

Transference-Focused Psychotherapy for Adult Borderline Personality Disorder

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THE RCT STUDY

Introduction

Borderline personality disorder (BPD) is a chronic and debilitating mental health problem characterized by a pattern of chaotic interpersonal relationships, emotional lability, impulsivity, angry outbursts, suicidality, and self-mutilation (APA, 2000, 2013; Skodol et al., 2002). It is a highly prevalent disorder; its prevalence is estimated at approximately 1%–6% of the general population (Grant et al., 2008; Lenzenweger, Lane, Loranger, & Kessler 2007; Torgersen, Kringlen, & Cramer, 2001; Zanarini et al., 2011), 10%–23% of psychiatric outpatients (Korzekwa, Dell, Links, Thabane, & Webb, 2008; Magnavita, Levy, Critchfield, & Lebow, 2010; Zimmerman, Rothschild, & Chelminski, 2005), 20%–25% of inpatients (Oldham et al., 1995; Zanarini et al., 2004), and 6% of primary care patients (Gross et al., 2002). The majority of individuals diagnosed with BPD are women (APA, 2013).

Individuals with BPD often suffer from significant behavioral problems. An estimated 69%–75% of individuals diagnosed with BPD have engaged in self-injurious behaviors (Kjellander, Bongar, & King, 1998). Alcohol and drug abuse, high-risk sexual behavior, and disordered eating are also common in this population. The completed suicide rate among BPD patients is also high, estimated as being between 3% and 9.5% (McGlashan, 1986; Paris, 1999; Stone, 1983).

Additionally, BPD is frequently comorbid both with other personality disorders and with other more episodic disorders that were formerly included on Axis I in previous editions of the *DSM* such as mood, anxiety, and substance use disorders (Zanarini et al., 1999). While patients with BPD utilize higher levels of mental health services, they often do so in chaotic ways; patterns of erratic attendance and repeated dropout, refusal to take psychiatric medications as prescribed, and pervasive noncompliance are common in this population (Bongar, Peterson, Golann, & Hardiman, 1990; Zanarini & Frankenburg, 2001). Patients with borderline personality disorder are notoriously difficult to treat. Given its prevalence, comorbidity, and significant risks of distress and behavioral dysfunction, BPD represents a major public health problem.

GOAL 1 OF THE RESEARCH: COMPARING THE EFFECTIVENESS OF DIFFERENT MODELS FOR TREATING BPD

The rationale behind the current RCT was twofold. First, the researchers wished to conduct a trial that would assess the efficacy of transference-focused psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006), a manualized psychodynamic psychotherapy for BPD. TFP had already shown evidence of effectiveness using patients as their own controls (Clarkin et al., 2001) and in comparison to a treatment-as-usual group (Levy, Clarkin, Foelsch, & Kernberg, in review), but it had not yet been tested in the context of an RCT. The researchers also wanted to avoid some of the weaknesses of previous RCTs for BPD, such as small sample sizes (Clarkin et al., 2004), and comparison with a treatment-as-usual (TAU) condition, rather than with another active treatment for BPD (e.g., Bateman & Fonagy, 1999; Linehan et al., 1991). The campus at Cornell Medical College presented a unique opportunity in that there were three distinct long-standing programs of treatment for BPD that were well represented by active faculty, all with a presence on campus. The three approaches were transference-focused psychotherapy, which had been represented on campus since the mid 1970s when Otto Kernberg arrived as medical director. In the early 1980s, along with John Clarkin and Frank Yeomans and other colleagues, he developed TFP, which evolved out of expressive psychodynamic psychotherapy as practiced in the Menninger Project (Kernberg et al., 1972). Dialectical behavioral therapy (DBT) was also well represented on campus. In the mid-1980s Marsha Linehan spent a sabbatical semester at Cornell Medical College where she brought DBT to the campus. Along with Charles Swenson and other colleagues (Cynthia Sanderson and Perry Hoffman among others), the first DBT program outside of Seattle was established. Swenson, Sanderson, Hoffman, and others at Cornell were personally trained by Linehan and have become leaders in the training and implementation of DBT.

Before DBT was brought to campus, a central debate among the Cornell psychiatry and psychology faculty concerned the emphasis on expressive versus supportive psychotherapy techniques in the treatment of borderline and narcissistic patients. The debate was represented internationally between Kernberg and Kohut with regard to narcissism and Kernberg and Adler with regard to BPD. On campus, the discussions centered on the work of Rockland (1992) and colleagues

(e.g., Appelbaum, 2005) on supportive therapy versus those of Kernberg and TFP (e.g., Clarkin, Yeomans, & Kernberg, 1998). Thus, the campus was flush with excitement and discussion of these various approaches.

All three approaches found interested constituents and subsequently flourished. Each program was able to adhere to its core principles, yet also interacted collegially and in the spirit of scholarship. In line with this, by having each of the three therapy models conducted by strong adherents of that model, we avoided the problem of bias due to researcher allegiance (Munder, Flückiger, Gerger, Wampold, & Barth, 2012). Thus, in developing the RCT reported in this chapter, the aim was to take advantage of this unique situation on campus and to compare the efficacy of TFP for treating BPD against that of DBT, an active alternative treatment for BPD whose efficacy had been previously established in a seminal clinical trial (e.g., Linehan et al., 1991). DBT was also being evaluated in several other clinical trials at the time (Linehan et al., 1999, 2002, 2006). Our RCT design allowed for the comparison of two theoretically contrasting approaches to the treatment of BPD: the psychodynamic model of TFP, and the CBT model using DBT. In taking advantage of the expertise on campus, rather than a treatment-as-usual comparison, a third active intervention, a supportive psychodynamic treatment, was adapted (Appelbaum, 2005) from Rockland's model for treating BPD (SPT; Rockland, 1992). This approach was also included as a component control for attention and support, as this modality does not utilize transference interpretation, an intervention considered to be one of the "active ingredients" of TFP; nor does it include skills training as does DBT. This design allowed for the comparison of TFP with another treatment based on a psychodynamic model (SPT), but one that explicitly avoids the process of transference and countertransference interpretations considered central to TFP.

GOAL 2 OF THE RESEARCH: INVESTIGATING PATIENT CHARACTERISTICS AND MECHANISMS

A second goal of the study was to examine patient characteristics and underlying mechanisms of BPD that might predict treatment response (Clarkin et al., 2004). In a series of manuscripts we have examined deficits in effortful control, amygdala and prefrontal cortex functioning, impulsivity, attention, executive functioning, aggression, positive and negative emotion, and mentalizing capacity (Critchfield et al., 2004; Fertuck, Lenzenweger, & Clarkin, 2005; Hoerman et al., 2005; Lenzenweger et al., 2004; Levy et al., 2005, 2006; Posner et al., 2002; Silbersweig et al., 2007). These studies have shown basic deficits in core aspects of neurocognitive and psychological functioning that are consistent with theories regarding the developmental psychopathology in BPD (Levy, 2005). For instance, Posner et al. (2002) found, relative to temperamentally matched controls, that those subjects with BPD tended to experience difficulty in resolving a nonaffective cognitive conflict task during the course of an attention task. Fertuck et al. further found that this attentional problem was related to the severity of BPD pathology. Likewise, Lenzenweger et al. (2004) found that BPD patients, as compared to normal controls, displayed deficits in sustained attention, working memory,

and executive functioning. Levy et al. (2005) found that these deficits in attention and executive functioning were related to impairments in mentalizing as measured by reflective function on the Adult Attachment Interview. These deficits in the conflict aspect of attention tasks were related to alliance in psychotherapy but were mediated by mentalizing (Levy et al., 2010). Importantly, although BPD patients showed difficulty with mentalizing, they were amenable to treatment in TFP (Levy et al., 2006).

HYPOTHESES TESTED

The RCT was designed to examine three questions. The first was whether TFP is as efficacious or more so than DBT, a treatment whose efficacy had already been well established in clinical trials. The second was whether TFP is more efficacious than a psychodynamic model that does not address transference-based phenomena. If this is the case, it would provide evidence of the clinical utility of addressing these phenomena through transference interpretation. The third was whether TFP would result in a different pattern of results on a range of outcome measures than would DBT or SPT, which could provide information about the impact on BPD psychopathology and dynamics of the different theories and approaches underlying the three treatments. Within the context of this hypotheses, this chapter is focused primarily on TFP, rather than on the three treatments equally.

INCLUSION OF ELEMENTS FROM BOTH EFFICACY AND EFFECTIVENESS DESIGNS

The design of the study incorporated characteristics of both efficacy and effectiveness studies. Similar to efficacy studies, the design of this RCT incorporated random assignment of patients to treatments, as well as the use of manualized treatments, blind raters, therapists blind to all baseline assessments, and specific and reliably measured outcome variables. Similar to effectiveness studies, a range of BPD patients were included in the study based on inclusion/exclusion criteria used in clinical practice; therapists provided treatment in their private offices in the community rather than in a university or hospital setting; and psychopharmacological treatment was decided on an individual case basis (see later). Finally, as mentioned earlier, the study was also designed to avoid some of the weaknesses of previous RCTs for BPD by including large sample sizes and comparison with other, active treatments.

Method

CASE-FINDING PROCEDURES, INCLUDING DIAGNOSTIC EVALUATION PROCEDURES AND AN INTENT-TO-TREAT ANALYSIS FLOW CHART

Patients were recruited within a 50 mile radius of New York City. The vast majority of patients (97%) were referred by mental health professionals. Others were self-referred or referred by family members. Potential participants were initially screened for age and location with telephone interviews; those who were deemed

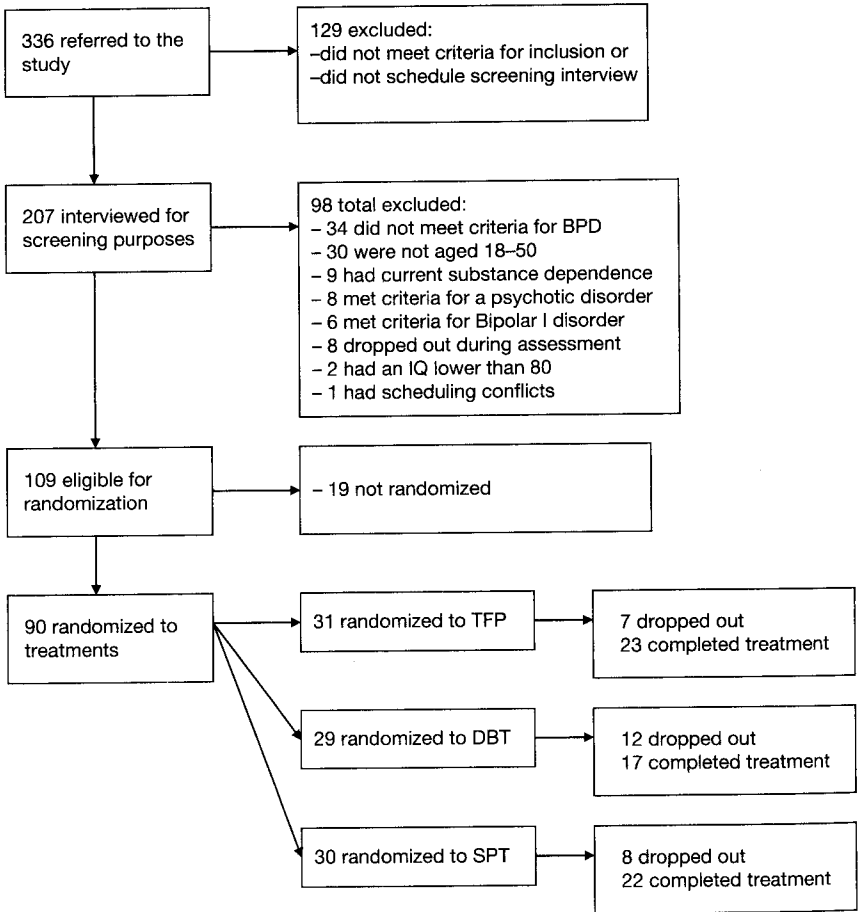


Figure 5.1 Intent-to-Treat Analysis Flow Chart.

suitable at this stage were then assessed in face-to-face interviews with trained evaluators, as described next, prior to being randomized to treatment. Written informed consent was obtained after all study procedures had been explained to participants.

As shown in the intent-to-treat flow chart presented in Figure 5.1, between 1998 and 2003, 336 patients were referred to the project. Of these, 129 either did not meet criteria for inclusion or decided not to schedule an intake interview. A total of 207 individuals were interviewed. Ninety-eight of these were excluded due to not meeting criteria for BPD ($n = 34$); age outside the 18–50 range ($n = 30$); meeting criteria for current substance dependence ($n = 9$), a psychotic disorder ($n = 8$), or bipolar I disorder ($n = 6$); dropouts during assessment ($n = 8$); having an IQ below 80 ($n = 2$); and prohibitive scheduling conflicts ($n = 1$). Of the 109 who were eligible for randomization, 90 were randomly chosen for treatment. These 90 participants so chosen did not differ from the 19 who were not chosen

for treatment in terms of demographics, diagnostic data, or severity of psychopathology. Further details about participant referral and selection, rater and participant characteristics, and reliability of assessments are available elsewhere (Critchfield, Levy, & Clarkin, 2007).

Diagnostic evaluation procedures The Structured Clinical Interview for DSM-IV-Research Version (SCID-I; First, Gibbon, Spitzer, & Williams, 1997) was used to assess DSM-IV Axis I diagnoses, including exclusion diagnoses such as psychotic disorders. The SCID-I is a structured clinical interview used for making DSM-IV Axis I diagnoses in adults.

The International Personality Disorder Examination (IPDE; Loranger, Sartorius, Andreoli, & Berger, 1994) was used to assess personality pathology in potential participants. The IPDE is a semistructured diagnostic interview used for diagnosing personality disorders. It consists of 99 items, each of which is designed to assess a DSM-IV personality disorder criterion, arranged according to six themes (e.g., Self, Work), along with a detailed scoring manual (Loranger et al., 1994). Items are rated on a three-point scale: 0 = *absent or normal*, 1 = *exaggerated or accentuated*, 2 = *meets criteria or pathological*. Items consist of one or more primary and follow-up questions; all positive responses are followed by requests for supporting examples. After the questions are exhausted, the interviewer is free to inquire further in order to be able to score the item to completion. The IPDE generates probable (when an individual meets a sub-threshold number of diagnostic criteria) and definite diagnoses for each of the DSM-IV personality disorder diagnoses, as well as dimensional scores for each diagnosis.

Interrater reliability of assessment interviews was good to excellent for all Axis I and Axis II disorders, with kappas ranging from .59 for anxiety disorders to 1.00 for alcohol or substance dependence. The kappa for BPD was .64, and the ICC for dimensional criteria ratings was .86. All kappa and ICC coefficients were in the good-to-excellent range (Fleiss, 1971). More information about diagnostic interviews, interviewer training, and reliability procedures is available elsewhere (Critchfield, Levy, & Clarkin, 2005).

RANDOMIZATION PROCESS

Following an initial assessment to determine whether they met criteria for participation in the trial, patients were randomized to one of three year-long outpatient treatment conditions, using a simple randomization procedure administered by a person independent of the study in order to protect against unseen threats to validity and to minimize bias in assignment to treatment conditions.

This randomization process resulted in 31 patients being assigned to TFP, 29 patients to DBT, and 30 patients to SPT. Of these, one patient assigned to TFP was removed early in the study, when it became apparent that this individual had a psychotic disorder that had not been detected during the assessment. Additionally, one patient assigned to DBT withdrew from the study following randomization but prior to attending the first session.

PARTICIPANTS, INCLUDING THEIR BACKGROUND DEMOGRAPHIC CHARACTERISTICS

Patients included 90 adults (83 women; 92.2%) who were between the ages of 18 and 50. Patient demographics are presented in Table 5.1.

