, TFP brings the patient's attention to the internal mental representations behind them, with the goal of understanding, modifying, and integrating them.

Key to the change process is the development of introspection or self-reflection: the patient's increase in reflection is hypothesized to be an essential mechanism of change. The disorganization of the patient involves not only internal representations of self and others, relationships with self and others, and predominance of primitive affects, but also the processes that prevent reflection and full awareness. These primitive defensive processes that characterize a split psychological structure erase and distort awareness. Thought processes can be so powerfully distorted that affects, particularly the most negative ones, are expressed in action without cognitive awareness of their existence.

As the patient progresses in the course of TFP from split-off contradictory self-states to reflectiveness and integration, from action to reflection, this increase in reflectiveness involves two specific levels. The first level is an articulation and reflection of what one feels in the moment. The patient increases his or her ability to experience, articulate, and contain an affect and to contextualize it in the moment. A second, more advanced, level of reflection is the ability to place the understanding of momentary affect states of self and others into a general context of a relationship between self and others across time. This level reflects the establishment of an integrated sense of self and others – a sense against which momentary perceptions can be compared and put in perspective.

To create the conditions that allow for the therapeutic work just described, the therapist and patient must initially set up an appropriate treatment contracts before beginning the therapy per se. The functions of the contract include defining the responsibilities of patient and therapist, protecting the therapist's ability to think clearly and reflect, providing a safe place for the patient's dynamics to unfold, setting the stage for interpreting the meaning of deviations from the contract as they occur later in therapy, and providing an organizing therapeutic frame that permits therapy to become an anchor in the patient's life. The patient responsibilities include attendance and participation, paying the fee, and reporting thoughts and feelings without censoring. The therapist's responsibilities include attending to the schedule, making every effort to understand and, when useful, comment, clarifying the limits of his/her involvement, and predicting threats to the treatment. The treatment contract makes the expectations of the therapy explicit [93]. There is some controversy regarding the value of treatment contracting. The APA guidelines recommend that the therapist contract around issues of safety. Others [94] have suggested that the evidence contraindicates their use and shows them to be ineffective [95]. However, the Kroll [95] study was designed to determine the extent that no-suicide contracts were employed (which was found to be 57%), and, although 42% of psychiatrists who used no-suicide contracts had patients that either suicided or made a serious attempt, the design of the study does not allow for assessment of the efficacy of no-suicide contracts. Other data suggest the utility of contracting around self-destructive behavior and treatment threats [34, 96–99]. For example, Yeomans et al. [96] in a pre–post study of 36 patients with borderline personality disorder found that the quality of the therapist's presentation and handling of the patient's response to the treatment contract correlated with treatment alliance and the length of treatment. In addition, in our earlier work on TFP [97], when we did not stress treatment contracting, our drop-out rates were high (31% and 36% at the 3-month and 6-month marks of treatment). However, based on the findings of Yeomans et al. [96], Kernberg and colleagues further systematized and stressed the importance of the treatment contract and in later studies [42, 57, 98, 99], our group found lower rates of drop-out (19%, 13%, and 25%) over a year-long period of treatment. We suggest that these findings taken together suggest that sensitively but explicitly negotiated treatment contracts may have one of the desired effects: resulting in less drop-out and longer treatments. Future research will need to address the issue of treatment contracts more directly, particularly testing the effects on parasuicidality and suicidality.

TFP Case Example

As an example of the contract, we will offer the case of a 35-year-old woman who was referred after 10 years of multiple outpatient and inpatient treatments for depression. For 6 months before presenting for treatment, she had remained isolated at home with chronic suicidal ideation. After careful diagnosis, her diagnosis was determined to be borderline PD with strong narcissistic features. The treatment contract begins with a discussion of the diagnostic impression and the conditions of treatment that allow for treatment that can lead to change in both symptoms and personality structure. The therapist therefore discussed with the patient that her depressive moods might stem from underlying ways of thinking of herself and others that were automatic to her, not fully in her awareness, and not fully accurate. The patient was interested in exploring this possibility so the therapist moved on to discuss the contract. One element of the contract was that treatment could not provide true gains unless the patient became involved in some kind of activity in life so that she could apply what functional capacities she had and report back in therapy about the difficulties that arose in that setting. The patient's initial response was that any kind of activity was so overwhelming to her that she relapsed back into the depths of depression. The therapist pointed out that the patient was not presently exhibiting the symptoms of a depressive episode. The patient replied that she had achieved a fragile equilibrium that would be shattered by any attempt to engage in an activity. The therapist was confident enough of the diagnosis of a primary Axis II disorder, and his consequent belief that the patient was capable of taking some responsibility in the area of functioning, to state:

> The choice of treatment is entirely up to you. If you find what I'm saying is unreasonable, or simply not something that would interest you, we could look into alternative more supportive treatments that would not ask as much of you, but would likely not lead to as much change. I understand that entering into situations where you are involved with other people is very stressful for you and that you have failed at efforts to function in the past. What I am proposing is that you begin some kind of activity, and, when you begin to have those reactions, we can explore here what is going on there that contributes to your anxiety and distress. It will very likely be related to the kind of reactions you have that we will be exploring here and in other settings.

The patient agreed in principle and the contracting went on to address what activity the patient might realistically engage in at that point. She initially proposed reading stories to children at the local preschool one afternoon each week. The therapist felt that this did not adequately address the needs of an intelligent adult woman to engage in an activity that would lead to ending her financial dependency on her parents. He proposed starting with a part-time clerical position while she looked into various training possibilities. The patient responded: "I'd rather die than work at a clerical job," a reaction that supported the therapist's diagnostic impression of strong narcissistic features. Their discussion of an appropriate activity, over two sessions, led to the patient's proposing that she could begin to get training in a paraprofessional area, which she did.

