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# Transference focused psychotherapy: Development of a psychodynamic treatment for severe personality disorders

John F. Clarkin[a,*], Kenneth N. Levy[a,b], Janine M. Schiavi[a]

[a]*Joan and Sanford I., Weill Medical College of Cornell University, Personality Disorders Institute, Macy Villa, The New York Presbyterian Hospital-Payne Whitney Westchester, 21 Bloomingdale Road, White Plains, NY 10605, USA*

[b]*Pennsylvania State University, Unversity Park, PA, USA*

**Abstract**

The Borderline Psychotherapy Research Project at New York Presbyterian Hospital-Weill Cornell Medical Center, headed by Drs Otto Kernberg and John Clarkin has developed and tested a treatment for Borderline Personality Disorder called Transference Focused Psychotherapy. The theory, development and empirical research for the treatment are discussed. A pre-post study and a comparison to treatment as usual both showed promising results. The structure of the randomized controlled trial that is currently underway is also discussed.



*Keywords:* Borderline personality disorder; Transference focused psychotherapy; Psychotherapy research; Parasuicidal behavior; Suicidality; Attachment

## 1. Introduction

In the second half of the 20th century, psychoanalysis lagged behind other psychological orientations in generating empirical research [1]. The once-revolutionary methods of psychological investigation introduced by psychoanalysis, namely free association and interpretation, had not been supplemented with other experimental methods. At the same time, across the broader field of psychology, the emphasis on empirically validated psychotherapies increased ([2], see [3] for a critique of this approach), widening the research gap between psychodynamically oriented psychotherapies and other treatments. However, in recent years, psychodynamic psychotherapy has begun a culture change. A growing number of psychodynamic researchers are now applying methods that were once thought to be an awkward fit with psychodynamic therapy. Although overall as a field psychodynamic psychotherapy has a long way to go in order to catch up to other treatment modalities like cognitive–behavioral therapy, major efforts have been made in instrument development, the manualization of therapies, and process and outcome studies [4–9]. There is also increasing dialogue with other fields, such as neurobiology, reflecting sophisticated attempts to link a psychodynamic understanding of pathology and treatment to physiological underpinnings. In this article we discuss our own efforts in the study of psychodynamic psychotherapy and utilize our own research as an example of the strides being made in this area as well as highlighting important issues and developments in the field.

Since the early 1980's, the Borderline Psychotherapy Research Project at New York Presbyterian Hospital-Weill Cornell Medical Center, headed by Drs Otto Kernberg and John Clarkin, has been systematizing and investigating an object relations treatment of borderline patients. As part of this project, we have developed a manualized [10–12], modified psychodynamic treatment for patients with borderline personality disorder called Transference Focused Psychotherapy (TFP).

TFP is a structured psychodynamic treatment based on Otto Kernberg's object relations model [13]. Kernberg's model focuses on the development of mental representations that are derived through the internalization of attachment relationships with caregivers. For Kernberg, the degree of differentiation and integration of these representations of self and others, along with their affective valence, constitutes personality organization. Borderline

* Corresponding author. Fax: +1 914 682 6964.
*E-mail address:* jclarkin@med.cornell.edu (J.F. Clarkin).

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personality can be thought of as a severely disturbed level of personality organization, characterized by the use of primitive defenses (e.g. splitting, projective identification, dissociation), identity diffusion, and deficits in reality testing.

The major goals of TFP are better behavioral control, increased affect regulation, more intimate and gratifying relationships, and the ability to pursue life goals. This is hypothesized to be accomplished through the development of integrated self and object representations, the modification of primitive defensive operations and the resolution of identity diffusion that perpetuates the fragmentation of the patient's internal representational world. Thus, in contrast to therapies that focus on the short-term treatment of symptoms, the treatment we are developing has the ambitious goal of not just changing symptoms, but changing the personality organization which is the context of the symptoms.

We were intent on developing a new treatment—not just using existing psychodynamic treatments—that effectively targets borderline pathology. In that process, we have utilized both the wisdom of the psychodynamic community, advances in object relations theory, attachment theory, and developmental theory and data on the maturation of attention, effortful control and emerging sense of self and others. Our orientation combines theory, clinical experience, research findings, and the reformulation of the treatment in response to new data.

## 2. Matching the treatment to borderline pathology

It seems obvious that the treatment should be focused on the pathology in question. This presupposes detailed knowledge of the pathology, in terms of phenomenology, etiology, mechanisms of action, and course. If one is psychodynamically oriented, it includes hypotheses about the patients inner life, including representations of self and others, and motivations for interpersonal behavior. We utilized the growing information on the borderline pathology, including cognition [18], temperament [19,20], and ways of attaching to others [21], in adapting an object relations treatment for borderlines in a number of ways.