PRIMARY AND SECONDARY OUTCOME MEASURES

Suicidality, aggression, and impulsivity were selected as primary symptom outcome domains—because of their direct and specific connection to the psychopathology associated with BPD. They were measured as follows:

Table 5.1 PARTICIPANT CHARACTERISTICS

Characteristic	N	%
Gender		
Women	83	92.2
Men	7	7.8
Marital status		
Married	7	7.7
Divorced	40	44.4
Living with partner	11	12.2
In a relationship	21	23.3
Education		
Less than high school	3	3.3
High school graduate	7	7.8
Some college	28	31.1
Associate's degree	6	6.7
College degree	29	32.2
Graduate training	17	18.9
Employment		
Full-time	30	33.3
Part-time	23	25.6
Ethnicity		
Caucasian	61	67.8
African American	9	10.0
Hispanic	8	8.9
Asian	5	5.6
Other	7	7.8
Lifetime Axis I disorders		
Any mood disorder	69	76.7
Any anxiety disorder	43	47.8
Any eating disorder	30	33.3
Drug/alcohol abuse/dependence	34	37.8
Suicidal behavior		
Prior suicidal behavior	51	56.7
Prior parasuicidal behavior	56	62.2
No history of suicidal/parasuicidal behavior	15	16.7

Suicidality. The suicidality subscale of the Overt Aggression Scale—Modified (OAS-M; Coccaro, Harvey, Kupsaw-Lawrence, Herbert, & Bernstein, 1991) was used to assess patients' suicidality. The OAS-M is a 25-item clinician administered semistructured interview covering the areas of aggression, irritability, and suicidality.

Aggression. Patients' aggression was assessed using the Anger, Irritability, and Assault Questionnaire (AIAQ; Coccaro & Kavoussi, 1997). The AIAQ is a 28-item self-report version of the OAS-M designed to measure impulsive aggressive behaviors and attitudes. It generates four scales: anger, irritability, verbal assault, and direct assault. It covers the past week, past month, in addition to past behaviors extending to childhood.

Impulsivity. The Barratt Impulsiveness Scale—II (BIS-II; Patton, Stanford, & Barratt, 1995) was used to assess impulsivity. The BIS-II is a 34-item self-report measure, with items rated on a 4-point Likert scale (from "Rarely/Never" to "Almost Always/Always"). The BIS-II consists of three factors: attention, motor/acting without thinking, and nonplanning. It is the most widely known and used measure of impulsivity. These factors are also referred to as Factor 1, 2, and 3, respectively.

Anxiety, depression, and social adjustment were considered secondary-outcome domains because they are associated with a range of psychological disorders, including BPD. These were measured as follows:

Anxiety. The anxiety subscale of the Brief Symptom Inventory (BSI; Derogatis, 1993) was used to assess anxiety. The BSI is the 53-item short form of the Symptom Checklist-90-R (SCL-90-R) and measures nine domains of distress and symptomatology, including measures of depression, anxiety, hostility, somatization, and psychosis.

Depression. The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) was used to assess depressive symptoms. The BDI-II is a 21-item self-report questionnaire, which measures cognitive, somatic, and behavioral indices of current depression; each item is rated on a scale from 0 to 3.

Social adjustment. The patients' SCID-I interview, using both interviewer ratings, was used to derive a social adjustment scale using the Global Assessment of Function (GAF) scale, called the "GAF Social Adjustment" measure (First et al., 1997). A second measure of social adjustment was derived from the Social Adjustment Scale ("SAS Social Adjustment"; Weissman & Bothwell, 1976). The SAS is a semistructured interview that assesses social functioning and adjustment in five domains: work (employment, housewife, student), social and leisure activity, relationships with extended family, marital role and parental role, as well as an overall global adjustment score, which comprises the SAS Social Adjustment score. This instrument has high test-retest reliability (.80). The primary and secondary outcome variables were assessed at four time points: baseline, 4 months, 8 months, and 12 months (end of the treatment period). Each patient in the RCT was measured on these variables at roughly the same intervals.

TFP-SPECIFIC, STRUCTURAL MEASURES

A distinctive aspect of the TFP model (but not the DBT or SPT models) is the incorporation of two major concepts of psychoanalytic theory—attachment organization and reflective functioning (RF), or mentalization. We therefore predicted that TFP would have a more positive impact on these two variables than would DBT or SPT. These variables, which were assessed prior to the beginning of treatment and after treatment had ended, were measured by means of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985). This semistructured interview consists of questions concerning the interviewee's experiences with childhood caregivers and the influence of these experiences on his or her adult personality. It is transcribed verbatim.

Attachment organization. Attachment organization was considered to be an important outcome domain given that the vast majority of BPD patients exhibit an insecure attachment organization, and given the predominance of interpersonal dysfunction associated with BPD (Levy, 2005). It was measured in two ways, derived from Main and Goldwyn's (1984) coding system: a Coherence of Narrative score and an attachment classification: secure, preoccupied, dismissing, unresolved, or "cannot classify" (Main et al., 2008).

Attachment organization is assessed based on the manner in which people discuss their childhood memories. There are five main AAI classifications: *Secure* individuals can discuss both positive and negative childhood memories coherently and openly, and appear to reflect on their thinking as they speak. *Preoccupied* individuals discuss childhood memories in an incoherent manner that suggests a lack of distance or perspective. *Dismissing* individuals discuss attachment relationships in either a devaluing or an idealized manner, with little use of concrete examples to support their view. The *Unresolved* classification represents a lack of resolution of experiences related to loss or trauma; unresolved individuals exhibit lapses in the monitoring of speech or reasoning in talking about traumatic experiences. The *Cannot Classify* category represents individuals who demonstrate contradictory or competing attachment patterns, or who fail to demonstrate a single state of mind with respect to attachment. AAI classifications do not appear to be influenced by social desirability, intelligence, or autobiographical memory not related to attachment experiences (Bakermans-Kranenburg & van IJzendoorn, 1993).

Reflective functioning (RF). This is an aspect of mentalization, defined as the ability to make inferences about the intent underlying behavior in oneself and others by evoking and reflecting on one's own experience (Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 1996). Fonagy, Steele, Steele, and Target (1998) have developed an RF score that can be derived from the AAI. Given that there is some association between low RF and a diagnosis of BPD (Fonagy et al., 1996), change in RF was considered to be a potentially relevant outcome variable. As with attachment organization, RF was assessed before and after treatment.

INTERVENTION, INCLUDING GUIDING CONCEPTION AND PROCEDURES

Transference-focused psychotherapy (TFP; Clarkin, Yeomans, Kernberg, 1999, 2006; Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989; Yeomans,

Clarkin, & Kernberg, 2015). TFP is a highly structured, manualized, twice-weekly modified psychodynamic treatment based on Kernberg's (1984) object relations model of BPD. The primary goal of TFP is to reduce symptomatology and self-destructive behavior by modifying disparate and split representations of self and others characteristic of BPD (Levy et al., 2006). TFP begins with explicit setting of the frame or contract-setting to clarify the conditions of therapy, the method of treatment, the hierarchy of behaviors to be addressed during sessions, the roles of patient and therapist in treatment, and the management of suicidal urges and behavior. The setting of the frame is a collaborative process that involves a diagnostic assessment using Kernberg's structural interview (Kernberg, 1984). The interviewing phase typically takes between 2–3 sessions and involves acquiring a complete symptom picture as well as information about the patient's relationship and work functioning. A central aspect of this assessment involves assessing the patient's descriptions of self and important others in order to understand the patient's level of differentiation and integration of self and other representations.

The information gathered during the structural interview is then used to set the treatment frame with the patient, which is established before beginning therapy. The process is a collaborative one in which the therapist presents the rationale for elements of the therapy, and the patient discusses any concerns he or she may have. The therapist combines flexibility and openness to discussion with adherence to essential aspects of the treatment. In addition to defining the responsibilities of patient and therapist, the structure provided by the contract protects the therapist's ability to think clearly and reflect, provides a safe place for the patient's dynamics to unfold, and sets the stage for exploring and interpreting the meaning of deviations from the frame such as missing or coming late to sessions or withholding details about suicidality. When there are deviations from the frame, referring back to the contract supports the patient's capacity to step outside of the moment and to view his or her behavior from alternate perspectives. An implicit message in the establishment of the contract is that all feelings can be experienced and reflected upon, in contrast to the patient's felt need to manage threatening aspects of affective experience through acting out and projection. The establishment of an agreed-upon frame can take another 2–5 sessions. It is important that the patient has the chance to express any concerns and conversely that the therapist explore any superficial acquiescence on the patient's part.

Once the contract is set, the primary focus of TFP in session is on the affect-laden themes that emerge in the relationship between BPD patients and their therapists. During the first year of treatment, TFP focuses on containing acting-out behaviors, as well as identifying and recapitulating the patient's predominant relational patterns as they are experienced and expressed in the here and now of the relationship with the therapist. To effect change, the therapist uses the techniques of clarification, confrontation, interpretation, and transference interpretation (interpretation of patient–therapist interactions in session that demonstrate the patient's split perceptions of self and other).

In TFP, interpretation is viewed as the route to integrating the disparate perceptions and representations of self and other that are characteristic of BPD. As the

split representations of self and other and dysfunctional relational patterns typical in this population are likely to arise in the relationship with the therapist, transference interpretation is viewed as one of the primary ways to effect change. TFP consists of two weekly individual sessions, typically of 45 or 50 minutes depending on what is the therapist's typical "therapy hour." Phone contact with the therapist between sessions is discouraged except to reschedule or, in the case of an emergency (understood to mean a significant and unexpected life event such as the death of a loved one, and not emotional upset or suicidal ideation, which is frequent and not unexpected in this population), in order to ensure that the action takes place within the twice-weekly sessions.

Sessions typically occur twice weekly, but the length of the treatment may vary. Unlike typical short-term structured manuals, the TFP manual is not written for a specific time frame nor is it highly structured. Rather it is principle-based, like that of Linehan's manual. Similar to Linehan, who conceptualizes treatment of BPD as being a multiyear process, TFP is a long-term treatment; however, for the purpose of the RCT treatment, length has been artificially constrained to a year for all treatments. Similar to studies of DBT (Linehan et al., 1993, 1994), patients in our RCT had the option of continuing in treatment past the initial year that the study assessed for purposes of testing its efficacy. In the TFP manual, treatment is conceptualized as having four phases: (1) the assessment phase; (2) the early treatment phase characterized by tests to the frame such as lateness or purposeful withholding and containment of impulsive behavior, such as suicidality; (3) the midphase characterized by movement toward integration and identity consolidation but with continued episodes of regression; and (4) the advanced treatment and termination phase. Phases 3 and 4 correspond to Howard and colleagues' (1996) conception of remediation and rehabilitation, with remediation being characterized by symptom improvement and rehabilitation characterized as personality change.

Dialectical behavior therapy (DBT). DBT is a manualized cognitive-behavioral treatment for BPD with two components: (1) individual therapy and (2) group skills training (Linehan, 1993). There is a weekly session of each. One of the guiding principles of this form of treatment is finding a balance between encouraging the patient to change and accepting the patient as he or she is. As such, the treatment integrates change-focused strategies such as problem solving with acceptance and validation of the patient's experience.

The individual therapy component focuses on an identified hierarchy of target behaviors, with suicidal and parasuicidal behaviors at the top, which the patient tracks using daily diary cards. "Behavioral chain analysis," which identifies the functional pattern and sequence of events, cognitions, and emotions resulting in these target behaviors is used in order to help the patient identify what triggers the behavior and alternative strategies for coping.

The group component consists of skills training intended to help patients develop more adaptive means of coping with seemingly intolerable emotions, instead of resorting to behaviors that may be destructive to the patient and to his or her relationships. Skills training sessions consist of teaching new skills to

patients and providing homework for patients to attempt between sessions in order to practice and reinforce these skills. Skills taught in DBT include mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Skills are integrated into individual treatment when problematic situations, such as suicidal or parasuicidal urges, present themselves. Therapists help patients identify appropriate skills to use in place of maladaptive coping strategies, with the hope that patients can eventually apply the skills on their own in order to function in a more adaptive manner.

Therapists are available via pager between sessions for brief coaching to help patients fight parasuicidal urges and engage in appropriate means of coping with intense emotions and stressful life events.

Supportive psychotherapy (SPT). SPT is a manualized, psychoanalytically oriented treatment for BPD (Appelbaum, 2005) adapted from a commonly used psychodynamic supportive psychotherapy (Rockland, 1989, 1992). Sessions are once or twice weekly. The primary goal of SPT is to bring about changes through the development of a healthy, collaborative relationship with the therapist, and to replace self-destructive enactments with verbal expression of conflicts. Instead of using interpretation to achieve these goals, as in TFP, in SPT, change is thought to occur through the patient's identification with the reflective capacities of the therapist.

As in the other two treatments, SPT begins with a contract-setting phase, and the initial stages of therapy focus on behaviors that threaten the patient's safety, interfere with therapy, and disrupt psychosocial functioning, as priorities for treatment. Another focus of the initial stages of SPT is fostering an atmosphere of safety and security, as well as a sense of collaboration between patient and therapist. Therapists are attuned to the type of transference the patient experiences, as well as the dominant affect associated with it; they accept and use any positive transference the patient may experience, but they refrain from interpreting transference.

SPT also utilizes supportive techniques, such as describing significant aspects of the patient's self in order to encourage greater identity consolidation, fostering the patient's sense of agency and mastery of impulses and emotions, and encouraging socially acceptable ways of expressing impulses (such as exercise or creative expression). Emotional support, advice, and direct environmental intervention may also be provided. Therapists foster the alliance and encourage mentalization and identification of defensive processes, but they also provide reassurance and advice in a manner consistent with other psychodynamic supportive psychotherapies (Adler, 1985, Wallerstein, 1986).

Comparison among treatments. In relation to TFP, the SPT treatment was conceptualized as a component control condition, with the proposed active ingredient of TFP (transference interpretation) being proscribed in this modality.

In relation to TFP, the DBT treatment was particularly different concerning the frame of the therapy. To avoid the secondary gain that can be experienced by extra contact with the therapist and to encourage the development of autonomy (Yeomans, 1993), 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) versus strategies used in DBT, including validation, coaching, and cheerleading, that may temporarily suppress, but not integrate negative internal forces. Still another difference between TFP and DBT is that while both deal with emotionally laden thoughts, in DBT these thoughts are examined in relation to specific behavioral situations in the patient's life, whereas the cognitions in TFP tend to be related to internal representations of important people and relationships in the patient's life.

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.

THERAPISTS

Therapists were selected on the basis of having previously established competence in their respective treatment modality (TFP, DBT, or SPT). All possessed advanced degrees in social work, psychology, or psychiatry, and had at least 2 years of experience treating BPD patients. The TFP therapists were eight experienced individuals with postdoctoral training. Their experience level ranged from faculty/staff psychiatrists with at least 10 years of experience to faculty/staff psychologists with at least 2 years of experience treating BPD patients and specific training in TFP.

The DBT therapists were five experienced individuals with postdoctoral training. Their experience level ranged from faculty/staff psychologists with 10 years of experience to faculty/staff psychologists with at least 2 years of experience treating BPD patients. Importantly, all the DBT therapists had specific training in DBT (all therapists having attended multiple intensive trainings with Linehan or other certified trainers) and were therapists within the Cornell and Columbia medical school day-hospital DBT programs.

The SPT therapists were seven experienced individuals with postdoctoral training. Their experience level ranged from faculty/staff psychiatrists with at least 15 years of experience to faculty/staff psychologists and social workers with at least 2 years of experience treating BPD patients and specific training in SPT.

PROCESS OF IMPLEMENTING THE RCT

Each of the three treatment groups was administered and supervised by a recognized expert in that treatment modality; TFP was supervised by Frank Yeomans, DBT was supervised by Barbara Stanley, and SPT was supervised by Ann Appelbaum. These treatment condition leaders selected a total of 19 therapists based on their previously established competence in their respective modality. Therapist characteristics are described earlier. All therapists were monitored and supervised weekly by the treatment condition leaders, who were available

to observe videotapes of sessions, provide feedback, and who rated therapists on their adherence and competence within their respective modality.

In addition to being assigned to a year-long therapy condition, all patients were evaluated for pharmacotherapy at entry into the study. Study psychiatrists were blind to treatment group assignments. To reduce subjectivity in deciding on medication, a medication algorithm was used to guide psychopharmacological treatment (Soloff, 2000).

Results

The present analyses are based on the patients who completed at least three assessments, which includes $n = 23$ in TFP, $n = 17$ in DBT, and $n = 22$ in SPT. These patients were deemed to have received a sufficient "dose" of treatment, having completed at least 9 months of the year-long treatment.