Once the treatment frame is in place, the therapy begins and the central work proceeds as described previously, helping the patient recognize and integrate the various split-off representations of self and other that make up her internal world. An example is that of a woman who started TFP at age 32 with problems of depression, chronic suicidal ideation, and an inability to maintain social relations or any job because of chronic arguments with others. The first prominent dyad that emerged in her discourse was the image of a weak, injured self who was constantly berated and put down by others. Yet, the patient's initial interactions with the therapist were characterized by a nonstop discourse on her part that left the therapist feeling controlled and unable to speak freely. Exploration of this revealed a devalued image of self in relation to another who would berate her and eventually abandon her. The patient's primitive defense mechanisms were such that she projected the "bad" critical and abandoning object on the therapist and then felt the need to then control it in him. The following interpretation began to free the patient from her use of projective identification to allow her to participate in a more open and interactive interchange.

Responding to the patient's rapid-fire speech in every session, the therapist commented: "Have you noticed how you fill the sessions with a kind of pressured speech that does not leave me any room to comment?" [Generally, if the therapist tried to speak, the patient would speak over him.] "It is as though you feel the need to control me, to keep me from acting freely."

Patient [with a combination of anger and tears]: "If I didn't control you, you'd leave me, like everyone else."

Exploration of this fear helped the patient understand that her behavior was rooted in an anxiety stemming from an internal image of the other that determined how she experienced her therapist. The next stage of therapy was marked by the patient's increasing criticism of the therapist, which she did not recognize as such consciously. She felt she was reacting in a justified way to his shortcomings and failures toward her (e.g., his going away at times). The therapist helped the patient observe her own identification with and enacting of the devaluing, critical one, helped her see its relation to feeling devalued and criticized, and also helped her understand that neither one of these needed to be the case. The patient gained awareness that the drama she experienced endlessly with others was the enactment of a relationship between two parts of herself and that she was living the contradiction of being both the victim and the critic/attacker, although with less awareness of the latter and usually experiencing this relationship as between her and others (a situation she often created) rather than within herself. This awareness allowed her to begin to tame the harsh critical part within her.

As therapy advanced, there were signs of the patient's attachment to the therapist: coming on time while protesting that therapy was a waste of time, missing her therapy while angrily proclaiming that her therapist was irresponsible for going away, etc. Her therapist made the interpretation that it must be difficult for her to be attached to him (thus going a step beyond anything she had stated and bringing the positive dyad into their dialog more explicitly) because of her fear that the kind of longing she experienced for him could never be reciprocated by anyone. The therapist's matter-of-fact mention of this felt-but-unspoken positive relationship freed the patient to begin to discuss her fantasies of an ideal relationship with him as the perfect provider and protector she had never experienced. The patient had been reluctant to express this idealized view of their relation for fear that the negative, rejecting image of the other would prove real and destroy her longing for closeness in a brutally humiliating way. The ability to discuss and observe both sides of the split allowed the patient to achieve an integrated, more balanced view of herself, others, and relationships.

Contrasting Clinical Approaches in TFP and MBT

According to Bateman and Fonagy [72], the goal of Mentalization-Based Therapy (MBT) is to help clients adopt a mentalizing stance by becoming curious about their thoughts, intentions, beliefs, and especially the awareness of manifest affects about themselves and others. As in TFP, MBT focuses on the transference in the here-and-now, but, in contrast to TFP, MBT emphasizes that since clients with BPD experience the transference as "real" and "accurate," it therefore should be responded to as such. Rather than challenging the aspects of the transference that involve distortion or displacement from past experiences, MBT focuses on the self-protective function of the transference and works with it to help the client stay in and progress in treatment. A further difference between TFP and MBT, and also DBT, is TFP's view of aggressive affects as innate to the human nature with a potential to be mastered and channeled to productive goals, in contrast to the view that aggression is principally or solely a response to mistreatment or abuse.

The vignette just given provides an opportunity to contrast the clinical approaches in TFP and MBT. For example, the TFP therapist responded to the patient's angry accusations of the therapist's irresponsibility by interpreting the unacknowledged positive attachment to the therapist. The goal of this intervention is to help her recognize a split-off part of her experience, her positive affect for the

therapist that remains outside of her awareness, and begin to integrate these disparate representations of herself in relation to the therapist (e.g., loving *and* hating). In contrast, a MBT therapist would be more likely to focus on the manifest affect of anger and the patient's own understanding of that "real" experience of the therapist's irresponsibility, without interpreting possible underlying affects.

An MBT therapist would be concerned that to interpret the patient's underlying positive feelings for the therapist would have the effect of inserting the therapist's own mental state into the therapeutic process rather than letting the patient's mental state emerge by inviting her to join the therapist in curiosity about her present experience. In contrast, a TFP therapist would be concerned that to not interpret her disparate experiences of herself in relation to the therapist threatens to leave these representations unintegrated and enacted outside of consciousness.

Another difference in the clinical approaches of TFP and MBT involves the timing of transference interpretations. Bateman and Fonagy [72] note that when the attachment system is highly activated in the context of strong affect, the capacity for mentalization becomes inhibited. For this reason, an MBT therapist would be reluctant to interpret the transference when the patient is feeling angry (as in the vignette) out of concern about the patient's diminished capacity to reflect on the interpretation being offered. An MBT therapist might respond to the patient's anger with supportive interventions intended to bolster the attachment between patient and therapist as a means of increasing the patient's capacity to mentalize.

In contrast, a TFP therapist would be interested in helping the patient to make links between disparate experiences of herself in relation to the therapist *as those affects are occurring in the treatment* as a means of integrating these affect-laden representations of self and others. Further, a TFP therapist would be concerned that providing supportive interventions in the context of the patient's anger may implicitly suggest to the patient that the aggressive part of her is not accepted by the therapist, and the therapeutic relationship can be sustained only so long as her aggression is hidden. In this context, a supportive intervention may actually bolster her perception of herself as vulnerable/victimized, while the aggressive aspects of herself remain split off and enacted outside of consciousness. (For a further explication of differences in the clinical approaches of TFP and MBT, see [100].)