The borderline patient is identity diffused and has difficulty structuring her own impulses and goals. Often the patient begins treatment with self-destructive behaviors (e.g. self-cutting, suicidal attempts, living in destructive relationships, engaging in risky sex) that lack control and healthy *self-interest*. In order to contain these destructive impulses, TFP begins with a verbal contract that is articulated by the therapist, and negotiated with the patient. The contract spells out in detail the responsibilities and obligations of therapist and the patient if the therapy is to proceed. In addition, the therapist, using the prior history of the patient, anticipates the individual patient's threats to self and the treatment and how that would be handled in TFP.

The patient is treated in a context that fosters growing attachment between therapist and patient, and this is done by scheduling two sessions per week. Only with the intensity of two sessions a week does the patient grow in attachment, usually not just positive, to the therapist, and this situation (analogous to that between mother and child) provides an opportunity for the patient to learn affect regulation and effortful control in the interrelational context of another who is concerned but not interfering (i.e. operates from a stance of neutrality). Learning must occur in the immediacy of the moment. The focus of TFP is not on the past, but on the present interaction between therapist and patient. Often patients bring up their past, seen as the cause of their current victimized situation, but TFP redirects the focus to the present.

Interactions with others are the final common pathway of affect dysregulation in the borderline patient. It is interactions with others, either via mental representations and/or in actual interaction, which lead borderline patients to depression, despair, and suicidal behavior. TFP is focused on the immediate interactions between therapist and patient. TFP uses clarification, confrontation, and interpretations in the here-and-now interaction to bring the patient's attention to her representations of self and the therapist (and others), to amplify those representations, to represent parts of self that were repressed and split off in a highly defensive way, and to articulate them over time in a fuller and more coherent manner. Transcripts of TFP sessions suggest that the therapy often goes from much verbalization on the therapist's part and little from the patient at the beginning of treatment, to growing articulation by the patient, a transformation of impulsive action into reflective and richer conceptions of self and others.

It is especially in 'hot' emotional interactions that borderline patients both incorporate split off conceptions of self and others, and play them out in the here and now interaction with the therapist. TFP provides a safe (guided by the treatment contract) opportunity in which the patient can both experience these intense emotional interactions, and begin to accept unwanted affects and integrate them into a more coherence sense of self that is acceptable and does not necessitate self-destruction.

## 3. Development of a treatment manual

A critical component of psychotherapy research is a manual that describes in written form a psychotherapeutic treatment in enough detail that clinicians at various sites can administer the same (see [14] this issue, [15]). The standardization typically imposed by using psychotherapy manuals reduces outcome variation that is due to therapist differences, making it easier to draw valid inferences about treatment differences. Thus, a large number of psychotherapy treatment manuals were written, describing cognitive–behavioral, interpersonal and psychodynamic treatments

delivered in brief therapy, often focused on a very specific patient population homogeneous for a specific symptom complex (e.g. depression).

Insofar as the TFP manual standardizes the treatment, it is similar to other published manuals, but in other ways, the manual is quite different. Because the TFP treatment goes beyond a brief duration of some 12–15 sessions, it is impossible to describe and proscribe in detail what will happen in each session. To the degree that one is treating more disturbed patients who often act rather than verbalize, and are more inclined to disrupt the flow of the session, uniformity gives way to many unexpected moments between patient and therapist. We fully acknowledge that in long treatment with borderline patients many unexpected and unanticipated events will arise, events for which no treatment manual can specify what the therapist should do. Therefore, ours is a treatment manual that describes *principles of intervention*, and does not pretend nor aspire to cover every conceivable event between patient and therapist or the exact order in which treatment will proceed. The principles of intervention guide the therapist, as opposed to manuals in which the actions of the therapist are predetermined session by session. The principles of TFP are embodied in the strategies, tactics, and techniques.

The written description of TFP was generated by a simultaneous dual process of articulating the principles of the treatment, combined with viewing many hours of video tapes of senior clinicians engaging in the psychodynamic treatment with BPD patients. This dual process was iterative, and enabled the authors to refine the principles of the treatment at the same time as we accumulated clinical illustrations of how the principles were utilized in somewhat unique situations with different individual patients.

The resulting treatment manual [10] combines the principles of treatment with clinical illustrations. Pedagogically, this means that one always proceeds from the general to the specific, from principle to application, from theory to practice. The manual describes the elements of the treatment (strategies, tactics and techniques), across early, mid, and late phases. We have also written about the contract setting process in TFP [16] and about the typical complications in the treatment [17].

## 4. Teaching the treatment

The written manual is only one aspect of the training tools and procedures that we have developed in our efforts to teach TFP to mental health professionals. We set out to improve the teaching and monitoring of TFP. In the traditional method of teaching psychotherapy, therapists write process notes that are reviewed by supervisors. This method has certain pedagogical advantages, but we were interested in a more direct assessment of the psychotherapy process. Therefore, we utilized video-taped sessions, with review and discussion by our clinical research group. Over time, the use of the video tapes contributed to articulating the treatment in a written manual, and the development of rating scales to assess therapist adherence and competence.