MEDICATION TREATMENT AT THE START OF TREATMENT

Based on the medication algorithm mention earlier, at the start of treatment, 52% of TFP patients, 70% of DBT patients, and 65% of SPT patients were prescribed medication, and the percentage of patients on medication remained relatively constant during the treatment period. Given that there were no differences between the three groups of patients on symptom domains assessed at the start of treatment, differences in the percentage of patients prescribed medication could not be attributed to differences in severity across the treatment groups.

PRIMARY AND SECONDARY OUTCOME MEASURES

Individual growth-curve analysis. The individual growth-curve approach hypothesizes that for each individual, the outcome variable is a specified function of time called the individual growth trajectory (comprised of two unknown individual growth parameters—an intercept and a slope—that determine the shape of individual true growth over time), plus error. The individual intercept parameter represents the net "elevation" of the trajectory over time. The individual slope parameter represents the rate of change over time and in this study is the within-person rate of change in the dependent variable over time. Individual growth trajectories were specified at level 1 and capture individual change over time. A level two model was then used to investigate the way that the individual growth parameters at level one are related to between-subjects factors. More information about the analytic procedures used is available elsewhere (Clarkin et al., 2007; Levy et al., 2006).

We used an unconditional growth model, which revealed that for all the domain dimensions, the average elevation for all three groups of patients differed significantly from zero ($p < .001$). These findings indicate significant levels of distress and impairment was present in our sample. This was expected, since borderline personality disorder patients are substantially impaired.

We also found that the estimated average rates of change (i.e., slopes) also differed significantly from zero for all of the domain dimensions except for the Barratt Factor 3 impulsivity and anxiety dimensions, indicating that much change over time was evident in the data (all $p \leq .05$).

First we examined whether the age at which a participant entered the study was related to change on the various domain variables. Age at entry into the study was not associated with the initial level of symptoms, or with change in most symptom domains; and age at entry was not included in further analyses.

The next second set conditional analyses we investigated were the impact of the three treatments on the level and rate of change (slope). The results of these level 2 conditional analyses are presented in Table 5.2. The prediction of slope (change) at level 2 by each of the three treatments was significant for depression, anxiety, global functioning, and social adjustment (all $p < 0.05$). The direction of effects was toward symptom improvement. Both transference-focused psychotherapy and dialectical behavior therapy were significantly associated with improvement in suicidality over time, and both transference-focused psychotherapy and supportive treatment were significantly associated with improvement in anger over time. Only transference-focused psychotherapy was significantly predictive of symptom improvement in Barratt Factor 2 impulsivity, irritability, verbal assault, and direct assault. Supportive treatment alone was predictive of improvement in Barratt Factor 3 Impulsivity. None of the three treatments was associated with improvement in Barratt Factor I impulsivity.

Thus, transference-focused psychotherapy predicted significant improvement in 10 of the 12 variables, dialectical behavior therapy in 5 of the 12 variables, and supportive treatment in 6 of the 12 variables.

Contrast analyses and intent-to-treat analysis. Contrast analyses (Rosenthal, Rosnow, & Rubin, 2000) were used to statistically test specific predictions about primary outcome symptom differences across the three treatments based on previous research and content focus in the treatment manuals. Two of the main ones included the prediction that DBT would lead to significantly lower levels of suicidality, and TFP, to significantly lower levels of anger. Although the latter prediction was not confirmed, the former yielded a contrast that approached significance ($p < .07$; Clarkin et al., 2007): TFP and DBT were associated with a greater improvement in suicidality than SPT, and there was no difference between TFP and DBT on this variable.

An intent-to-treat analysis (Clarkin et al., 2006) was also conducted in order to determine whether patients dropping out of treatment groups impacted the pattern of findings across treatments compared to when analyses were restricted to patients who completed the treatment. The results indicated that patient attrition did not change the pattern of results.

CHANGE IN TFP-SPECIFIC OUTCOME DOMAINS

Attachment. Because patients were administered the AAI only before and after treatment, only those patients who completed treatment could be included in these analyses.

Table 5.2 RESULTS OF CLARKIN ET AL. (2007) RANDOMIZED CLINICAL TRIAL

Symptom-Based Measures	Significance of Change		
	TFP	DBT	SPT
PRIMARY			
Suicidality ^a	<.05	<.05	<i>ns</i>
Anger ^a	<.05	<i>ns</i>	<.05
Irritability ^a	<.05	<i>ns</i>	<i>ns</i>
Verbal Assault ^a	<.05	<i>ns</i>	<i>ns</i>
Direct Assault ^a	<.05	<i>ns</i>	<i>ns</i>
Barratt Factor 1 Impulsivity: Attention ^b	<i>ns</i>	<i>ns</i>	<i>ns</i>
Barratt Factor 2	<.05	<i>ns</i>	<i>ns</i>
Impulsivity: Motor/Acting Without Thinking ^b			
Barratt Factor 3	<i>ns</i>	<i>ns</i>	<.05
Impulsivity: Nonplanning ^b			
SECONDARY			
Anxiety ^c	<.05	<.05	<.05
Depression ^d	<.05	<.05	<.05
GAF Social Adjustment ^e	<.05	<.05	<.05
SAS Social Adjustment ^f	<.05	<.05	<.05

NOTE: All significant change was in the direction of less impairment.

^aSuicidality, Anger, Irritability, Verbal Assault, and Direct Assault were assessed with the Overt Aggression Scale—Modified version (OAS-M; Coccaro, Harvey, Kupsaw-Lawrence, Herbert, & Bernstein, 1991) and the Anger, Irritability, and Assault Questionnaire (AIAQ; Coccaro & Kavoussi, 1997).

^bBarratt Factors are from the Barratt Impulsivity Scale (Patton, Stanford, & Barratt, 1995).

^cAnxiety was assessed with the Brief Symptom Inventory (BSI; Derogatis, 1993).

^dDepression was assessed with the Beck Depression Inventory (Beck, Steer, & Brown, 1996).

^eGAF represents the DSM-III Global Assessment of Functioning scale score (First et al., 1997).

^fSAS represents the Social Adjustment Scale (Weissman & Bothwell, 1976).

Prior to the start of treatment, patients' attachment classifications were as follows:

- 3 (5%) were classified as securely attached,
- 9 (15%) were classified as preoccupied,
- 18 (28.3%) were classified as dismissing,
- 19 (33.3%) were classified as unresolved, and
- 11 (18.3%) were coded as "cannot classify."

Following the treatment process, a total of 9 patients (15%) were classified as securely attached across the entire sample, which represented a significant change

enhancing the motivation of the therapists in the Schema-Focused Therapy group (Chalmers et al., 1981). In light of these issues, it would be premature and irresponsible to conclude that TFP is less efficacious than SFT on the basis of this one rather flawed study.

Because the different models are based on different theories of change, our overall finding of the equivalence of TFP, DBT, and SPT suggests that there may be different routes to improvement. In DBT, there is a focus on direct, behavioral skills training to help patients regulate emotions and reduce symptoms; in TFP, there is a focus on developing greater self-control through integrating representations of self and others as they become active in the therapeutic relationship, with a particular use of transference interpretation; and in SPT, the focus is on a supportive relationship and using the therapist as a model of reflection, without the use of transference interpretation. Both future group studies and future case studies like the ones described later in this chapter will be helpful in comparing and contrasting these different theoretically based routes to improvement in patients with DBT.

As summarized in Table 5.2, the fact that of the eight primary symptom variables, TFP was statistically significantly associated with improvement in six; DBT, with improvement in one; and SPT, with improvement in two suggests that TFP has a particularly efficacious impact on the primary symptom variables.

Future research will need to examine (a) whether the overall improvements in primary outcome symptoms across the three therapies are maintained over time; and (b) whether the improvement differences in the outcome measures we found hold up with larger samples and, if so, how these improvement differences are related to the differences in the theories behind the TFP, DBT, and SPT treatments (Clarkin & Levy, 2006).

Finally, our hypotheses about the greater ability of TFP to effect structural personality changes in patients with BPD were confirmed, indicating the statistically significant superiority of TFP in effecting improvements in healthy attachment, in reflective functioning, and in narrative coherence. This confirmation provides additional evidence of the theoretical promise of TFP and its ability as a treatment to effect the positive personality changes that underlie and sustain symptomatic change.

THE CASE STUDIES

The Nature and Rationale for the Specific Cases Selected for the Case Studies

Of the 30 patients randomized to TFP, we have chosen two patients who are illustrative of the process of treatment in TFP, and yet each experienced and responded to like interventions in distinct ways that were reflected in differential outcomes. The two patients, Ms. J and Ms. V, were both women in their early 30s who presented for treatment after having little benefit from prior psychotherapies

and pharmacotherapies as well as little success in past work environments. Both women were diagnosed with BPD and randomized to the same therapist in TFP. The therapist was male and an experienced clinician who had practiced and supervised TFP for many years. Each patient was treated twice-weekly in his private practice office in close proximity to the affiliated medical center sponsoring the RCT. As part of the RCT, each patient agreed to be treated in 1 year of TFP. However, at the end of that year each patient was offered the option of continuing treatment in the therapist's private practice. Although the primary focus of the summaries of these cases will be on the year when the RCT was conducted, changes and developments subsequent to the RCT will be discussed as well.

Despite similarities, these two women also differed in a number of respects that shall be elaborated on in their respective summaries. The cases differ in the trajectory of change observed—however, it is important to note that in assessing change we are not limiting ourselves to symptomatic change on self- and clinician-report measures. In fact, one of the explicit goals of TFP is to take the patient beyond symptom change and strive toward structural change—a process of integration of disparate aspects of personality functioning. It has been observed empirically that although many patients with BPD become less symptomatic over time when evaluated longitudinally, impairments in work and relationship functioning tend to persist (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010a, 2010b). By enacting change at the level of personality organization, TFP seeks not only to decrease impulsive and aggressive behaviors but also to increase the capacity to create, enjoy life, develop intimacy, and invest in goals and relationships. Though both women were less symptomatic in terms of the primary outcome measures after 1 year, they differed considerably in terms of the degree of structural change that was accomplished.

The Clients

Ms. J, A CLIENT WITH A POSITIVE OUTCOME

Ms. J was a single, unemployed Asian woman who started TFP at age 32 after having been in psychotherapeutic and psychiatric treatments since age 17 with no demonstrable change. In fact, her condition had worsened to the point where she spent the 6 months prior to beginning TFP isolated in her apartment, watching television, eating and gaining weight, and only rarely bathing. She presented for treatment because of depressed mood with chronic suicidal ideation, occasional self-destructive behavior, anger and irritability, and very poor interpersonal and work functioning.

Ms. V, A CLIENT WITH A NEGATIVE OUTCOME

Ms. V, a 33-year-old single Caucasian woman, was referred for TFP by staff at the hospital where she had been receiving outpatient psychotherapy. V was unemployed and depended on medical disability benefits to pay her expenses. V, who had a history of abusing alcohol, led a very limited life. She lived in a subsidized

apartment and had no regular activities outside of the treatments she had participated in and AA meetings two or three times a week. She had not worked or studied in many years. She had limited social involvements, having coffee with friends from AA and having an intermittent and stormy relationship with a boyfriend with no plans for settling down in a permanent relationship or establishing a family. She had been treated in just about every inpatient, partial, and outpatient program in the hospital associated with the RCT for the previous 10 years with little benefit.

Guiding Conception With Research Support

The guiding conception as well as relevant research that informs this case study is presented in "Intervention, Including Guiding Conception," in the Method section in the description of the RCT Study earlier.

Ms. J's Positive-Outcome Therapy: Assessment, Formulation, and Course

ASSESSMENT OF MS. J'S PROBLEMS, GOALS, STRENGTHS, AND HISTORY PRESENTING PROBLEMS

J was a 32-year-old woman who had immigrated to the United States from Asia as a young child with her parents. She had been referred by a psychiatrist psychoanalyst she consulted with after reading about borderline personality. She was concerned that she had experienced little benefit from a number of psychotherapies and pharmacotherapies over the last 15 years that had considered her diagnosis to be bipolar disorder. While she presented with self-destructive, angry, and irritable behaviors that led to the destruction of many relationships and jobs, in the 6 months prior to treatment she had withdrawn from social and occupational functioning altogether and had rarely left her apartment.

In terms of relational functioning, a striking feature of J's presentation was her attribution of hostile intentions to others, and a tendency to locate her own anger as residing within others rather than herself (i.e., projection). For example, her first words on entering her therapist's office for the first time were: "The woman on the bus was staring at me. I could tell she hated me, so I stared right back!" J did not have insight into the fact that she may be eliciting, and not just subject to, hostile interactions. Aside from past stormy interactions with coworkers, J had no friends. She dated occasionally but had no history of sexual relations.

History

J was the middle daughter in a highly educated family and her father was a successful professional. J's education ended when she dropped out of school at age 25 after 1 year of postcollege training in a technical field. After that she held a series of semiskilled jobs but was repeatedly fired from these jobs because of her

difficulty getting along with others. She stopped working when she began to get rejected from every job to which she applied. She attributed this to an irrational prejudice against her, denying that her behavior and attitudes had any role in her interpersonal difficulties.

BPD Features

J's scores on the standardized measures, both at intake and at 1 year, are shown in Table 5.4. To put these scores in context, the clinical cutoff point for each measure is presented where available, along with the means of Ms. V, the other patient described here, and the TFP group means at both those time points. As can be seen, relative to other patients in the TFP group, J's scores were more impaired in a variety of areas. Specifically, on the primary aggression symptom scores, J presented with higher levels on the irritability score ($J = 1.91$; TFP $M = 1.79$); verbal assault score ($J = 2.44$; TFP $M = 1.58$); the direct assault score ($J = 1.00$; TFP $M = .68$); and the nonplanning component of the Barratt Factor 3 impulsivity score ($J = 23.00$; TFP $M = 21.38$).

On the secondary symptom scores, J was more impaired in social functioning, as reflected in her two social adjustment scores (on the GAF scale [$J = 40.00$; TFP $M = 51.82$] and on the SAS scale¹ [$J = 7.00$; TFP $M = 4.53$]). Also J was more depressed ($J = 55.00$; TFP $M = 42.17$).

Consistent with these scores, J evidenced many of the clinical features characteristic of patients with BPD: emotional instability, behavioral instability, relational instability, and identity instability (or identity diffusion). In fact, on a structured diagnostic interview for personality disorders (IPDE; Loranger, 1999) the clinician confirmed the presence of all nine of the *DSM-IV* criteria for BPD. She additionally met criteria for narcissistic personality disorder (NPD; 7 of 9 symptoms endorsed) and for avoidant personality disorder (APD; 4 of 7 symptoms endorsed).

In terms of primary outcome domains, J had a history of episodes in which she would self-injure in the context of chronic suicidal ideation that included a combination of despair and anger. Although J did not present with active suicidal behavior in the month prior to the initial assessment on the OAS-M, she did present with some self-injurious behaviors in the form of superficially cutting her arms. J's elevated aggression scores in Table 5.4 were reflected in instances of verbal anger and irritability toward strangers (e.g., angrily accusing people she encountered such as salespeople, bus drivers, and security officers of being rude to her, sometimes filing complaints that seemed to be based on very little). Moreover, given that the time period evaluated was over the prior month, during which she had been shut in her apartment, her aggression measures were thought to underestimate her capacity for verbal aggression.

In terms of measures of attachment organization, which are thought to be specifically targeted in TFP (Levy et al., 2006), J presented on the Adult Attachment

1. On this measure, higher scores reflect more impairment.

Table 5.4 CONTINUED

Measure	Clinical Cutoff Point	TFP Mean at Intake	TFP Mean at 1 Year	Ms. J at Intake	Ms. J at 1 Year	Ms. V at Intake	Ms. V at 1 Year
SECONDARY OUTCOME							
Anxiety	1.5	1.64	1.16	1.33	0.67	2.83	0.50
Depression	14	42.17	35.27	55.00	26.00	54.00	27.00
GAF Social Adjustment	70	51.82	60.38	40.00	45.00	50.00	60.00
SAS Social Adjustment	na	4.53	4.04	7.00	5.00	5.00	3.00
STRUCTURAL MEASURES							
Reflective Functioning	5	2.81	4.11	-1.00	6.00	3.00	3.00
Coherence of Narrative	5	2.93	4.02	1.50	4.00	2.50	3.00

NOTE: Lower scores indicate less impairment, except for GAF Social Adjustment, Reflective Functioning, and Narrative Coherence, which are the reverse. For citations on the scales, see Tables 5.2 and 5.3.