Contrasting Clinical Approaches in TFP and DBT

According to Linehan [23], the treatment approach of Dialectical Behavior Therapy (DBT) balances two goals, validation of the patient's experience and change in problem behaviors. DBT starts with the assumption that patients are doing the best they can to improve their lives given the resources available to them, but have not been provided with the skills and problem-solving strategies to more effectively lead their lives. Towards this end, patients are taught mindfulness, emotion regulation, distress tolerance, and interpersonal skills in individual and group treatment contexts. DBT notes that the decision-making strategies of patients with BPD are often over-influenced or under-influenced by emotion (known as "emotion mind" and "rational mind," respectively). Therefore, one of the main goals of treatment is help patients more consistently make decisions in "wise mind," which integrates and extends emotional and rational thinking. To put it differently, one could say the goal of DBT is that "where emotion mind was, there shall be wise mind" – which bears a striking similarity to Freud's [101] goal of treatment "where id was, there shall ego be."

Like TFP, a main focus of treatment in DBT is suicidal and self-destructive behaviors, treatment-interfering behaviors, and behaviors that interfere with the patient's quality of life. Both treatments include explicit contracting around these behaviors as well as explicit instructions to the patient to prioritize these topics respectively above all others in sessions. When these destructive behaviors arise during the course of therapy, both treatments emphasize a relentless, disciplined and detailed analysis of what has occurred. Finally, both treatments stress the importance of therapists being in

supervision or consultation with colleagues when working with patients of this level of intensity. In some ways, the parallels between the frames of these treatments are not surprising given that Linehan spent a half-year sabbatical at Cornell University Medical Center, Westchester, studying with Otto Kernberg and John Clarkin in 1986 during the early days in her developing DBT.

Despite these similarities, the process of treatment in DBT and TFP are markedly different. The vignette just given again provides an opportunity to contrast the clinical approaches in TFP and DBT. For example, to return to the moment when the patient became angry and critical of the therapist's perceived shortcomings, the TFP therapist responded by interpreting her ambivalence about developing a positive attachment to the therapist. In contrast, a DBT therapist would be more likely to focus on the effectiveness of this angry interpersonal behavior, rather than its underlying motivation. The DBT therapist would validate the real disappointment that accompanies the therapist's going away, while at the same time teach the patient to use a gentler and more light-hearted, courteous expression of disappointment (i.e., the GIVE skills).

To give another example, in the vignette where the patient voiced a concern that to engage in work would be so overwhelming to her that it would "throw her back into the depths of depression," a DBT therapist would validate the patient's perspective on how painful and overwhelming increased activity may feel, while at the same time advocating for making change in order to improve the individual's quality of life. In contrast, once the treatment frame was in place, the TFP therapist explored and clarified, rather than validated, the patient's perception of a weak and injured self who was controlled by others (in this case the therapist). Further, the TFP therapist helped the patient to examine this perception of self and others in all the forms it took, including times when the patient acted controlling and put others in a weakened state (as observed in the treatment process). A TFP therapist would argue that discussing and observing the totality of her experience allowed her to achieve a more integrated, balanced view of herself, others, and relationships.

In evaluating these two examples, a TFP therapist would have a number of concerns about validating the patient's subjective experience (of justified anger at others' failings, of a view of oneself as weak and vulnerable). Specifically, a TFP therapist would be concerned that this approach evades the patient's aggression, colludes with the patient's distortions, and fosters a defensive idealization of the therapist. For example, to validate the patient's self-perception as weak, helpless, and easily thrown "into the depths of depression," a TFP therapist would say, would be to validate a distortion the patient has about herself. In contrast, a DBT therapist would maintain that the patient's outrage and vulnerable self-image stem from countless painful invalidating, and these real experiences need to be acknowledged as such. To not validate this aspect of the patient's experience, a DBT therapist would say, would be to provide the patient with one more version of an invalidating environment. More akin to MBT, a DBT therapist would accept the patient's subjective experience as "real" and "accurate" to her and therefore respond to it as such.

A TFP therapist would counter that accepting the patient's motivation at face value (i.e., to engage in work would be overwhelming) leaves a crucial underlying motivation unaddressed; the patient's statement, "I'd rather die than work at a clerical job," indicates that she experienced an acknowledgement of her current level of functioning to be a narcissistic injury that her inactivity protects her from. In contrast, a DBT therapist would be concerned that interventions focusing on the patient's underlying narcissism only pathologize the patient. However, a TFP therapist would argue that this approach is not only not pathologizing, but is actually a validating intervention (albeit validation in a different sense of the word). While DBT validates the self-perceptions the patient accepts of herself (i.e., incapable), through technical neutrality, TFP aims to accept the total experience of the patient, including those split-off parts that the patient cannot accept about herself (i.e., narcissistically injured). A TFP therapist would be concerned that to not acknowledge, label, and give voice to the totality of the patient's experience implicitly suggests to the patient that relationships can be sustained only so long as her unacceptable aspects of self remain hidden. For this reason, it is our experience that interpretations of unacceptable split-off parts of the self are eventually met with

relief, because it signals to the patient that the therapist can see them "warts and all," and it will not destroy the relationship.

Both TFP and DBT are interested in comprehensive change, with DBT working towards a "life worth living," while TFP aims to achieve the capacity "to love and to work" as Freud famously said (quoted by [102]). In TFP, this is thought to be primarily accomplished through an integration of disparate representations of self in relation to other (i.e., being able to tolerate and integrate both loving *and* hating feelings). In contrast, in DBT, treatment promotes change when the therapist "blocks or extinguishes bad behaviors, drags good behaviors out of the patient, and figures out ways to make the good behaviors so reinforcing that the patient continues the good ones and stops the bad ones" ([23], p. 97). A TFP therapist would have concerns about this approach to lasting comprehensive change, in that while DBT seems to be effective in replacing bad with good behaviors, it has less to offer in helping patients move towards deep, intimate relationships and a consolidated sense of self. To be sure, there is enormous value in reducing or eliminating intense, chaotic acting-out behaviors, and to the degree that DBT addresses such behaviors it should be lauded. However, a TFP therapist would note that when the storms of acting out subside often, what lies underneath is an unintegrated self that struggles with the complexities of love relationships. It is in this midphase of TFP that the integration of aggression with love and sexuality becomes a central focus of treatment.