Interview (AAI) with the attachment style labeled "Cannot Classify" (CC). The name of the CC category is deceptive, in that it implies a style that could not otherwise be specified, when in fact the CC style is distinctive in its vacillations between contradictory or competing attachment patterns. In the context of her narrative of attachment relationships, J was observed to swing between a preoccupied style of angry and entangled descriptions that suggested a lack of distance from these early experiences, and a dismissive style in which attachment relationships were discussed in devaluing and derogatory terms. These were often not supported by examples that might flesh out the reasons for her contempt. The dramatic swings in the narrative—from needy and overinvolved to distant and unconcerned—resulted in little coherence overall (as reflected in her narrative coherence score of 1.5).

The AAI was also evaluated for the level of reflective functioning (RF; Fonagy et al., 1998), which assesses the capacity for mentalization with regard to attachment relationships. As shown in Table 5.4, J's interview was rated a -1 , which is the lowest score allowable on the interview. When the measure was initially developed, $+1$ was the lowest score allowable and reflected a disavowal of reflection on relationships (e.g., "I have absolutely no idea why my mother would do that, not a clue"). However, Fonagy and colleagues found that when seeking to apply the scale to a forensic sample they observed an even more dramatic type of disavowal of reflection in which the very act of being asked to reflect on the mental states of attachment figures was experienced as a hostile affront (e.g., "How dare you ask me why my mother would do that, only a monster parading around like a psychologist would ask such a thing"). J evidenced many instances of these kinds of antireflective statements in which the very act of clarifying attachment experiences on the part of the interviewer was experienced as an intrusive aggression.

The initial stages of TFP involve not only diagnostic and attachment interviews but also a structural interview (Kernberg, 1985) that evaluates the level of integration of the patient's internal representations of self affectively related to others. J said at one point in the structural interview that she had never had sexual relations, and at another point that she considered herself promiscuous. While clarification led to understanding that she considered herself promiscuous in her fantasy life, it was clear that J's sense of self was characterized by identity diffusion—her self-perception fluctuated according to how she felt about herself internally at a given moment, rather than a stable sense of self anchored in the realities of her external life. This assessment by the therapist, although not coded or categorized by a rating scale by the therapist, was consistent with the ratings shown in Table 5.4 made by independent coders based on a separate independent assessment, including the aforementioned reflective functioning score (Clinical Norm = 5; TFP = 2.81; J = -1.50) and narrative coherence score (Clinical Norm = 5; TFP = 2.93; J = -1.50).

In terms of treatment history, J had three brief psychiatric hospitalizations. J's past outpatient therapists and pharmacologists most often diagnosed her as bipolar, and she had had many trials of neuroleptics, antidepressants, anxiolytics, and mood stabilizers; she was on a mood stabilizer with questionable efficacy when she began TFP. A diagnostic assessment indicated that her affective instability was

characterized by dramatic shifts in mood that were short lived and context driven, with no indication of persistent mood episodes, necessitating a change of diagnosis from bipolar to borderline personality disorder.

Despite these challenges, J also evidenced a number of strengths. J was clearly intelligent and articulate; her interpersonal difficulties in occupational and academic settings seemed to be in spite of her possessing genuine skills. Furthermore, J was also motivated for treatment; despite reticence about her therapist's capacity and intention to help her, she clearly wanted to improve her mood, relationships, and work functioning.

Ms. J's FORMULATION AND TREATMENT PLAN

J presented with a combination of labile emotions, intense negative affects, identity diffusion, and primitive defenses (e.g., projection) that indicated both a diagnosis of BPD and a poor level of integration in the patient's internal representational world. Narcissistic features were also present in a chronic devaluing and contemptuous stance toward others despite the patient's failure to succeed in the very same areas in life that were the focus of her criticism (e.g., calling others "losers" for not achieving more occupationally).

In formulating a treatment plan, TFP utilizes a hierarchy of priorities that first emphasizes the safety of the patient and, secondly, emphasizes the stability of the continuing treatment. Despite a past history of self-injury in the context of suicidal ideation, at the start of treatment her suicidal ideation, although chronic, was passive and of low intensity.

While vigilant for changes in her mental status that might put her safety at risk, the therapist planned to focus primarily on aspects of the patient's presentation that were most likely to impede her utilization of the treatment and her achieving higher levels of occupational and relational functioning. In this regard the therapist was most impressed with the level of aggressive affect that J consistently attributed to others. Her hostile attributions led to accusatory and inflammatory behaviors that had toxic effects in all past work, academic, and relationship contexts. Furthermore, aggressive affect was observed to be manifesting in the treatment almost immediately, with responses of condescension and contempt to relatively benign questions by the therapist. Whereas her emerging anger and mistrust toward the therapist presented a risk to the continuity of the treatment, from a TFP perspective it also created an important opportunity in that the patient's core dynamic was activated in the immediate experience of the therapist, and therefore subject to reflection and modification.

Furthermore, the therapist's formulation of J's aggressive affect also included its potential protective function—her pervasive anger precluded experiencing and metabolizing other emotional experiences that may have been too painful to experience. With so many lost relationships and squandered opportunities in her past, J had much to mourn; however, her pervasive anger seemed to keep potential sadness, regret, and shame at bay, with periodic but intense surges of despair in the form of suicidality. That is, her unrelenting anger created an obstacle to her understanding and effectively acting on a wider repertoire of emotions.

The therapist hoped that working with the patient's narratives of her experiences of herself in relation to others, in combination with her way of experiencing the relationship with him, would help her become more aware of the full range of her affects and more able to incorporate them into an integrated and harmonious identity.

The treatment plan was for twice-weekly TFP for 1 year. After the diagnostic assessment, the therapist provided the patient with a layman's description of his diagnostic impression and then went on to discuss the treatment contract. The therapist's discussion of the diagnosis with the patient represents a psychoeducational element of TFP. It is considered necessary to have some common ground in the therapist's and patient's understanding of the latter's difficulties in order to have a meaningful discussion of the rationale for the treatment that will be recommended. The therapist first explained that we can think of personality in general as the spontaneous ways a person thinks and feels about himself/herself and others and the ways he/she spontaneously reacts to events in life. The therapist further described personalities as encompassing a broad range of personality traits and styles (e.g., introverted versus extraverted). He went on to explain that we think of a personality disorder when an individual's personality traits are (1) extreme and (2) inflexible in a way that does not permit successful adaptation to different life circumstances. With this broad concept of personality disorder in mind, he specified that the diagnosis that he felt best characterized her—borderline personality disorder (BPD)—involved difficulties in four areas: (1) emotions, which are experienced intensely and are rapidly shifting, (2) relationships, which tend to be characterized by confusion and conflicts, (3) behaviors, such as cutting in her case, that are an attempt to discharge distressing affects states, and (4) an underlying confusion and lack of clarity about her sense of self. He explained that this last characteristic of BPD is often the central problem in that the lack of a coherent identity can lead to a desperate sense of emptiness, difficulty in contextualizing and modulating affects, and confusion in a person's position in life and in relation to others. This discussion of diagnosis is essential to see if the patient will join the therapist in considering that her problems have a significant psychological component (in contrast, for example, with the view that the problem is exclusively biologically determined). I said that this understanding of her difficulties made sense to her.

With regard to the contract, in addition to the general requirements of treatment regarding attendance and participation in therapy, the therapist discussed parameters around self-destructive behaviors, which includes clear communications about the patient's responsibility for her own behaviors, as well as expectations of limiting the use of hospital visits to only the most acute crises. Another one of the first conditions of treatment was to become involved in a regularly scheduled activity. Although providing specific directives around participating in work or other structured activities is not usually associated with psychodynamic treatments, in our experience many patients with BPD often function below their occupational capacity, and this is often motivated by fear of interpersonal conflicts in such settings and/or the shame of working in a diminished role as evidence of

their having not thrived in life. At the time of assessment, J was avoiding life as a way of avoiding her shame, and this left her so socially isolated that addressing her experience of self in relation to others in the treatment would be of limited value. Therefore, part of the treatment-planning process involved coming to an agreement about what structured activities would be appropriate to increase the patient's level of functioning. The therapist explained to her that attending therapy sessions without any active engagement with others (the patient had been living a very isolated life) would likely be a sterile endeavor. J's initial response was that she could not work with others because they were prejudiced toward her and always rejected her. The therapist explained that he understood the interactions would be difficult but that one of the functions of the therapy sessions would be to explore and understand the difficulties she experienced interacting with others. J then found a part-time volunteer position tutoring high school students.

Ms. J's COURSE OF THERAPY

Early Phase of TFP Therapy, Sessions 1 to 24: From 1 to 3 Months

In the early stages of TFP, the therapist works to clarify the patient's experience of the self in relation to others and the accompanying affect (or the object relational dyad), both in external relationships and inside sessions with the therapist. From the first session, J's interactions with her therapist were characterized by a non-stop monologue that overrode any attempt he might make to speak. His initial attempts at intervention were to try to clarify the role of the patient in relation to the therapist in such moments. That is, her verbal domination had the effect of putting her in control, in response to which the therapist found himself feeling helpless. Thus, the dominant affects for each of them were frustration and muted anger. After being immersed in this experience for over a month, he began to direct her attention to this behavior, offered a description of it, and wondered with her what might motivate this controlling way of interacting. This interchange comes from the twelfth session.

T: It might help to look at the style of communication that's developed in these sessions.

J: I don't know what you're talking about.

T: You're telling me a lot of things, but there's a particular style you have of talking here.

J: So what?

T: It might help us understand something about how you feel about yourself and about others.

J: What do you mean?

T: Would you agree that you tend to talk nonstop here without leaving me much room to participate?

J: You told me to say everything on my mind—are you contradicting yourself now?

T: It's true that you're doing what I suggested, but there might be something to learn about how you're doing it.

J: What do you mean?

T: Would it surprise you to hear that the way you talk so rapidly and without stopping leaves me feeling a little “pinned down”?

J: “Pinned down”?

T: Yes, like it’s hard for me to participate, like I’m under a kind of control of yours.

J: That sounds like your problem.

T: It could be, but it involves you. I just wonder what would lead to your talking in a way that leads to this feeling of control . . .

J: (bursting into tears) If I didn’t control you, you’d leave me . . . like everyone else!

In this way, J began to reflect on the interaction she was displaying with her therapist. Such interventions brought into focus two object relational patterns. The first was what was visible on the surface: the patient rigidly controlling her therapist. The second was deeper—that of the abandoner and the abandonee. After describing J’s controlling behavior in a way that brought it to her awareness, the therapist began to become more aware of a subtle level of the interaction suggesting the longing for a relationship—a positive connection with desire for connection of a still unspecified nature (partly parental, partly friendly, partly romantic) that emerged at times in the tone of the interaction between them and that had been largely kept from view because of her controlling behavior. J’s anxiety about this possibility (feeling attached) seemed to motivate the controlling behavior since it was connected with the assumption of rejection. Starting in the third month of therapy, the therapist began a process of repeated clarification of this dynamic in the context of the therapeutic relationship. He would point out the hidden longing for connection, which J tentatively agreed with, and her pattern of responding to it by a controlling or rejecting gesture toward him. In the third to sixth month of therapy, J was able to access the longing for attachment and fear of abandonment that fueled her angry and controlling behavior, and she was able to begin to take a reflective stance in relation to her view of the therapist.

As a TFP treatment progresses, the therapist slowly works toward confronting discrepancies within the patient’s experience of self, as well as disparities between how the patient views himself or herself and acts in the world (including with the therapist). As previously noted, although J experienced herself as victim to the hostility and prejudices of others, she struggled to see and acknowledge how aggressive her condemnations of others could be. In sessions, this could take the form of her refrain that therapy was not helping and she may as well jump out the window. Outside of therapy it was reflected in actions such as threatening to report a security guard to her apartment building’s administration, and thus endangering his job, because she felt he had been rude to her. As the treatment progressed and J became more aware of her need to control the therapist out of fear of his abandoning her, the therapist began to gently confront J with the fact that it was she—not the therapist—who was placing distance between them as

they worked to form an alliance; that of the two of them she appeared to be the one who was on the verge of becoming fed up and leaving.

Although discrepant with her self-experience and its accompanying anxiety, she was intrigued by such observations and began occasionally to notice that while she often complained of others treating her harshly and rejecting her, she could treat others, including her therapist, in a similar way. In TFP terms, she became aware of oscillations within a dyad involving a critical abandoning person and the abandoned object of criticism. For example: "I guess I see now that when I say you're useless and that I may as well jump out the window, that I'm being hard on you and threatening to end the relation. Before I thought it was just telling you how bad I felt." Thus, in the initial months of therapy, J began to consider not only that her attributions regarding the therapist might not be accurate, but also that she could behave in the rejecting way she had experienced him behaving toward her. This was the beginning of her understanding of how she may project aggressive affects within her onto others; that experiences of anger that she felt to be happening in the external world may, in fact, be driven by her own internal world.

Middle Phase of TFP Therapy, Sessions 25 to 72: From 3 Months to 9 Months; and End Phase, Sessions 73 to 100, From 9 Months and Beyond

The phases of TFP overlap to some degree. Early-phase issues might still recur at points after middle-phase issues, like exploring oscillations of internal dyads, has begun. In the middle phase of TFP, the therapist begins to actively interpret the function of oscillations between dyads as experienced in the relationship with the therapist. The therapist begins to evaluate the motivation for the patient's rigid adherence to pathological patterns despite the damage caused to relationships and life goals. In a session 6 months into the treatment, J started as she often had by talking in a challenging and controlling way. However, building on the work they had done up to that point, her therapist was able to help her more quickly get to the point of reflecting on the interaction and considering emotional aspects of the situation against which she had been defending. She began by stating that she had been feeling suicidal and had taken "a lot of pills." After conducting an assessment and feeling assured that her safety was not at risk, the therapist tried to understand the affective and relational context of her suicidal gesture. In response, J said, "My wanting to kill myself has nothing to do with your going away." (The therapist was about to leave for 10 days.) The therapist pointed out that J's critical and controlling discourse might be related to a sense of humiliation if she was convinced he did not care about her, while there was indirect evidence that he and the therapy were important to her.

J: You say the same thing to every one of your patients! I'm not like all of them!

T: That's a powerful statement. It seems that you feel here like you're an object on an assembly line.

- J: [with sudden change from anger to sadness]: I don't feel that I deserve to be here . . . [covering her face with her hands]. I just feel badly that I have to walk around with other human beings. . . .
- T: I think you don't want me to see you in the longing that you feel. You don't mind if I see you in your anger and your rejection of me. You don't want me to see the longing, because you think I'll just use that to humiliate you, by rejecting, by turning away from you. (The therapist then suggested that her fear of rejection could explain the off-putting way in which she interacted—she might induce rejection to feel she controlled it.)
- J: You mean because I think that rejection is inevitable I try to confirm it, like by dressing this way [she typically dressed in an unkempt way]? I just feel like the tragedy of everything, of all of this, is that I have help available. . . . You're actually working with me . . .

An essential element of TFP is picking up on evidence of emotions that appear either at separate moments in time from the more predominant emotions, or that are communicated through the nonverbal or countertransference channels of communication in contrast to direct verbal communication. For example, despite her hostile and rejecting verbalizations, J communicated her deep commitment to the treatment through consistently and punctually attending appointments, giving significant thought to what the therapist said between sessions, and displaying apparent upset at his impending departure for a vacation.

In terms of the therapist's countertransference, his internal emotional experience of her, despite J's hostility, was a warm and a genuine interest in working with her and a feeling of commitment to and concern about her struggles. From this vantage point, the disparity between what she said with words and what she conveyed in behavior and evoked within the therapist became a meaningful point of intervention.

Interpretation of the motivations for the split between the idealized and persecutory segments of her mind helped to resolve her identity diffusion and bring about a coherent sense of self. J came to the understanding that she harbored an intense longing for the perfect caretaker/companion in life (the idealized segment) and that any failure in others' responses to her was perceived by her as harsh rejection and attack (the persecutory segment). She further came to understand that the attack she saw as coming from others corresponded to the aggressive response she experienced (but consciously denied) toward others when they disappointed her. As J shifted from talking about wanting to kill herself to what she was feeling toward her therapist, she moved from a dyadic interaction imbued with negative affect that served defensive purposes (an internalized critical other rejecting an unworthy abandoned self) to a dyad imbued with care and dependency. She was beginning to become aware of the part of her internal world that consisted of a harsh angry voice and was a condensation of aspects of her fiery temperament and internalized experiences of

criticism and rejection as she was growing up. She was also becoming aware of a part of her internal world that longed for an ideal loving connection. She continued, "I guess there's a longing in a way, 'cause I did come on time, I didn't really want to come, but I do long to come here, in a way, I guess I do. . . . I remember this boy in high school. I never thought he'd speak to me. One day . . ."

J's relinquishing her chronic, defensive, belligerent stance can be understood in relation to her having begun to reflect on negative affects she had consistently projected onto others. This process of reflection helped her see that the negative affects in relation to others—affects that had dominated her life for years—were not the whole story. Her therapist helped her understand that, in addition to existing in their own right, these negative affects protected her from an even more distressing prospect: the hopeless experience of having and then losing positive affects through rejection. J came to understand and acknowledge that, in fact, she very badly wanted to experience closeness and connection with others, but the fear of having and then losing intimacy led her to rage at the forgone conclusion of its loss. This awareness, in turn, allowed her to experience other, more positive and nuanced states of mind with regard to her therapist. In place of her extreme reactions based on the projection of the image of a powerful but indifferent and rejecting other, she could begin to see that he had genuine concern for her even if it did not correspond to her wish for a perfect caretaker who could perceive and take care of her every need.

En route to integration of the positive and negative mental representations of self and others, the TFP therapist is often alert to shifts in these representations, which may manifest as idealization of previously devalued others (and vice versa). With regard to intimate and sexual relations, while J had previously eschewed relationships with men, whom she expected to be predatory and rejecting, she began an early period of being attracted to narcissistic, unavailable men. She would initially idealize these men, as they idealized themselves, which precluded the development of deeper and more intimate relationships.

A subtle parallel process also began to emerge in the treatment, with J's erotic transference to the therapist suggested in moments of seductive posture toward him, although only rarely verbalized. When acknowledged, J's mention of sexual feelings toward the therapist alternated between an initial excitement followed by shame and a sense of danger. The therapist helped her to appreciate the multiple meanings and functions of her sexual feelings: On the one hand, she was beginning to allow herself to experience feelings of intimacy and vulnerability with the therapist that she had previously denied, while, on the other hand, she was doing this yet again with an unavailable man (the therapist) who could not respond to her wishes on that level. This awareness allowed her to begin to appreciate experiences of intimacy between herself and others in more nuanced and realistic terms.

The termination process with Ms. J is described later in this chapter in the section on her therapy outcome.

Ms. V's Negative-Outcome Therapy: Assessment, Formulation, and Course

ASSESSMENT OF MS. V'S PROBLEMS, GOALS, STRENGTHS, AND HISTORY PRESENTING PROBLEMS

V was a 33-year-old single Caucasian woman who presented for TFP by her outpatient psychotherapist. V had been unemployed for some time and depended on medical disability benefits. V led a very limited life. She lived in a subsidized apartment, spent time reading, and occasionally writing poetry. She had a history of alcohol abuse and attended two AA meetings each week. She had a boyfriend but reported regular conflicts with him. She was alienated from her family of origin. For 10 years, since the age of 23, the patient's activities centered on the hospital associated with the RCT. She was always in some form of treatment there, moving from inpatient stays for suicidal ideation, to the partial hospital program, to every form of individual and group therapy that the hospital offered. She also had trials of every type of antidepressant and antianxiety medication with little benefit.

In the first evaluation session, V responded to the therapist's question about why she was seeking treatment by calmly responding that she had "refractory depression." This surprised the therapist, because the outpatient staff had referred her to TFP for treatment because of their impression that she had a severe personality disorder.

History

V was the product of a volatile marriage that ended in divorce when she was 15 years old. Her parents were both physically aggressive with her as well as with each other, and at a young age she was exposed to their sexual improprieties that eventually led to the marriage dissolving. She also reported instances of physical abuse from her older brother, to which her parents turned a blind eye. As a result, she described often feeling in a heightened state of vigilance and terror, a feeling she began to numb with alcohol in her late teens. However, at the start of treatment she had maintained abstinence from alcohol for a number of years.

BPD Features

At intake, there appeared to be a discrepancy between V's self-report on the standardized measures and the clinician's assessment of V's functioning. Upon initial evaluation on a structured diagnostic interview for personality disorders (IPDE; Loranger, 1999), the clinician diagnosed V with BPD (six of nine symptoms endorsed). She additionally met criteria for antisocial personality disorder (ASPD; seven of seven symptoms plus two conduct specifiers endorsed) and for avoidant personality disorder (APD; five of seven symptoms endorsed).

In contrast, on the standardized measures shown in Table 5.4 and relative to the TFP mean, V presented with a lower level on the suicidality measure (for the past week, $V = 0$; TFP $M = 1.07$; for the past month, $V = 1.00$; TFP $M = 2.15$); a lower

score on anger ($V = 12$; TFP $M = 54.9$); a lower score on irritability ($V = .91$, TFP $M = 1.79$); and a lower score on direct assaultive behavior ($V = .60$; TFP $M = .68$).

On the other hand, *V* did have a higher score on verbal assault ($V = 2.22$; TFP $M = 1.58$), presenting instances in her clinical interview of verbal anger and irritability, primarily toward her boyfriend (e.g., yelling at him in public places or storming out of restaurants in the course of a meal).

In terms of impulsivity on the Barratt factors, *V* endorsed difficulties on a par with the TFP average in the areas of motor/acting without thinking and nonplanning. Overall, it should be noted that the vast majority of her social contacts in the period prior to treatment were either with her outpatient providers or her boyfriend—*V*'s functioning was otherwise too impoverished to be having interactions because of the potential for conflict.

In terms of measures of attachment organization, *V* presented on the AAI with a Dismissive attachment style. She tended to discuss attachment relationships with a sparseness that left attributions of herself and others, including vaguely positive and negative statements, without substantiation. Of note, despite being both exposed to and the victim of terrifying violence throughout her childhood, she discussed these events with a cool detachment that excluded any sense of her affective experience.

The AAI was also evaluated for the level of reflective functioning (see Table 5.4) and *V* scored a 3 (on a scale of -1 to 9, with a clinical cutoff of 5), which represents concrete or canned attributions of mental states. For example, after reporting her parents being physically abusive toward each other, and turning a blind eye to her brother's physical abuse toward her, when asked to reflect on why her "parents acted as they did when you were a child" she responded, "It was the people they were, they were doing the best they could as they were. Um, it was the forces that shaped their lives . . ." Unlike the antireflective refusals to consider mental states seen at the lowest points of the reflective functioning scale, in this naïve/simplistic type of reflective functioning, broad generalities of what motivates all people (and therefore not these parents in particular) are the focus of attributions. For *V* this seemed to function to disavow knowledge of how her parents could have been capable of enacting cruelty on each other and not protected her from the same.

In the initial assessment, despite her low level of occupational and relational functioning, *V* also evidenced a number of strengths. Her commitment to abstinence and regularly attending AA suggested an ability to set and carry through on treatment goals. Furthermore, *V* was a bright woman who appeared to have genuine artistic talents in both writing and music, and derived enjoyment from practicing her art. She expressed frustration at not having been able to actualize her artistic dreams, and she appeared motivated to find ways to bring her musical and literary goals to fruition.

Ms. V's FORMULATION AND TREATMENT PLAN

In formulating the case, it was notable that *V*'s mood did not appear depressed, and after a thorough evaluation the therapist concluded that she had BPD as well as comorbid narcissistic personality disorder (NPD) with antisocial traits. This

diagnosis was based, among other things, on the therapist's observation that the patient's history of depression seemed related to a discrepancy between her image of what her life should be like (a famous musician) and her lack of success in life—a state that she attributed to depression but that actually was more a cause of her depressed state.

Furthermore, the therapist observed that there seemed to be no medically valid barrier to V working and thus no indication that her disability status was valid. Whereas her borderline and narcissistic personality traits created anxiety and tension in her interactions with others, our experience in TFP is that a patient's "real-time" experience of interactions provides important material for the therapy sessions and that, in turn, working on this material in therapy can help the patient change the anxious and conflicted responses to others that he or she traditionally experienced.

A significant impediment to V's working was her narcissistic attitude that she should not have to participate in work that she considered "average," which she was told her job was. Notably, while V was reluctant to concur explicitly with this assessment, she communicated in many ways that she felt entitled to her disability benefit not because she saw herself as an incapacitated person but because she had felt severely wronged in her life and deserving of compensation. She did not view her benefits as transitional income while attempting to "get back on her feet," but rather, given that she had for many years supported herself with these benefits and would continue to do so for the foreseeable future, viewed them as her right. She evidenced no remorse for past exploitative use of social welfare and treatment systems.

V was randomly assigned to the TFP condition. In accordance with the TFP model, the therapist discussed his diagnostic impressions with the patient. Clinicians are commonly reluctant to share personality disorder diagnoses with patients (and this is especially so with BPD, NPD, and ASPD), often out of fear that the patient will experience the diagnosis as invalidating or inflammatory. However, from a TFP perspective not only is it important to come to a shared understanding of the nature of the pathology, but also in our experience patients often feel validated by a clear explication of their internal processes. The therapist explained to V that while he did not question that she experienced depressed moods, such moods can stem from different sources. He shared his impression that she experienced a gap in her mind between the person she would like to be, that she felt she deserved to be, and the realities of her life.

V's depressed moods and difficulty functioning were contextualized in terms of moments in which she felt too in touch with having fallen short of aspirations and recognitions of which she felt deserving. V was willing to consider the new personality disorder diagnoses; though wary, she felt it better captured her experience and sounded less hopeless than "refractory depression." In a similar way, the therapist described the elements of BPD in her clinical picture as manifestations of an underlying lack of clarity about her identity and sense of self, which left her subject to anxiety and depression about the course of her life. Furthermore, her

difficulty internally processing and modulating painful affects led to them often being acted out behaviorally, which resulted in instability in her relationships.

An essential early intervention in TFP is the contract-setting process, during which the general conditions of treatment are articulated and agreed upon. Because the manner in which the terms of the treatment plan are negotiated often become emblematic of the relational patterns of focus in the treatment, the treatment contracting process in TFP is often longer than other treatments (usually 2–5 sessions). In addition to discussing expectations within sessions (consistently attending, arriving on time, speaking without censoring, etc.), expectations about the ways in which the patient will work toward increasing his or her level of functioning outside of sessions were also discussed. What was striking about V, as with many patients with BPD, was the degree to which she seemed to be underfunctioning relative to her intelligence and capabilities. Essentially, she had been functioning as a professional patient for the past decade, despite being an artistically talented woman who was clearly capable of more. However, when the therapist discussed the need for her to engage in some form of work or study in conjunction with treatment, V vehemently responded that any such activity would lead to relapsing into a depressed state that would destroy any progress she had made and could threaten her life.

During the contract-setting process the TFP therapist does not necessarily have the expectation that the requirements of treatment will be immediately agreed upon and subsequently adhered to. In fact, the patient's ambivalence about agreeing to or complying with treatment expectations often provides an essential window into the patient's experience of the self as affectively related to others (i.e., the "object relational" dyad). In response to the expectation of structured activity, V saw herself as potentially harmed, and in fact the therapist's initial countertransference reaction to her was to feel guilty for proposing a condition of treatment that could harm her. However, after internally reviewing the basis for his diagnostic impressions and assessment of her capacity to work, he felt confident that structured activity was necessary to increase her level of functioning: something like a part-time job or volunteer job or enrolling in college classes. From that vantage point, he could see that a pattern seemed to be emerging, in which the patient saw herself as victim to the therapist's harmful behaviors and attitudes. However, the therapist was also aware that when V vehemently rejected the notion of structured activity that he brought up in the contract-setting sessions, she did it in a menacing way, and the therapist was afraid that she would leave treatment. Yet, for V, the notion of herself as aggressor, as opposed to victim, appeared to be outside of her immediate awareness.

Another major goal of the contract-setting process in TFP is to address any areas of secondary gain, that is, benefits that the patient derives from symptoms that may serve to undermine treatment goals. In discussions of increasing her level of structured activity, not only did it become clear that V feared that her increased functioning might threaten the stability of her medical disability benefits and subsidized housing, but also that she felt entitled to this support and saw others (e.g., the therapist, the government) as trying to steal what was rightfully

hers. A dyadic interaction seemed to be emerging in which V saw the world along the lines of predator and prey, leading to an attitude that you need to take what you must to survive; "don't let what's yours be stolen from you."

Accordingly, the therapist proceeded with the discussion of the need for her to work, now very attentive to V's attempt to safeguard the secondary gains of her illness. As he continued to discuss active engagement in a structured activity, he reminded her that the decision to enter into this treatment was up to her, and that alternately he could refer her to a less intensive maintenance therapy for people with chronic conditions who did not have the potential to get better in significant ways, as she had received at the hospital in the past (to no benefit). He reminded her that the treatment they were discussing was an intensive treatment geared to people who had the potential for significant change, including increased autonomy and better functioning. This discussion seemed to appeal to the part of the patient that wished to have a more productive life and not to give in to the passive dependency wishes that went along with her narcissistic disappointment in life. The therapist's reasons for recommending this RCT included the fact that these treatments have been shown to help people with severe personality disorders, and TFP in particular has been shown to help patients change from a borderline to a more integrated personality structure, with a corresponding improvement in the ability to function and find some measure of satisfaction in work and love. His reasons also included the fact that V appeared to be intelligent and articulate.

Even so, the nature of V's goals remained unclear. Therefore, the therapist continued the discussion of the treatment contract, which included coming to an agreement about treatment goals. As the discussion continued, V stated that she would like to become autonomous. However, the therapist was not sure if this was a sincere wish or if she was stating it in order to have treatment. Deciding to take the patient at her word, he continued with the discussion of what kind of engagement in an activity would be in line with the patient's interest and serve a therapeutic purpose. The notion of finding an activity that corresponds to an interest of the patient can be a step in addressing and working on the identity diffusion that characterizes patients organized at a borderline level. In the treatment contract-setting phase of the therapy, after a discussion that lasted two sessions, in which the patient began by proposing unsubstantial activities such as helping out at the neighborhood girls' basketball practice on Saturday afternoon, the patient and therapist came to an agreement that the patient would enroll in two classes at the local community college to improve her computer skills.

Ms. V's COURSE OF THERAPY

The early phase of therapy was characterized by difficulty engaging the patient in observing and reflecting on her interpersonal patterns and on her experience of self as affectively related to others, including aspects of the interaction with the therapist. In one of the first sessions after the treatment moved from the contracting phase to the therapy itself, the therapist tried to bring the patient's attention to how reactions she may be having to him might have an influence on her feelings, thoughts, and behaviors. The therapist, having just returned from a week's

absence, suggested: "Although you say the session before my going away 'just slipped your mind,' I wonder if the fact that I was going to be away may have had an impact on how you were feeling." V responded very defensively: "I don't want to go there. I had an earlier therapist who thought that everything I thought and did was related to her and it got very messy. I started thinking about her too much and everything got worse. We had to end that therapy." The therapist was disappointed to encounter this level of resistance to working within the transference and kept in mind that any references to issues and feelings that emerged between them would have to be proposed with utmost tact.

In TFP, the therapist remains continually attentive to threats to a continued and productive treatment, which may include enactments in the transference that make the experience of the treatment either unproductive or intolerable for the patient. It was unclear what got "messy" for V in her last treatment, and she made clear her intentions not to elaborate, but the therapist wondered if a relationship reflecting intolerably painful attachment experiences in the past came to be replicated in the relationship with the prior therapist. The current therapist was eager to discuss that prior therapist's experience with the patient, in order not to replicate interventions or ways of relating to V that had previously been unsuccessful. However, after obtaining V's consent to contact the previous therapist, that therapist never returned his calls. Although it remained unclear what happened in the therapeutic relationship in her past treatment, what was striking was the degree to which V denied any emerging attachment relationship in the present treatment. V displayed a generally dismissive and devaluing attitude toward the therapist. When he tried to draw the patient's attention and curiosity to this, she responded regularly: "You're a means to an end. You're like my dentist. I go to him for specific help and I'm coming here for specific help. What I feel isn't the issue, and I don't feel much about you anyway."