Empirical Evidence for Transference-Focused Psychotherapy

There is now accumulating evidence for the effectiveness and efficacy of TFP [26, 42, 57, 98]. The initial study [98] examined the effectiveness of TFP in a pre–post design. Participants were recruited from varied treatment settings (i.e., inpatient, day hospital, and outpatient clinics) within the New York metropolitan area. Participants were all women between the ages of 18 and 50 who met criteria for BPD through structured interviews. All therapists (senior therapists to postdoctoral trainees) selected for this phase of the study were judged by independent supervisory ratings to be both competent and adherent to the TFP manual. Three senior supervisors rated the therapists for TFP adherence and competence. Throughout the study, all therapists were supervised on a weekly basis by Kernberg and at least one other senior clinician.

Overall, the major finding in this pre–post study was that patients with BPD who were treated with TFP showed marked reductions in the severity of parasuicidal behaviors, fewer emergency room visits, hospitalizations, days hospitalized, and reliable increases in global functioning. The effect sizes were large and no less than those demonstrated for other BPD treatments [49, 75]. The 1-year drop-out rate was 19.1%, and no patient committed suicide. These results compared well with other treatments for BPD: Linehan et al. [49] had 16.7% drop-out, and one suicide (4%); Stevenson and Meares' study [103] had a 16% drop-out rate and no suicides; and Bateman and Fonagy's study [75] had 21% drop-out and no suicides. None of the treatment completers deteriorated or were adversely affected by the treatment. Therefore, it appears that TFP is well-tolerated. Further, 53% of participants no longer met criteria for BPD after 1 year of twice-weekly outpatient treatment [71]. This rate compared quite well with that found by others [76, 103]. In addition, reliable increases in global functioning were observed in these patients. These results suggest the potential utility of TFP for treating BPD patients and that more research on TFP is warranted (Table 8.2).

A second study [104] provided further support for the effectiveness of TFP in treating BPD. In this study, 32 women diagnosed with BPD and treated with TFP were compared to 17 patients in a TAU group. There were no significant pretreatment differences between the treatment group and the comparison group in terms of demographic or diagnostic variables, severity of BPD symptomatology, baseline emergency room visits, hospitalizations, days hospitalized, or global functioning scores. The 1-year attrition rate was 19%. Patients treated with TFP, compared to those treated with

Table 8.2 Results of Clarkin et al. [98] TFP pre–post study ($N = 17$)

	Means		
	Pre-Tx	Post-Tx	*p*-Value
BPD Dx	100%	47.10%	–
Parasuicidal behavior	5.18	4.24	0.45
Medical risk	1.72	1.14	0.02
Physical condition	1.89	1.12	0.01
Hospitalizations	1.24	0.35	0.02
Days hospitalized	39.21	4.53	0.06
GAF	45.57	59.85	<.001

Note: BPD Dx was assessed as the percentage of patients with a DSM-III diagnosis of BPD, from the SCID-II. Parasuicidal Behavior, Medical Risk, and Physical Condition were all assessed from the suicidality subscale of the Overt Aggression Scale – Modified Version for Outpatients [129] over the previous 12-month period. Medical Risk was indicative of the severity of parasuicidial and suicidal behaviors. Physical Condition was indicative of the condition following such behaviors. Hospitalizations were assessed my checking medical records and represent the total number of hospitalization in the previous 12-month period. GAF represents the DSM-III Global Assessment of Functioning scale score

Table 8.3 Results of TFP vs. TAU study

	TFP (N = 32)	Completers	ITT		TAU (N = 17)				
	Pre-Tx	Post-Tx	Post-Tx	Change Sig	Pre-Tx	Post-Tx	Change Sig	Between Group Comparison	
ER Visits	1.18	0.42	0.59	<.01	1.53	1.73	*ns*	TFP > TAU	<.01
Hospitalizations	1.72	0.46	0.91	<.001	2.47	1.93	*ns*	TFP > TAU	<.01
Days Hospitalized	61.1	7.08	25.87	<.001	0.48	53.4	*ns*	TFP > TAU	<.01
# of BPD Criteria Met	7.74	4.41	5.15	<.001	7.69	–	–	TFP > TAU	–
GAF	45.57	61.0	59.85	<.001	44.8	44.66	–	TFP > TAU	<.01

Note: ER visits represents the number of emergency room visits in the previous 12-month period. Hospitalizations represents the total number of hospitalization in the previous 12-month period. # of BPD criteria was assessed with the SCID-II and provides a dimensional rating of the severity of the disorder. GAF represents the DSM-III Global Assessment of Functioning scale score

TAU, showed significant decreases in suicide attempts, hospitalizations, and number of days hospitalized, as well as reliable increases in global functioning. All of the within-subjects and between-subject effect sizes for the TFP-treated participants indicated favorable change. The within-subject effect sizes ranged from 0.73 to 3.06 for the TFP-treated participants, with an average effect size of 1.19 (which is well above what is considered "large") [105] (Table 8.3).

The only RCT to date that has compared an experimental treatment for BPD to a well-established, well-delivered, alternative treatment has been the RCT conducted by The Personality Disorders Institute, funded in part by the Borderline Personality Disorders Research Foundation, to assess the efficacy of TFP compared with DBT and supportive psychotherapy (SPT) for patients with BPD. DBT, which has received preliminary empirical support for its effectiveness, was selected as the active comparison treatment. The putative mechanisms of change in these two treatments are conceived in very different ways. DBT is hypothesized to operate through the learning of emotion-regulation skills in the validating environment of the treatment [106]. TFP is hypothesized to operate through the integration of conflicted, affect-laden conceptions of self and others via the understanding of these working models as they are actualized in the here-and-now relationship with the therapist. SPT [107, 108] was used in contrast to these two active treatments as a control for attention and support but also as a component control for TFP.

Table 8.4 Results of Clarkin et al. [26] randomized clinical trial

	Significance of change		
Symptom-based measures	TFP	DBT	SPT
Primary			
Suicidality	<.05	<.05	ns
Anger	<.05	<.05	ns
Irritability	<.05	ns	ns
Verbal assault	<.05	ns	ns
Direct assault	<.05	ns	ns
Barratt Factor 1 impulsivity	ns	ns	ns
Barratt Factor 2	<.05	ns	ns
Barratt Factor 3	ns	ns	<.05
Secondary			
Anxiety	<.05	<.05	<.05
Depression	<.05	<.05	<.05
GAF	<.05	<.05	<.05
Social adjustment	<.05	<.05	<.05

Note: Suicidality, Anger, Irritability, Verbal, and Direct Assault were assessed with the Overt Aggression Scale – Modified version [129]. Barratt Factors are from the Barratt Impulsivity Scale [130]. Anxiety was assessed with the State-Trait Anxiety Inventory [131]. Depression was assessed with the Beck Depression Inventory [132]. GAF represents the DSM-III Global Assessment of Functioning scale score. Social Adjustment was assessed by the Social Adjustment Scale [133]

In this study, BPD patients were recruited from New York City and adjacent Westchester County. Ninety-eight percent of the participants were clinically referred by private practitioners, clinics, or family members. Ninety patients (6 men and 84 women) between the ages of 18 and 50 were evaluated using structured clinical interviews and randomized to one of the three treatment cells. Results showed that all three groups had significant improvement in both global and social functioning, and significant decreases in depression and anxiety. Both TFP- and DBT-treated groups, but not the SPT group, showed significant improvement in suicidality, depression, anger, and global functioning. Only the TFP-treated group demonstrated significant improvements in verbal assault, direct assault, irritability [26] (Table 8.4).

In an earlier report on this sample, we [57] examined changes in attachment organization and reflective function as putative mechanisms of change. Attachment organization was assessed using the Adult Attachment Interview (AAI [109]) and the reflective function coding scale (RF [74]). After 12 months of treatment, we found a significant increase in the number of patients classified as secure with respect to attachment state of mind for TFP, but not the other two treatments. Significant changes in narrative coherence and RF were found as a function of treatment, with TFP showing increases in both constructs during the course of treatment. Findings suggest that 1 year of intensive Transference-Focused Psychotherapy can increase patients' narrative coherence and reflective function. Our findings are important because they show that TFP is not only an efficacious treatment for BPD but works in a theoretically predicted way and thus has implications for conceptualizing the mechanism by which patients with BPD may change. In addition, patients in TFP did better on those variables than the patients in DBT and SPT. Our findings are especially important given the literature showing that many treatments do not show specific effects on specific, theory-driven mechanisms [110–118] (Table 8.5).

There are a number of methodological strengths of these studies [26, 42, 57] such as the use of multiple domains of change to measure outcome, including behavioral, observer-rated, phenomenological, and structural change (i.e., attachment representations, object relations, and mentalization skills). In addition, this study included a broad range of BPD patients and not exclusively those with

Table 8.5 Results of Levy et al. [42] and Levy et al. [57] randomized clinical trial

	TFP		DBT		SPT		
Structural measures	Pre-Tx	Post-Tx	Pre-Tx	Post-Tx	Pre-Tx	Post-Tx	Contrast
Reflective functioning	2.86	4.11	3.31	3.38	2.8	2.86	TFP > DBT = SPT
Coherence of narrative	2.93	4.02	3.00	3.25	3.25	3.16	TFP > DBT = SPT

Note: Reflective Functioning was assessed based on Fonagy's [74] manual for scoring RF. Coherence of Narrative was assessed based on the Adult Attachment Interview coding system [134]

parasuicidality, representing the full spectrum of BPD manifestations. Further, all therapists were experienced in their respective treatment model, had practice cases prior to beginning the study, and were rated for adherence and competence in their delivery of therapy during the study. Adding to the external validity of this research, treatments were delivered in community mental health settings, including outpatient hospitals and private offices of therapists.

However, there are also a number of critiques that can be made of these [26, 42, 57] studies. First, allegiance effects should be considered. Allegiance effects occur when the therapy condition that is consistent with the investigator's own orientation produces larger effects than the comparison treatment due to subtle methodological choices that favor the investigator's preferred therapy. Recent research by Luborsky et al. [83] suggests that this effect may be even more powerful than previously thought, accounting for 69% of the variance in treatment outcome even in high-quality studies. One might argue that, because the investigators in this study were psychodynamic in their orientation and the study was conducted at Cornell Medical Center where the developers of TFP are well established, an allegiance effect may have been operating. However, the fact that these studies were conducted by people strongly associated with the therapy and at a "home" institution is no different from existing studies on BPD where all studies are done by investigators who are highly devoted to the treatment under study and most have been completed at "home" or "satellite" sites (i.e. [27, 49, 52, 64, 75]).