The therapist believed that understanding these dismissive and distancing reactions to him was crucial to understanding V's relational problems in external relationships. V often vacillated between volatility and avoidance in relationships, but she externalized all responsibility for these difficulties to others, whom she saw as unfairly critical and manipulative of her. For example, she often felt exploited by the people in her AA group because they gave her too many tasks and responsibilities. The therapist heard echoes of their therapeutic relationship in these concerns, because he also imposed on her tasks and responsibilities that were likely evoking similarly negative affects, but she was adamant in wanting to keep the focus on her life outside the therapy. Although there is value in noting patterns in external relationships, the most progress in understanding, according to TFP, generally comes from experiencing, observing, and reflecting on the patterns as they emerge "live" in the treatment. However, V shut down that process of exploration in ways that precluded the type of "here-and-now" examination that is the core of TFP and is believed to lead to change and growth. Instead, V kept the focus on "extra-transference" relations and issues, expressing the concern that she was barely able to manage somewhat superficial relationships in AA meetings and her classes.

In hindsight, this too paralleled her relationship to the therapist, which she kept superficial and hanging by a thread. V completed the 1 year of the RCT. Despite

her experience in her classes that others did not like her and were unfair to her, she completed her course work and was able to start a clerical job in which she could use the computer skills she had learned. However, her therapist continued to have the impression that she was holding onto this job "by a thread," both because in this setting she again felt exploited, and because her commitment to her occupational development seemed tenuous. V was dismissive of the therapist's efforts to understand this pervasive feeling of exploitation. He noted that perhaps this feeling seemed to show up in every context because she carried it within her, and that if they could address the feeling of exploitation inside the therapy, she would be able to function better in outside settings. V was also dismissive of successfully completing her coursework and getting a job, which were viewed not as personal or professional accomplishments but rather as demands imposed upon her with which she resentfully complied. The gap between her significant, creative talents and her minimal functioning at work was again discussed, but met with frustration that she had "checked the box" asked of her by the therapist in getting a job, and therefore she could not understand why he was pushing her on her functioning at work.

The termination process with Ms. V is described later in the chapter in the section on her therapy outcome.

Therapy Monitoring and Use of Feedback Information

The therapists attended weekly supervision group meetings. Traditional clinical supervision was augmented by the use of the TFP Rating of the Therapist Adherence and Competence Instrument. This instrument rates the therapist's adherence to the basic principles and techniques of TFP, such as setting up and maintaining the treatment contract and appropriate use of the techniques of clarification, confrontation, interpretation, technical neutrality, and the use of countertransference.

Therapists took turns presenting video recordings of sessions to the cell leader, Otto Kernberg, as well as to peers. Kernberg and other therapists commented on material presented in the videotapes, and all participants completed the adherence instrument forms. These forms were used both to monitor therapist compliance and to aid in providing supervision, especially by Kernberg and other senior therapists (e.g., Frank Yeomans). Therapists were alerted if they deviated from adherence to the treatment model. Additional individual supervision was available if the therapist appeared to deviate from the treatment model for more than two sessions.

Concluding Evaluation of the Therapy's Process and Outcome

Ms. J's POSITIVE OUTCOME AND THERAPY PROCESS

On the standardized measures, J showed improvement—dramatic in some instances—in almost all her primary- and secondary-outcome standardized

scores. Specifically, as shown in Table 5.4, she had improved from intake to 1 year on suicidality, the four aggression scores, on one of the three impulsivity scores (with basically no change on the other two), and on all four of the secondary-outcome scores.

From the therapist's point of view, he independently observed that J had made substantial changes in 1 year of TFP, in some areas much more than was reflected in her standardized measures. As has been previously noted, while in the month prior to beginning treatment J endorsed some self-injurious behaviors on the Overt Aggression Scale-Modified (OAS-M) and verbally aggressive behaviors on the AIAQ subscale of the OAS-M, she had been so isolated in her apartment that she struggled to produce recent examples of the fiery and explosive behaviors that she had struggled with for some time. At the end of 1 year of TFP she had a markedly richer social life and was actively dating. Therefore, she was exposed to a far greater repertoire of social opportunities that included both positive and pleasurable experiences as well as some angry and irritable ones. Furthermore, the ruptures with these somewhat narcissistic men did at times bring about feelings of shame and subsequent suicidal ideation (that she had previously avoided through never dating at all). Thus, J's improvement at 1 year was all the more impressive.

After 1 year of treatment the changes in J's attachment organization and reflective functioning were more dramatic and consistent with the therapist's perception of the changes she made. J had shifted to a Preoccupied attachment style. The fact that this is not a "Secure" attachment style may belie the improvement observed. Whereas before her Cannot Classify (CC) attachment pattern described earlier led to marked vacillations between a Preoccupied style of angry and entangled descriptions and a Dismissive style of devaluing and derogatory descriptions, over the course of the year she organized around a consistent style. Unlike CC, the Preoccupied style is thought to represent an intact (albeit not secure) strategy for getting one's attachment needs met, and thus serves an adaptive function. The same cannot be said for the incoherent and disorganizing effect of vacillating between two opposing styles, and therefore this stabilization is understood to be a sign of progress on the path toward security of attachment for such patients (Diamond et al., 2014).

J evidenced a dramatic improvement in her capacity to reflect on mental states with herself and within others on the reflective functioning (RF) scale. As shown in Table 5.4, prior to treatment J's interview was rated as a -1, which is considered "negative" RF and indicative of resistance and/or bizarre responses to an opportunity to reflect. At the end of treatment, J's interview was rated as a 6, which is between "ordinary" and "marked" RF. Whereas clinical samples tend to display RF around 3, healthy control samples display RF at 5 or higher, and thus this aligns J's capacity for mentalization with nonpatient samples. Not only did she no longer experience being asked to reflect on the mental states of attachment figures as a hostile affront, but now she was actually curious about her mind and the minds of others, and displayed genuine insights into others' motivations.

As part of this same growth in J's structural functioning, her related, narrative coherence score went from 1.50 at intake to 4.00 at 1 year, just below the clinical cutoff of 5.00.

Of note, there is often the assumption that psychodynamic treatments focus a great deal on early childhood experiences, which would make gain in the capacity to reflect on those relationships not particularly impressive. However, TFP does not place particular emphasis on childhood relationships, but rather focuses on relational dynamics in the here and now. This is consistent with the therapist's own impression of this treatment, which spent relatively little time on early experiences with parents except to contextualize her relational assumptions in her current life.

At the end of 1 year in the RCT, J was offered the option of continuing TFP in the therapist's private practice, to which she agreed and during which time she continued to make substantial gains. J's complaints of mistreatment gradually decreased; she reported less anxiety and more positive interactions in her volunteer work setting, where she was offered a paid position after a year. After 3 years of therapy, she started a relationship with and eventually married a man whose empathy she appreciated, in contrast to the illusion of an ideal she was attracted to in the earlier objects of her desire. By the end of 5 years of therapy, J had achieved stability in her work life, having obtained a master's degree and become steadily employed in a full-time position, got married, and developed friendships and meaningful interests in the arts.

Ms. V's NEGATIVE OUTCOME AND THERAPY PROCESS

V was noted to evidence improvement on her standardized, primary- and secondary-outcome measures after 1 year of TFP. As shown in Table 5.4, she showed modest improvement on the primary measures of suicidality, verbal assault, and motor/acting without thinking, and on the four secondary-outcome measures. On the other hand, she showed worsening on measures of anger, irritability, and attention. Notably, in V's case as well there was a discrepancy between changes observed on the measures as compared to the therapist's report, but this time in the other direction; despite her self-reported changes, the therapist continued to have concerns that core aspects of her pathology remained intact.

As has been previously noted, in the month prior to beginning treatment, V presented with instances of verbal anger and irritability on the AIAQ and impulsivity on the BIS-II, and the vast majority of her social contacts were limited to therapists or her boyfriend, otherwise being too impoverished to be having interactions with the potential for conflict. After 1 year of TFP her irritable and impulsive behaviors had slightly reduced on some of these measures, but the therapist had the impression that this was despite never having really challenged herself in the relational contexts most likely to elicit the very feelings that she sought to address. She kept her contacts with people at her AA meeting, her classes, and eventually her clerical job to a minimum, and was in a stable pattern of conflict with her on-again/off-again boyfriend.

In terms of measures of attachment organization and reflective functioning, V continued to demonstrate a Dismissive attachment style, as well as low levels of reflective functioning (scores of 3 at both intake and 1 year) and narrative coherence (scores of 2.50 at intake and 3.00 at 1 year). V continued to discuss attachment relationships with a cool detachment, although qualitatively it was observed that she was more derogatory and overtly angry and negative in her descriptions of attachment relationships than the year prior. For example, the 1-year score of 3 on reflective function was associated with numerous instances of broad generalities regarding mental states that provided little specificity for what her parents may have thought, felt, or wanted in particular (e.g., they are merely “screwed up” people who alternately “tried their best”). By contrast, the TFP group mean scores increased significantly after 1 year of treatment on both reflective functioning (intake = 2.81, 1 year = 4.11) and narrative coherence (intake = 2.93, 1 year = 4.02).

At the end of 1 year in the RCT, V was offered the option of continuing TFP in the therapist’s private practice. Although she accepted this offer, a few months later V stated that she had decided to end the therapy. Her therapist was concerned because she had not addressed the overwhelming feeling of being exploited in relationships, which not only put her job at risk but was also reflected in ongoing conflicts with the men she dated and the few friends she had. Despite her therapist’s strong recommendation to continue with treatment, the patient thanked him for his help in a perfunctory way and ended the therapy. The therapist had no way to be sure of V’s reasons for ending therapy, but in hindsight the therapist wondered whether the toxic effect of V’s overwhelming feeling of exploitation, in combination with her tendency to “turn the tables” and find ways to exploit others and the social system, made the therapy relationship intolerable, as it had in so many other relationships, and also undesirable, insofar as it called on her to take responsibility for her life.

Regarding these feelings of exploitation, in V’s early attachment relationships, such as those with her parents and older brother, she was treated in violent and manipulative ways, which led her to view dependent relationships in terms of predator and prey. V may have feared the answers to the therapist’s questions about what she thought motivated the expectations he placed on her, perhaps not wanting to even consider the possibility that she had again found herself being exploited by someone on whom she had begun to depend. Keeping the therapeutic relationship superficial functioned temporarily to keep that fear at bay. However, despite some modest gains in her work functioning, keeping affect at a distance also precluded a deeper understanding of the nature of her fear, and as a result little changed in her relational functioning. As the treatment plodded along, the therapist likely felt an urgency for her to want more out of her life and began to increase the pressure, which may have played into her fear of exploitation as she felt manipulated by the therapist’s changing expectations. Perhaps, rather than confront the predator she imagined but had been working hard not to see in her therapist—which would have brought that element of her internal world into the therapeutic dialogue—she evasively ran for the door.

COMPARISON OF THE MS. J AND MS. V CASES

Both J and V presented with BPD and avoidant personality disorder (AVPD), although they differed in terms of J further presenting with narcissistic personality disorder (NPD), and V, with antisocial personality disorder (ASPD). At the end of 1 year of TFP, both J and V evidenced modest improvements in their angry, irritable, and impulsive behaviors (note the improvements on the OAS-M, AIAQ, and Barratt Impulsivity Factors in Table 5.4; for instance, over the course of treatment, J's reported verbal assault score dropped from 2.44 to 1.11, while V's verbal assault score dropped from 2.22 to 2.11). Furthermore, after 1 year of treatment both women were gainfully employed, although they each had a different subjective experience of working (muted pride in J, resentment in V).

Regarding social adjustment, even though V was functioning at a higher absolute level than J at 1 year (60 versus 45, respectively), qualitatively J had made substantial changes in her willingness to risk feeling vulnerable in order to work toward creating the kinds of relational experiences she sought for herself. In contrast, V continued to privilege protecting herself from experiences of vulnerability, even at the expense of working toward richer relationships. Furthermore, J grew considerably in her capacity to mentalize thoughts, feelings, and motivations within herself and others (with a 1-year reflective functioning score of 6). Her capacity to provide a coherent narrative to her attachment experiences, while still somewhat angry and entangled, stabilized around an organized pattern of seeking out her attachment needs. In contrast, with a 1-year reflective functioning score of 3, V showed no change in these domains, continuing to approach her mental state and that of others with a cool detachment and clichéd understandings that also likely served to protect her from experiences of vulnerability.

The discrepancies in both their attachment organization and comorbid personality pathology shed light on why J and V may have differentially benefitted from TFP. What became clear both in J's attachment narratives and her approach to relationships was that underneath it all she desperately wanted to relate to others. While her desire to be loved and respected was revealed to be considerable during the course of treatment, she went to great lengths in the early phases of treatment to deny this longing for connection, both to others as well as to herself. Her derogation of relationships served as a defense against her longing; J would have surely put a twist on Tennyson and asserted that it is "better to never have loved at all, than to have loved and lost."

J was so sure of her inevitable disappointment that she lashed out at those whom she believed would surely abandon her in a matter of time, if they had not done so already, and therefore at the start of treatment J had stopped bothering to relate to anyone. She would narcissistically denigrate others as a preemptive strike against the denigrations that were surely going to be directed at her. However, that longing for connection was still there, acting as a quiet but powerful motivation. The therapist's capacity to endure and contain her derogation long enough to see and give voice to her underlying needs for intimacy and connection in the form of transference interpretations paved the way for powerful change in the way she oriented herself toward relationships. This is most clearly reflected in her

attachment status after 1 year of treatment, which was organized around her preoccupation with the degree to which her relational needs were being met, whereas the need to disavow attachment longings had receded into the background.

In contrast, any desire for longing or connection experienced by V was consistently muted by representations of relationships organized in terms of predator and prey, as is often the case in patients with comorbid antisocial personality disorder. Any desire she may have had to connect (with the therapist, her classmates, her coworkers, a more stable boyfriend) was likely equated in her mind with the kind of vulnerability and letting down of one's guard that occurs in the moment before an attack begins. Whereas deep down J wanted (and yet feared) her underlying needs for intimacy and connection to be seen, V's experience of similar transference interpretations may have been experienced as the actualization of the vulnerable experience she had organized her life around avoiding. Furthermore, the therapist's efforts to move her toward higher levels of occupational functioning were likely perceived as seeking to deny her the very benefits that were rightfully hers.

From what seemed to be V's vantage point of the therapy dyad being organized around predator-prey, why would the therapist ask V to relinquish her disability status and return to work? At best he was naïve (as predators often are), blindly giving her bad advice, unintentionally hurting her in the process, and in doing so revealing his incompetence as a therapist. This possibility—therapist-as-naïve—also left him open to the possibility of being V's prey, in that she might be able to use him to get benefits for which she might not genuinely qualify. At worst he was out to steal from her (as predators often do), tricking her into giving up what she needed to survive and leaving her with nothing. While we can only speculate as to how she may have perceived the therapist, either (or, likely, both) of these perceptions of the therapist would have contributed to maintaining a cool detachment both within her relationships and within her own mind, as reflected in no change in attachment or reflective functioning scores.

This raises the question of whether or not V might have responded better to a different kind of treatment. For example, V may have been more receptive to a supportive treatment that would likely have done more to meet her where she was, rather than nudge her toward life changes she clearly did not want to make. The TFP therapist was concerned that V had spent a large portion of her adult years supported by hospital staff and government assistance, despite being clearly capable of more. However, it became apparent over time that the therapist felt more urgently about changing V's life circumstances than V did. This raises a question with important clinical (and ethical) implications—should the therapist have kept the focus on the more modest changes V was willing to make—or fought even harder for V to feel a sense of urgency and work to reach her potential?