Clarkin et al. explicitly attempted to address allegiance issues in two ways [84]. First, they conducted the study at an institution which had long established programs in all three treatments under study. Although Kernberg had implemented training and treatment in his expressive psychotherapy for BPD (which would later be structuralized into TFP), proponents of supportive psychotherapy (e.g. [119–122]) had also established training and treatment on the Cornell campus. Further, Linehan herself helped develop the Cornell DBT program with Swenson [123–125] which is the second oldest and most established DBT program after Linehan's in Seattle. Second, they utilized treatment cell leaders for all three conditions that were internationally recognized experts in their respective treatments. All three treatment cell leaders were published in their modality and had years of experience treating patients and supervising therapists in their respective modality. Treatment cell leaders selected their own therapists based on the therapists' previous demonstration of adherence and competence in their respective treatments, and all therapists were supervised, monitored, and rated through weekly in-person supervision of video-taped sessions. Luborsky et al. [83] note that one of the most potent methodological choices that result in allegiance effects is the selection of therapists who differ in skillfulness that favor the allegiance of the researcher. Therefore, it was ensured that therapists in the treatment cells did not differ in terms of level of experience. Until the McMain et al. [69] study, Clarkin and colleagues had made the most extensive and honest attempt to insure comparability across therapy conditions and minimize allegiance effects. However, the Clarkin and colleagues studies did not include a research investigator from control conditions as did the McMain study.

A second critique may have to do with the adherence of therapists in the DBT condition [94]. However, it is important to remember that the DBT therapists in the Clarkin and colleagues studies all had specific training in DBT, including having attended the requisite number of intensive trainings with Linehan or other certified trainers (see [42, 57]). They had demonstrated prior competence and were supervised by an acknowledged expert who has received multiple grants from NIH for

treatment studies utilizing DBT. Additionally, throughout the study the DBT therapists were videotaped and their sessions were supervised in a group on a weekly basis. The supervisor provided feedback and rated therapists for adherence and competence with instructions to notify the PI of any concerns in these areas ([26], see p. 923). The supervisor reported no concerns about adherence and competence during the course of the study. Additionally, the findings from the Clarkin et al. study are consistent with the McMain findings in which therapists were also adherent and competent.

Finally, the fact that there were no differences in outcome between DBT and TFP cannot technically be interpreted as equivalence between TFP and DBT due to a lack of power to detect existing group differences. The number of participants in each group was 30, which although consistent with the Division 12 guidelines for demonstrating equivalence, is underpowered to detect differences. However, we can say that there were no differences in outcome between DBT and TFP other than in the attachment and mentalization constructs for which TFP was significantly superior.

As more data from this RCT are assessed, we will have a better understanding of how the treatment performs under more stringent experimental conditions. Because the RCT better controls for unmeasured variables through randomization, offers controls for attention and support, and compares TFP to an already established, well-delivered, alternative treatment, its outcome will be a strong indicator of the treatment's efficacy and effectiveness. In addition to assessment of outcome, the RCT has also generated process-outcome studies designed to assess the hypothesized mechanisms of action in TFP that result in the changes seen in these patients [41, 42, 57].

Despite the initial evidence that these studies provide for the value of TFP, the fact that the Giesen-Bloo et al. [27] study, discussed earlier, found that patients treated in TFP did not improve as well as those treated in SFT led the American Psychological Association Division 12 to conclude that "TFP is designated as having controversial research support because of mixed findings. TFP performed favorably in one randomized controlled trial [26], but did not perform well in another [27]. Thus, more research is needed before TFP can be considered to have modest or strong research support."

A recent study in Germany and Austria by Doering et al. [28] provides a response to this recommendation directly by further establishing TFP as an efficacious treatment. Doering et al. [28] completed an RCT comparing 1 year of TFP to treatment by experienced community psychotherapists (ECP). While patients improved in both treatments, patients randomly assigned to TFP evidenced lower drop-out and showed significantly greater reductions in number of patients attempting suicide, number of impatient admissions, BPD symptoms, and significantly greater improvements in personality organization and psychosocial functioning after 1 year of treatment. Both groups improved significantly in depression and anxiety and the TFP group in general psychopathology, all without significant group differences. Self-harming behavior did not change in either group.

There are a number of strengths of this study. First, the study had a large sample size of 104 women. Second, the researchers reported both intent-to-treat and completer analyses, addressing the concern that the efficacy of TFP in clinical and psychosocial functioning was not an artifact of treatment dose and missing data due to drop-out. Third, both the TFP and ECP therapists were well trained and conducting treatment at multiple sites, and the ECP group was composed of experienced therapists who are committed to treating BPD patients. Fourth, the efficacy of TFP was demonstrated by an independent group not affiliated with Cornell Medical Center. In terms of limitations, a number of weaknesses of this study were related to the healthcare system in Germany and Austria, where insurance covers most psychotherapy at most levels of care. As a result, drop-out was higher in this study, as patients had the freedom to transfer to another therapist with ease (Figs. 8.1–8.4).

In sum, despite the aforementioned critiques, the evidence for TFP is strong and significantly strengthened by the findings from Doering et al. [28] and consistent with the literature overall. That is, there is no evidence that any one approach is significantly better than any other as a function of effect sizes or comparisons with bonafide alternative treatments. TFP represents one of a number of treatments that may be useful in the treatment of BPD. TFP is the only treatment to date that has shown evidence of changing mental representations or internal structure.

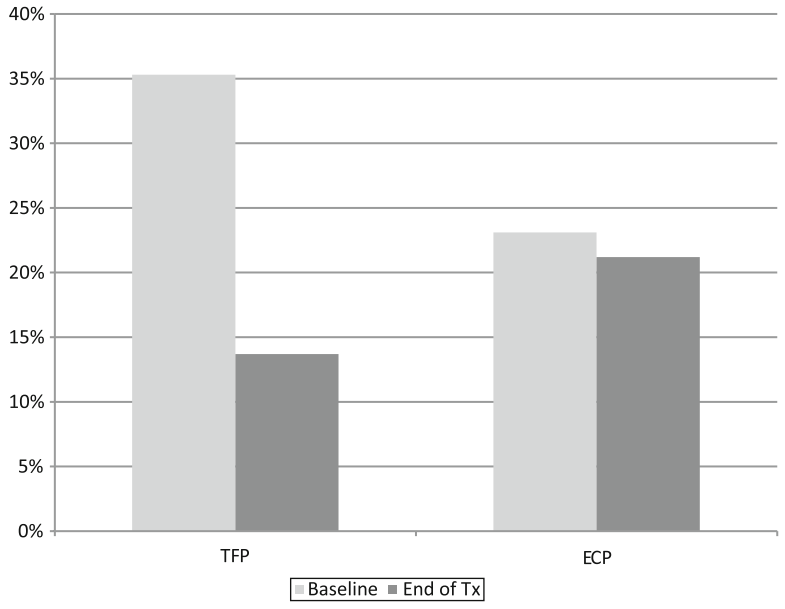

Fig. 8.1 Percent attempted suicide. Within group – TFP: $p = .001$, $d = 0.8$; ECP: ns. Between group – TFP > ECP $d = 0.8$, $p = 0.009$

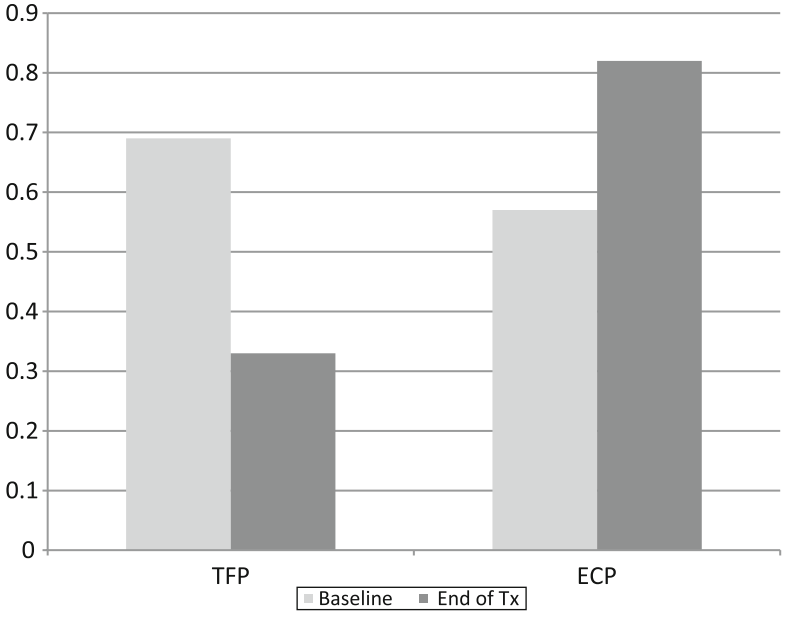

Fig. 8.2 Number of inpatient hospital admissions. Within group – TFP: $p = .001$, $d = 0.5$; ECP: ns. Between group – TFP > ECP $d = 0.5$, $p = 0.001$

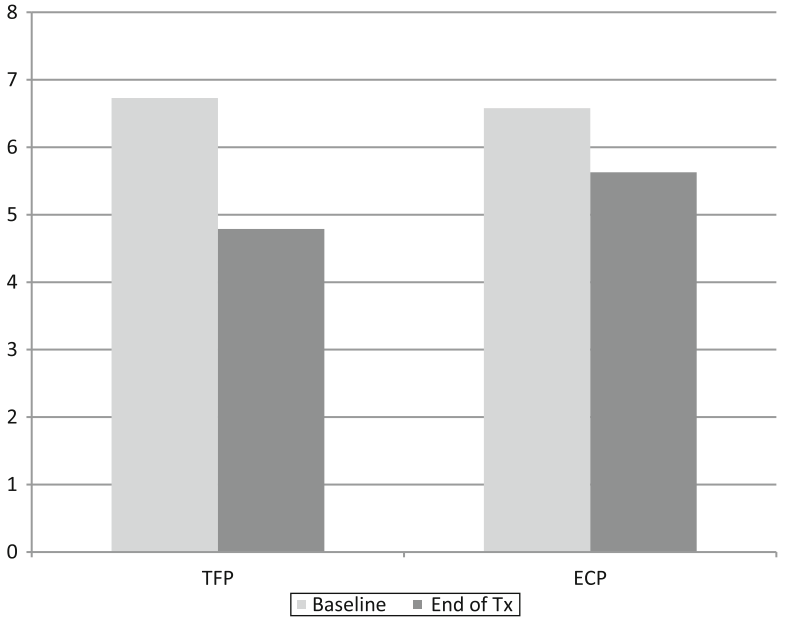

Fig. 8.3 Number of DSM-IV criteria for BPD. Within group – TFP: $p = .001$, $d = 1.6$; ECP: $p = .001$, $d = 0.8$. Between group – TFP > ECP $d = 1.6$, $p = 0.001$

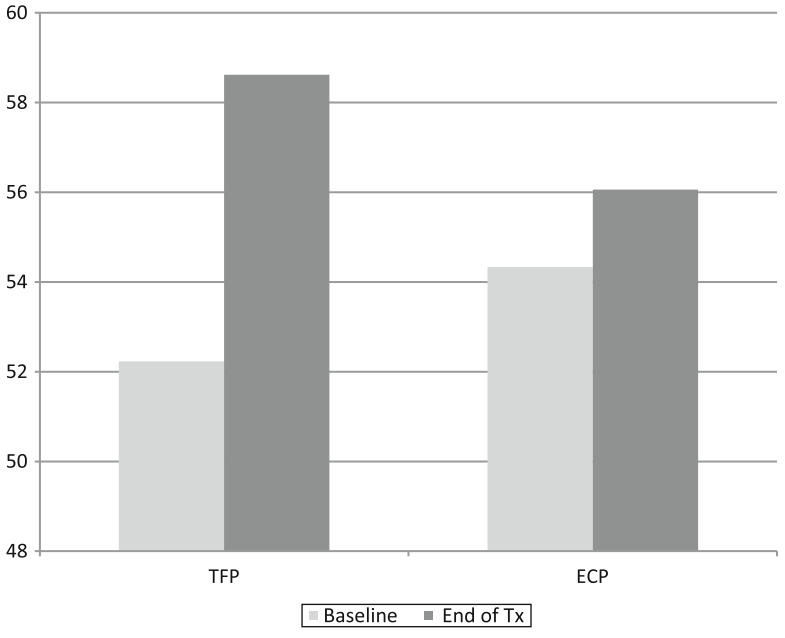

Fig. 8.4 GAF score. Within group – TFP: $p = .001$, $d = 1.0$; ECP: $p = .01$, $d = 0.3$. Between group – TFP > ECP $d = 1.0$, $p = 0.002$

Conclusions

In summary, there are a number of conclusions that can be drawn from the data reviewed in this chapter. Most generally, there are a number of different psychodynamic treatment models that are useful and supported empirically for treating BPD. In addition, there may be other models, which share similar principles that are also quite effective but remain untested. We would recommend that proponents of these approaches work toward their examination in RCT designs.