In terms of the treatments in this RCT, supportive psychotherapy (SPT) would likely have done more to understand V's "refractory depression" as a reality of her subjective experience and worked to help her understand her experience of being abused and manipulated by others. Another BPD therapy not included in the present RCT, mentalization-based therapy (MBT; Bateman & Fonagy, 1999),

would similarly have focused on V adopting a mentalizing stance by becoming curious about her thoughts, intentions, beliefs, and especially the awareness of manifest affects about herself and others. Rather than challenging self-attributions as involving distortions, as would be done in TFP, SBT and MBT would be more likely to accept V's subjective experience of being exploited and manipulated as "real" and "accurate" to her. Such interventions may have bolstered the therapeutic alliance, which was felt by V's therapist to be often strained in TFP. While it is quite likely V would have preferred these other therapeutic approaches, it should be noted that during the course of V's many previous hospital-based outpatient treatments she had received a number of supportive psychotherapies, with little change noted, leading those supportive therapists to recommend her to this RCT in the hope of her receiving TFP.

In terms of the other treatment in this RCT, dialectical behavior therapy (DBT; Linehan, 1993) likely would have approached the aforementioned question regarding acceptance of V's more modest goals versus substantial change in her level of functioning not as a dichotomy, but as a dialectic within which both needs could be respected and understood. The DBT therapist would likely have sought to validate V in her current experience of feeling abused and exploited, while also questioning whether she was working toward "a life worth living." A DBT therapist would maintain that V's abused and exploited self-image stems from countless painful invalidating experiences, and these real experiences need to be acknowledged as such. Not to validate this aspect of V's experience, a DBT therapist might say, would be to provide the patient with one more version of an invalidating environment. More akin to mentalization-based therapy, a DBT therapist would accept the patient's subjective experience as "real" and "accurate" to her, and therefore respond to it as such.

By contrast, the TFP therapist actively challenged the notion of V as always the one being exploited by examining this perception of self in relation to others in all the forms it took, including situations in which V was the one to exploit others. The TFP therapist aimed to observe the totality of V's experience, with the hope this would allow her to achieve a more integrated, balanced view of herself, others, and relationships. The therapist worried that to validate V's self-perception as being victimized and manipulated would be to affirm a distorted view of herself. Furthermore, this would leave a crucial underlying motivation of this self-perception unaddressed—namely, the secondary gain derived from her benefits. In that light, it could be argued that the TFP therapist might have utilized *more* transference interpretations. For example, these would have included interpretations that highlighted V's efforts to keep the focus outside of the transference so as to maintain V's view of herself as exploited, including by the therapist.

However, this "doubling down" on transference interpretations may not be supported by data indicating high rates of dropout when therapists overinterpret (or when CBT therapists continue with their techniques) in the face of a patient's non-responsiveness (Piper et al., 1999). Perhaps most fruitful for V may have been a more integrative approach that combined elements of DBT, such as joining a skills group, to supplement her work in TFP. Recent research suggests that DBT skills

groups may successfully augment non-DBT treatments (Harely, Baity, Blais, & Jacobo, 2007).

SYNTHESIS OF THE FINDINGS FROM THE RCT AND CASE STUDY APPROACHES

What We Learned From the RCT Study

In this section we discuss what we have learned from our study. We focus on issues related to efficacy and effectiveness of TFP, the nature of improvement, the role of structural variables, personal qualities that promote and hinder change, structural and change processes, and the matching different treatment theories to different patients.

THE EFFICACY AND EFFECTIVENESS OF TFP AS ANOTHER APPROACH TO BPD

Historically, BPD has been thought to be difficult to treat, with patients frequently not adhering to treatment recommendations, using services chaotically, and repeatedly dropping out of treatment. They also happen to be harder on therapists than any other disorder. Many clinicians are intimidated by the prospect of treating BPD patients and are pessimistic about the outcome of treatment, with good reason. Therapists have displayed high levels of burnout and have been known to be prone to enactments and even engagement in iatrogenic behaviors. Beginning with Linehan's seminal 1991 RCT showing that DBT was efficacious in comparison to treatment as usual, and the increasing number of studies finding efficacy for treatments based on both cognitive-behavioral therapy and psychodynamic therapy, we now know that BPD can be a treatable condition. These RCT studies and their follow-ups, like the one we described earlier, consistently find that 50%–60% of BPD patients improve during the course of year-long treatments.

With this in mind, the findings in the present RCT of equivalence between TFP and DBT provide important evidence to specifically support TFP's efficacy against the benchmark of DBT. This finding is strengthened by a number of methodological elements in the study design. First, the possibility of bias from therapist research allegiance was controlled by having each therapy model administered by a team highly knowledgeable in and committed to it. Second, the design included essential efficacy elements to ensure internal validity, such as random assignment of patients to treatments, manualized treatments, blind raters, therapists blind to all baseline assessments, and specific and reliably measured outcome variables. Third, the design also built in the external validity associated with effectiveness studies by including in the study a range of BPD patients based on inclusion/exclusion criteria used in clinical practice; therapists who provided treatment in their private offices in the community rather than in a university or hospital setting; and psychopharmacological treatment decided on an individual basis so that

the use of medication was not standardized, but on the basis of a clinical algorithm, so as to be independent of assignment to treatment group.

Because the different models—TFP, DBT, and SPT—are based on different theories of change, the overall finding of their equivalence suggests that there may be different theoretically based routes to improvement in the treatment of BPD as gauged by symptoms. In DBT, there is a focus on direct, behavioral skills training to help patients regulate emotions and reduce symptoms; in TFP, there is a focus on developing greater self-control through integrating representations of self and others as they become active in the therapeutic relationship, with a particular use of transference interpretation; and in SPT, the focus is on a supportive relationship and using the therapist as a model of reflection, without the use of transference interpretation. Both future group studies and future case studies like the ones described here will be helpful in comparing and contrasting these different theoretically based routes to improvement in patients with DBT.

In addition to the general equivalence among the three treatment models, in one of the contrast analyses, TFP and DBT approached statistical significance in their association with decreased suicidality compared with SPT, and they were not statistically significant from each other. In addition, the TFP group showed statistically significant improvement in 10 of 12 primary- and secondary-outcome variables, compared with the DBT group being associated with statistically significant improvement in 5 of 12 variables, and the SPT group, with statistically significant improvement in 6 of 12 variables. Overall, while these differences among the three groups were not statistically significant, they suggest the possibility of certain advantages in TFP over the other two treatments that merit further study.

THE NATURE OF IMPROVEMENT

The improvements documented in Tables 5.2 and 5.3 are statistically significant and, while often much less than we desire for our patients, do indeed represent clinically significant improvement. By clinically significant improvement, we do not necessarily mean that these patients are functioning at levels consistent with non-BPD patients but that the level of improvement shown represents a change in clinical functioning. For example, many patients treated in our RCT were no longer engaging in self-injury on a regular basis or at all by the end of treatment (often within 4–6 months of beginning treatment). The reduction in this behavior frequently would lead to fewer emergency room visits, hospitalizations, and days hospitalized. For example, after one year the GAF Social Adjustment scores increased from 40–50 to 60–70.

However, despite these changes, many of these patients were still frequently unhappy, experienced shifts in their perception of themselves and others that interfered with intimacy, and were still unable to decide and commit to productive work in a way consistent with their interests and capacities. Along these lines, Linehan et al. (1994) themselves noted in their early naturalistic follow-up that although the “subjects in the dialectical behavior therapy group acted better . . . *they were still miserable*,” experiencing “moderate symptoms” and/or “generally functioning with some difficulty” and living lives of quiet desperation (p. 1775).

Similarly in our study, many patients in all three treatment conditions made important improvements. However, those symptom improvements were not always associated with sufficient change. Clearly, more improvement was needed. A GAF score of 65 represents a clinically significant improvement when compared to functioning at a 45; however, a GAF score of 65 is far from that to which most people would aspire. Nonetheless, we would contend that this improvement is clinically significant. A BPD patient who is not self-injuring and therefore needing to be taken to the emergency room and possibly hospitalized is typically able to relate better with significant others.

The "successful" case of J underlines the aforementioned points in a dramatic way. Although, as we documented, she made considerable progress in her first year, she had only made a gain in her GAF Social Functioning score from 40 to 45. She achieved a full recovery (a GAF of around 70) only after 4 additional years of therapy.

THE ROLE OF STRUCTURAL VARIABLES

TFP's theory of BPD psychopathology and its associated treatment model are organized in part around the variables of attachment, mentalization/reflective functioning, and narrative coherence, and thus the treatment targets these variables. Our findings support the unique role that TFP has in facilitating improvement in these areas. Specifically, for attachment, only in the TFP group was there a significant increase in the number of patients who moved from an insecure to a secure attachment by the end of the 1-year therapy. And for reflective functioning and narrative coherence, TFP patients experienced a statistically significantly greater improvement in both these variables than did those in DBT or SPT.

The greater improvement in the attachment, reflective functioning, and narrative coherence measures for the TFP group confirms our hypothesis that TFP would have a bigger impact on these two variables because of their particular relevance in TFP's theory of BPD psychopathology and methods for combating it.

What We Learned From the Case Studies

The findings from the RCT are important for establishing the efficacy and effectiveness of TFP in treating the average BPD patient, and the findings are useful in the study of mechanisms of change, such as the findings concerning the structural variables. However, by necessity, RCT knowledge has to simplify the clinical complexity of a year of psychotherapy with an individual with severe BPD psychopathology. This simplification limits the value of RCT knowledge in providing practitioners a rich picture of the patient and pragmatic guidance in the therapeutic process. In contrast, and in a complementary way, case studies are designed to capture this clinical complexity, with the resultant advantages for the practitioner. In addition, by revealing and exploring in rich context the nature of BPD psychopathology and the effects of treatment on it, case studies provide an alternative route for uncovering mechanisms of change.

The comparison of client characteristics and the therapeutic process embedded in the cases of J and V are instructive. In many ways, J and V and their therapies were quite similar. They were both women in their early 30s who presented for treatment after deriving little benefit from prior psychotherapies and pharmacotherapies as well as little success in past work environments. Both women were diagnosed with BPD and avoidant personality disorder and were randomized to the same therapist in TFP. The therapist was male and an experienced clinician who had practiced and supervised TFP for many years. Each patient was treated twice-weekly in his private practice office in close proximity to the affiliated medical center sponsoring the RCT. As part of the RCT, each patient agreed to be treated in 1 year of TFP. At the end of that year each patient was offered the option of continuing treatment in the therapist's private practice.

And yet J and V had such different outcomes. For example, the therapist perceived J as a strong success, who showed dramatic movement over the 1-year therapy in connecting to the therapist and acknowledging and processing her vulnerabilities, and who enthusiastically continued in therapy for 4 more years to make more pervasive structural personality and social functioning improvements.

In contrast, the therapist viewed V as making no movement in her highly defensive stance to the world over the 1 year of therapy, and then refusing to continue in the therapy. Some of this difference is reflected in the pre-post standardized measures. For example, at the end of therapy, both J and V had substantial decreases in the secondary symptoms. However, on the anger-during-the-previous-month measure, J had a substantial decrease (from 42 to 13), while V had an actual increase over the same period (from 12 to 18). Also, J showed dramatic increases in her attachment, reflective functioning, and narrative coherence measures, while V showed essentially no change.

PERSONAL CAPACITIES PROMOTING OR HINDERING CHANGE

In examining the personal qualities of the two clients, the contrast between J and V highlights the importance of a patient's capacity to respond and overcome layers of resistance and defensiveness (as in the case of J) and a patient's lack of this capacity (as in the case of V). Another mechanism of change frequently missed involves the role of secondary gain. It seemed clear from V's case study that the secondary gain associated with her illness was a strong force in her resisting openness to the pain and distress associated with change. Specifically, for the 10 years before the RCT, V had been treated in just about every inpatient, partial hospitalization, and outpatient program in the hospital associated with the RCT. Although this did not result in change, it did legitimize her disability payments and subsidized housing, creating an equilibrium she did not seem motivated to change.

UNDERSTANDING STRUCTURAL OR PROCESS CHANGES

J's case study also helps to elaborate on the way in which TFP impacts on reflective functioning and narrative coherence, revealing a process in which J moved from the lowest score on reflective functioning of -1.00 to a 6.00 at 1 year, above the clinical cutoff of 5.00 ; and from 2.50 to 4.00 on narrative coherence. From

the detailed data about J's therapeutic process, it seems clear that the structural changes she made in the first year of treatment, for example, in her reflective functioning, provided the tools she was able to use in the next 4 years of therapy to move beyond symptomatic change to completely transform her life such that she established a healthy, mutually compatible marriage; obtained a master's degree; became steadily employed in a full-time position; and developed genuine friendships and meaningful interests in the arts.

The cases suggest that structural changes in attachment, reflective functioning, and narrative coherence brought about through the therapeutic process are predictors of the maintenance of improvement and continued improvement. For example, J's great improvement in these variables after 1 year seemed to be core in facilitating her great success in the next 4 years of therapy, and V's lack of improvement in these variables was associated with very little change and dropping out of the therapy after 1 year.

To understand when these variables come into play in the change process, Howard et al. (1996) suggested a three-phase dose-response model of psychotherapy in which patients initially experience remoralization (the initial boost experienced from the feeling that help is there), followed by remediation (symptom reduction), and finally by rehabilitation (establishing adaptive ways of living, also conceived of as personality change). Remoralization is usually accomplished quickly, whereas remediation is more gradual and typically occurs between 3 and 8 months. Rehabilitation is quite gradual and can take years. Each phase may have different treatment goals, measurable by different outcome variables, and require different interventions.

We would suggest that the pattern of changes we observed in our two patients, J and V, illustrates quite nicely the process articulated by Howard and colleagues. Whereas both patients showed remoralization and remediation, with statistically significant increases on the four secondary variables (see Table 5.4), we would contend that only J achieved rehabilitation. While it was clear by the end of the first year that J had made important strides, many of her most substantial changes occurred a number of years after the completion of the study. We believe that these improvements were set in motion, at least in part, by the structural and process changes indicated by healthier attachment, more reflective functioning, and better narrative coherence. We would contend that J's continued symptomatic improvement over the subsequent 4 years is highly suggestive of rehabilitative change. Interestingly, despite obvious changes in her life as reflected in the standardized secondary-outcome measures at 1 year as shown in Table 5.4, in the therapy V continued to present herself as quite distressed and in fact much more so than J, who had similar symptom scores after 1 year of therapy (see Table 5.4).

MATCHING DIFFERENT TREATMENT THEORIES TO DIFFERENT PATIENTS

Because the different models—TFP, DBT, and SPT—are based on different theories of change, the overall finding of their equivalence suggests that there may be different theoretically based routes to improvement in the treatment of BPD as gauged by symptoms. As we mentioned earlier, “in DBT, there is a focus on

direct, behavioral skills training to help patients regulate emotions and reduce symptoms; in TFP, there is a focus on developing greater self-control through integrating representations of self and others as they become active in the therapeutic relationship, with a particular use of transference interpretation; and in SPT, the focus is on a supportive relationship and using the therapist as a model of reflection, without the use of transference interpretation." Both future group studies and future case studies like the ones described herein will be helpful in comparing and contrasting these different theoretically based routes to improvement in patients with DBT.

Typically, 40%–50% of DBT patients in RCTs do not get better. Based on the design of an RCT, there is no way to know if those who are not successful in a particular treatment model would have done better in a different treatment model. It is possible that the reason why the different treatment models all significantly work on average is that they are working for *different types* of clients, not necessarily that a particular change mechanism works in the same way on all clients. For example, TFP seemed particularly well suited to J, as reflected in her very positive gains in healthy attachment and reflective functioning, which in turn anchored her in long-term therapy and led to a positive transformation in her relational and work life.

On the other hand, we speculated as to whether V's poor response to TFP was due to a poor fit between what V and what TFP requires of patients, as opposed to the more supportive modes of therapy within DBT and SPT. By focusing on the individual patient, case studies provide an excellent method for looking at the match between the complexities of the patient and the "demands" and "potential payoffs" associated with a particular treatment model.

In this regard, we could learn a great deal about matching by comparing a successful patient, "A," and an unsuccessful patient, "B," in, say, the DBT treatment condition. Comparing the differences between A and B versus J and V could enable us to start to better understand the common processes across TFP and DBT that lead to success, along with the treatment-model-specific processes that are differentially related to the patients, such that TFP would not have worked well with A, and DBT would not have worked well with J. Similar comparisons are suggested by bringing in SPT, which, to remind the reader, was psychodynamic like TFP, but unlike TFP, did not use transference interpretations.

Moreover, the example of patients J, V, A, and B include only four of the 62 patients who completed the TFP, DBT or SPT therapies. Conducting case studies on larger numbers of patients would allow for more methodologically powerful comparisons and "replications" of different patient-therapist-therapy matches and different patterns of therapeutic process and outcome.

In sum, the change variables found in our RCT were quantitatively observable and qualitatively and quantitatively elaborated in the close examination of the cases of J and V using systematic case study methods articulated by Fishman, Messer, and their colleagues (Dattillo, Edwards, & Fishman, 2010; Fishman, 2005; Fishman & Messer, 2013; Messer, 2007). The case studies not only provide in-depth illustrations of the RCT findings that resonate with the experience of

clinicians but also are an excellent source of hypotheses about the patient capacities and processes of structural change that help or hinder transference-focused psychotherapy.

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REFERENCES

- Adler, G. (1985). *Borderline psychopathology and its treatment*. New York, NY: Jason Aronson.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- Appelbaum, A. H. (2005). Supportive psychotherapy. In J. Oldham, A. Skodol, & D. Bender (Eds.), *Textbook of personality disorders* (pp. 311–326). Arlington, VA: American Psychiatric Publishing.
- Arntz, A. (2004). Borderline personality disorder. In T. A. Beck, A. Freeman, & D. D. Davis (Eds.), *Cognitive therapy of personality disorders* (2nd ed., pp. 87–215). New York, NY: Guilford Press.
- Bakermans-Kranenburg, M. J. & Van IJzendoorn, M. H. (1993). A psychometric study of the Adult Attachment Interview: Reliability and discriminant validity. *Developmental Psychology*, 29(5), 870–879.
- Bateman, A. & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *American Journal of Psychiatry*, 156(10), 1563–1569.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory* (2nd ed.). San Antonio, TX: The Psychological Corporation.
- Bongar, B., Peterson, L. G., Golann, S., & Hardiman, J. J. (1990). Self-mutilation and the chronically "suicidal" emergency room patient. *Annals of Clinical Psychiatry*, 2, 217–22.
- Chalmers, T. C., Smith, H., Blackburn, B., Silverman, B., Schroeder, B., Reitman, D., & Ambroz, A. (1981). A method for assessing the quality of a randomized control trial. *Controlled Clinical Trials*, 2(1), 31–49.

- Clarkin, J. F., Foelsch, P. A., Levy, K. N., Hull, J. W., Delaney, J. C., & Kernberg, O. F. (2001). The development of a psychodynamic treatment for patients with borderline personality disorders: A preliminary study of behavioral change. *Journal of Personality Disorders, 15*(6), 487–495.
- Clarkin, J. F. & Levy, K. N. (2006). Psychotherapy for patients with borderline personality disorder: Focusing on the mechanisms of change. *Journal of Clinical Psychology, 62*, 405–410.
- Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2004). The Personality Disorders Institute/Borderline Personality Disorder Research Foundation randomized control trial for borderline personality disorder: Rationale, methods, and patient characteristics. *Journal of Personality Disorders, 18*, 52–72.
- Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry, 164*, 922–928.
- Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (1998). *Psychotherapy for borderline personality*. New York, NY: Wiley.
- Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2006). *Psychotherapy of borderline personality*. Washington, DC: American Psychiatric Press.
- Coccaro, E. F. & Kavoussi, R. J. (1997). Fluoxetine and impulsive-aggressive behavior in personality disordered subjects. *Archives of General Psychiatry, 54*, 1081–1088.
- Coccaro, E. F., Harvey, P. D., Kupsaw-Lawrence, E., Herbert, J. L., & Bernstein, D.P. (1991). Development of neuropharmacologically based behavioral assessments of impulsive aggressive behavior. *The Journal of Neuropsychiatry & Clinical Neurosciences, 3*, s44–s51.
- Critchfield, K. L., Levy, K. N., & Clarkin, J. F. (2005). The relationship between impulsivity, aggression, and impulsive-aggression in borderline personality disorder: An empirical analysis of self-report measures. *Journal of Personality Disorders, 18*(6), 555–570.
- Critchfield, K. L., Levy, K. N., & Clarkin, J. F. (2007). The Personality Disorders Institute/Borderline Personality Disorder Research Foundation randomized control trial for borderline personality disorder: Reliability of axis I and II diagnoses. *Psychiatric Quarterly, 78*(1), 15–24.
- Dattilio, F. M., Edwards, D. J. A., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Toward a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy Theory, Research, Practice, Training, 47*, 427–441.
- Derogatis, L.R. (1993). *Brief Symptom Inventory (BSI): Administration, scoring, and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.
- Fertuck, E. A., Lenzenweger, M. F., & Clarkin, J. F. (2005). The association between attentional and executive controls in the expression of borderline personality disorder features: A preliminary study. *Psychopathology, 38*(2), 75–81.
- First, M. B., Gibbon, M., Spitzer, R. L., & Williams, J. B. W. (1997). *Structured clinical interview for Axis I DSM-IV disorders (SCID-I), clinical version*. New York, NY: Biometrics Research Department, New York State Psychiatric Institute.
- Fishman, D. B. (2005). Editor's introduction to PCSP—From single case to database. *Pragmatic Case Studies in Psychotherapy, 1*(1), 1–50. Available at <http://pcsp.libraries.rutgers.edu/>. doi: <http://dx.doi.org/10.14713/pcsp.v1i1.855>
- Fishman, D. B. & Messer, S. B. (2013). Pragmatic case studies as a source of unity in applied psychology. *Review of General Psychology, 17*, 156–161.
- Fleiss, J. L. (1971). Measuring nominal scale agreement among many raters. *Psychological Bulletin, 76*, 378–381.

- Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.
- Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., Target, M., & Gerber, A. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology, 64*(1), 22–31.
- Fonagy, P., Steele, M., Steele, H., & Target, M. (1998). *Reflexive-function manual: Version 5.0 for application to the adult attachment interview*. Unpublished manual, University College, London.
- Fonagy, P. & Target, M. (1996). Playing with reality: I. Theory of mind and the normal development of psychic reality. *International Journal of Psychoanalysis, 77*, 217–234.
- George, C., Kaplan, N., & Main, M. (1985). *The adult attachment interview*. Unpublished manuscript, University of California at Berkeley.
- Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., . . . , & Ruan, W. J. (2008). Prevalence, correlates, disability and comorbidity of DSM-IV borderline personality disorder: Results from the Wave 2 National Epidemiologic Survey on alcohol and related conditions. *Journal of Clinical Psychiatry, 69*(4), 533–545.
- Gross, R., Olfson, M., Gameraoff, M., Shea, S., Feder, A., Fuentes, M., . . . & Weissman, M. M. (2002). Borderline personality disorder in primary care. *Archives of Internal Medicine, 162*(1), 53–60.
- Howard, K. I., Cornille, T. A., Lyons, J. S., Vessey, J. T., Lueger, R. J., & Saunders, S. M. (1996). Patterns of mental health service utilization. *Archives of General Psychiatry, 53*, 696–703.
- Kellogg, S. H. & Young, J. E. (2006). Schema therapy for borderline personality disorder. *Journal of Clinical Psychology, 62*(4), 445–458.
- Kernberg, O. F., Burnstein, E. D., Coyne, L., Appelbaum, A., Horwitz, L., & Voth, H. M. (1972). Psychotherapy and psychoanalysis: Final report of the Menninger Foundation's psychotherapy research project. *Bulletin of the Menninger Clinic, 36*(1), 1–275.
- Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies*. New Haven, CT: Yale University Press.
- Kernberg, O. F., Selzer, M., Koenigsberg, H. W., Carr, A., & Appelbaum, A. (1989). *Psychodynamic psychotherapy of borderline patients*. New York, NY: Basic Books.
- Kjellander, C., Bongar, B., & King, A. (1998). Suicidality in borderline personality disorder. *Crisis, 19*(3), 125–135.
- Korzekwa, M. I., Dell, P. F., Links, P. S., Thabane, L., & Webb, S. P. (2008). Estimating the prevalence of borderline personality disorder in psychiatric outpatients using a two-phase procedure. *Comprehensive Psychiatry, 49*(4), 380–386.
- Lenzenweger, M. F., Lane, M. C., Loranger, A. W., & Kessler, R. C. (2007). DSM-IV personality disorders in the national comorbidity survey replication. *Biological Psychiatry, 62*(6), 553–564.
- Levy, K. N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. *Development and Psychopathology, 17*, 959–986.
- Levy, K. N., Clarkin, J. F., Foelsch, P. A., & Kernberg, O. F. (in review). Transference focused psychotherapy for patients diagnosed with borderline personality disorder: A comparison with a treatment-as-usual cohort. *Manuscript submitted for publication*.
- Levy, K. N., Edell, W. S., & McGlashan, T. H. (2007). Depressive experiences in inpatients with borderline personality disorder. *Psychiatric Quarterly, 78*(2), 129–143.
- Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Weber, M., Clarkin, J. F., & Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a

- randomized control trial of transference focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, 74(6), 1027–1040.
- Levy, K. N., Meehan, K. B., & Yeomans, F. E. (2012). An update and overview of the empirical evidence for transference-focused psychotherapy and other psychotherapies for borderline personality disorder. In R. A. Levy, J. S. Ablon, & H. Kächele (Eds.), *Psychodynamic psychotherapy research* (pp. 139–167). New York, NY: Springer.
- Linehan, M. M., Tutek, D. A., Heard, H. L., & Armstrong, H. E. (1994). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry*, 151, 1771–1776
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.
- Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48, 1060–1064.
- Loranger, A. (1999). *International Personality Disorder Examination (IPDE) manual*. Odessa, FL: Psychological Assessment Resources, Inc.
- Loranger, A. W., Sartorius, N., Andreoli, A., & Berger, P. (1994). The international personality disorder examination: The World Health Organization/alcohol, drug abuse, and mental health administration international pilot study of personality disorders. *Archives of General Psychiatry*, 51(3), 215.
- Magnavita, J. J., Levy, K. N., Critchfield, K. L., & Lebow, J. L. (2010). Ethical considerations in treatment of personality dysfunction: Using evidence, principles, and clinical judgment. *Professional Psychology: Research and Practice*, 41(1), 64–74.
- McGlashan, T. H. (1986). The Chestnut Lodge follow-up study: III. Long-term outcome of borderline personalities. *Archives of General Psychiatry*, 43, 20–30.
- Messer, S. B. (2007). Psychoanalytic case studies and the pragmatic case study method. *Pragmatic Case Studies in Psychotherapy*, 3(1), 55–58. Available at <http://pcsp.libraries.rutgers.edu/>. doi: <http://dx.doi.org/10.14713/pcsp.v3i1.894>
- Munder, T. F., Flückiger, C., Gerger, H., Wampold, B. E., & Barth, J. (2012). Is the allegiance effect an epiphenomenon of true efficacy differences between treatments? A meta-analysis. *Journal of Counseling Psychology*, 59(4), 631–637.
- Oldham, J. M., Skodol, A. E., Kellman, H. D., Hyler, S. E., Doidge, N., Rosnick, L., & Gallahar, P. E. (1995). Comorbidity of Axis I and Axis II disorders. *American Journal of Psychiatry*, 152(4), 571–578.
- Paris, J. (1999). Borderline personality disorder. In T. Millon, P. H. Blaney, & R. D. Davis (Eds.), *Oxford textbook of psychopathology* (pp. 625–652). New York, NY: Oxford University Press.
- Patton, J. H., Stanford, M. S., & Barratt, E. S. (1995). Factor structure of the Barratt Impulsiveness Scale. *Journal of Clinical Psychology*, 51, 768–774.
- Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., McCallum, M., Rosie, J. S., O'Kelly, J. G., & Steinberg, P. I. (1999). Prediction of dropping out in time-limited, interpretive individual psychotherapy. *Psychotherapy*, 36(2), 114–122.
- Posner, M. I., Rothbart, M. K., Vizueta, N., Levy, K. N., Evans, D. E., Thomas, K. M., & Clarkin, J. F. (2002). Attentional mechanisms of borderline personality disorder. *Proceedings of the National Academy of Sciences*, 99(25), 16366–16370.
- Rockland, L. H. (1989). *Supportive therapy: A psychodynamic approach*. New York, NY: Basic Books.
- Rockland, L. H. (1992). *Supportive therapy for borderline patients: A psychodynamic approach*. New York, NY: Guilford Press.

- Roth, A. & Fonagy, P. (2005). *What works for whom? A critical review of psychotherapy research* (2nd ed.). New York, NY: Guilford Press.
- Rosenthal, R. & Rosnow, R. L. (1991). *Essentials of behavioral research: Methods and data analysis* (2nd ed.). New York, NY: McGraw-Hill.
- Rosenthal, R., Rosnow, R. L., & Rubin, D. B. (2000). *Contrasts and effect sizes in behavioral research: A correlational approach*. New York, NY: Cambridge University Press.
- Roth, A. & Fonagy, P. (2005). *What works for whom? A critical review of psychotherapy research* (2nd ed.). New York, NY: Guilford Press.
- Skodol, A. E., Gunderson, J. G., Pfohl, B., Widiger, T. A., Livesley, W. J., & Siever, L. J. (2002). The borderline diagnosis I: Psychopathology, comorbidity, and personality structure. *Biological Psychiatry*, 51(12), 936–950.
- Soloff, P. H. (2000). Psychopharmacology of borderline personality disorder. *Psychiatric Clinics of North America*, 23(1), 169–192.
- Stone, M. H. (1983). Long-term outcome in personality disorders. *British Journal of Psychiatry*, 162, 299–313.
- Torgersen, S., Kringle, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *Archives of General Psychiatry*, 58, 590–596.
- Wallerstein, R. (1986). *Forty-two lives in treatment*. New York, NY: Guilford Press.
- Weissman, M. M. & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry*, 33, 1111–1115.
- Yeomans, F. E. (2007). Questions concerning the randomized trial of schema-focused therapy vs. transference-focused therapy. *Archives of General Psychiatry*, 64(5), 609–610.
- Yeomans, F. E., Clarkin, J. F., & Kernberg, O. F. (2015). *Transference-focused psychotherapy borderline personality disorder: A clinical guide*. Washington, DC: American Psychiatric Publishing.
- Yeomans, F. E. (1993). Treatment planning: When a therapist overindulges a demanding borderline patient. *Hospital and Community Psychiatry*, 44(4), 334–336.
- Zanarini, M. C. & Frankenburg, F. R. (2001). Olanzapine treatment of female borderline personality disorder patients: A double-blind, placebo-controlled pilot study. *Journal of Clinical Psychiatry*, 62(11), 849–854.
- Zanarini, M. C., Frankenburg, F. R., Hennen, J., & Silk, K. R. (2004). Mental health service utilization of borderline patients and Axis II comparison subjects followed prospectively for six years. *Journal of Clinical Psychiatry*, 65(1), 28–36.
- Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2010a). The 10-year course of psychosocial functioning among patients with borderline personality disorder and axis II comparison subjects. *Acta Psychiatrica Scandinavica*, 122(2), 103–109.
- Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2010b). Time-to-attainment of recovery from borderline personality disorder and its stability: A 10-year prospective follow-up study. *American Journal of Psychiatry*, 167(7), 663–667.
- Zanarini, M. C., Frankenburg, F. R., Reich, D., Marino, M. F., Haynes, M. C., & Gunderson, J. G. (1999). Violence in the lives of adult borderline patients. *Journal of Nervous and Mental Disease*, 187, 65–71.
- Zanarini, M. C., Horwood, J., Wolke, D., Waylen, A., Fitzmaurice, G., & Grant, B. F. (2011). Prevalence of DSM-IV borderline personality disorder in two community samples: 6,330 English 11-year-olds and 34,653 American adults. *Journal of Personality Disorders*, 25(5), 607–619.
- Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The prevalence of DSM-IV personality disorders in psychiatric outpatients. *American Journal of Psychiatry*, 162(10), 1911–1918.