Specifically, we have learned that:

1. Psychoanalysis can be modified to specific types of pathology and can be modified in different ways successfully [26, 75, 103].
2. The principles and goals of psychodynamic treatments for borderline personality disorder can be articulated and manualized [22, 72].
3. Psychodynamic psychotherapy can be taught to trainees, early career therapists, experienced therapists, and nurses (not just experienced psychoanalyst) [28, 75, 78, 98, 103].
4. Psychotherapy sessions can be video or audio taped without disrupting the treatment [26, 98, 116].
5. There is little evidence that purely noninterpretive psychodynamic psychotherapies (such as some supportive psychotherapies) are effective with BPD patients, although little is known about the extent to which supportive techniques can be or should be integrated in treatments for BPD [26, 42, 57]. Kernberg would argue for less supportive techniques particularly with for low-level BPD patients, whereas Bateman and Fonagy [72] would argue more integration of supportive techniques. Recent data from an RCT by Hoglend further support the notion that patients with low-levels of object relations do particularly well in transference-based treatments [126].
6. Data suggest that therapists can reduce drop-out by increasing the structure and explicitly focusing on frame issues with BPD patient; explicit contracts are particularly helpful but may not be necessary if a solid structure and frame can be established and maintained [26, 28, 42, 57, 98].
7. Randomized clinical trials of psychodynamic treatments for BPD can be performed [26, 28, 42, 57, 75].
8. Some dynamic treatments for BPD can be considered to have beginning empirical support that meets the APA Division 12 criteria for well-established treatments [26, 28, 42, 57, 75–77].
9. Unselected and severely disturbed BPD patients can be treated in psychodynamic psychotherapy, not just those with high IQs, high reflective function, or good quality of object relations [26, 42, 57, 75, 98, 126].
10. BPD patients can show important change in just 1 year [26, 28, 42, 57, 75, 98].
11. Psychodynamic treatments may have broader outcome, longer lasting outcome, and show changes in personality than those shown in other treatments [26, 28, 42, 57, 75, 77, 98].
12. Long-term treatment is necessary and important in the treatment of BPD in order to see structural changes in personality organization.
13. Supervision is a critical component for the treatment of BPD. All the empirically supported treatments for BPD, not just the psychodynamic ones, have structured ongoing supervision for therapists [26, 27, 42, 49, 57, 75, 78, 98]. Additionally, in some studies, differences between groups [27, 64] appear related to difference in the delivery of adequate supervision [42, 57, 85].
14. All treatments for BPD with empirical support are well structured, devote considerable effort to enhancing compliance (e.g., attention to contracting and frame), have a clear focus, whether that focus is a problem behavior or an aspect of interpersonal relationship patterns; are highly coherent to both therapist and patient; encourage a powerful attachment relationship between therapist and patient, enabling the therapist to adopt a relatively active rather than a passive stance; and are well integrated with other services available to the patient.
15. With regard specifically to TFP, accumulating evidence indicates that TFP is an effective treatment for BPD. The study by Doering et al. is significant in that it is an independent replication

of the efficacy of TFP, directly addressing the need for greater empirical support for TFP raised by APA Division 12. As previously discussed, multiple sources of treatment evidence are necessary in order to build an empirically grounded framework for specific forms of psychotherapy. TFP has demonstrated its efficacy through treatment evidence at different levels of internal and external validity, including clinical case studies, pre–post design study, quasi-experimental comparison study, RCT with comparison to experienced therapists in the community, and finally RCT with comparison to established well-delivered alternative treatments, in combination with the examination of evidence for specific mechanisms of action. Taken together, this body of research raises TFP to the criteria articulated by APA Division 12 for well-established treatments.

The next step is the identification of the active ingredients or mechanisms of therapeutic action in these treatments [41]. Effectiveness and efficacy aside, the probative importance of these studies for understanding a treatment's actual mechanisms of action are both indirect and limited [127]. Therefore, despite the support for the effectiveness and efficacy of existing treatments for borderline personality disorder, clinicians and researchers are still confronted with a high degree of uncertainty about the underlying processes of change. The examination of putative mechanisms of change has the potential to answer theoretical questions and validate models by showing that theoretically specified mechanisms of change are actually related to the treatments' effectiveness. It is very possible that these treatments may work due to unintended mechanisms such as common factors (e.g., expectancies; see [128]) or a specific technique factor that is essential to good outcome but not necessarily unique to any one treatment [34]. Finally, there may simply be different avenues to effect change in patients with BPD or that different treatments may be more effective with different types of BPD patients.

Additionally, establishment of the underlying mechanisms of the psychopathology in BPD will help to validate clinical approaches. For example, showing through the use of experimental psychopathology paradigms that identity diffusion or deficits in reflective function underlie the symptoms in BPD would go a long way to establishing the importance of the treatment goals emphasized in TFP.

Finally, given the chronicity of BPD, it is crucial to establish the long-term significance of the changes that occur in our treatments. There is already some preliminary evidence that MBT has long-term effectiveness. Currently, with funding from the American Psychoanalytic Association, we are in the process of carrying out a long-term follow-up of the patients treated in our RCT to examine the maintenance of treatment gains and the long-term efficacy of TFP.

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