Videotapes of actual treatment sessions conducted by senior clinicians provide trainees an opportunity to see the treatment modeled, rather than simply described. It has been our experience over more than 20 years that the videotaping quickly becomes an accepted part of the treatment. The patients accept the taping with little concern, and the therapists who have difficulty initially with the procedure gradually become accustomed to it as they grow more comfortable in revealing their work to colleagues.

A library of videotapes of senior clinicians conducting TFP, both effectively and at times with difficulty and mistakes, provides an important model for those learning TFP. We have also developed a library of videotapes of trainees who demonstrate growing expertise in the treatment. Watching the elegance of the work of senior clinicians should be tempered with the reality of watching their colleagues whose skills are developing.

Group supervision in which one therapist plays parts of the video tape of a recent session, with frequent breaks and discussion with a supervisor is at the heart of the training. Especially helpful is the articulation of the dominant transference theme by the supervisor with suggestions for interpretative strategies for the next session. The application of these suggestions in the next session can be pursued in following supervisory sessions. Supervisory attention and detail are helped by the use of a supervisor's rating scale that quantifies the therapist's adherence and competence in the individual session. The ratings are always open and shared with the trainee in order to be specific about areas needing change and development, as well as describing areas of improvement and excellence.

## 5. Preliminary research on TFP

Once the treatment was manualized and taught to our therapists, we were prepared to begin the initial study of pre-post effects [5]. In 1994, we received a National Institute of Mental Health (NIMH) treatment development grant (*Treatment Development for Borderline Personality Disorder Project*, John F. Clarkin, PI) in order to continue the development of a treatment manual for TFP, a methodology for teaching and supervising TFP, and tools for assessing therapist adherence and competence in the delivery of the treatment. To generate initial effect sizes, NIMH also funded treatment for a small study group of BPD patients over a 1-year period.

For this phase, participants were recruited from all treatment settings (i.e. inpatient, day hospital, and outpatient clinics) within the New York-Presbyterian Hospital—Weill Cornell Medical Center, Westchester Division. Women between the ages of 18 and 50 who met criteria for BPD

with at least two incidents of suicidal or self-injurious behavior in the last 5 years, who did not criteria for schizophrenia, bipolar disorder, delusional disorder, organic pathology, and/or mental retardation were admitted to the study. In total, 32 patients were evaluated and met the study inclusion criteria. Nine individuals declined participation. Of the 23 patients that entered the study, seventeen completed the planned 1-year of treatment. They were assessed at baseline, 4, 8, and 12 months with a variety of interview and self-report measures.

All therapists (senior therapists to postdoctoral trainees) selected for this phase of the study were judged by independent supervisory ratings to be both competent and adherent to the TFP manual. Three senior supervisors rated the therapists for TFP adherence and competence. Throughout the study all therapists were supervised on a weekly basis by Dr Otto Kernberg and at least one other senior clinician (A. Appelbaum, F. Yeomans, and M. Stone).

The 1-year attrition rate was 26% and no patient committed suicide. Two patients dropped out early in the treatment after 4 months, and two dropped out after 8 months of treatment. Two other participants were administratively discharged due to protocol violations (e.g. refusal to be videotaped or refusal to terminate from existing treatments). These results compare well with other treatments for BPD: Linehan, Armstrong, Suarez, Allmon, and Heard [22] had 16.7% drop out, and one suicide (4%); Stevenson and Meares' study [23] had a 16% drop out rate; and Bateman and Fonagy's study [4] had 21% drop out. None of the treatment completers deteriorated or were adversely affected by the treatment. Therefore, it appears that TFP is well-tolerated.

## 6. Pre-post psychotherapy changes

We analyzed outcomes in a set of parasuicidal variables that included the number of parasuicide attempts, the medical risk of all attempts, and the average resulting physical condition after the attempts. For this set of variables, the overall multivariate model was significant for the completer group and approached significance for the intent-to-treat group ($P < 0.06$). In both the intent-to-treat and completer analyses, there was a significant decrease in the average medical risk of parasuicidal acts and an improvement in the average physical condition following these acts.

We also examined the patients apos; service use in the year prior to TFP treatment as compared to the use of services during the year of treatment. For both the intent-to-treat and completer groups, there was a significant reduction in the number of hospitalizations, and a decrease in the number of days hospitalized that approached significance ($P < 0.06$).

We also examined the number of subjects no longer meeting DSM-IV criteria for BPD after twelve months of treatment. In our study, 52.9% of subjects no longer met criteria for BPD after one year of twice-weekly outpatient treatment. This rate compares quite well with that found by others. Stevenson and Meares [23] found that 30% of patients in their treatment study no longer met criteria for DSM-III BPD at a one-year follow-up. Perry, Banon, and Ianni [24] note that naturalistic follow-up studies of patients with BPD yield an estimated recovery rate of only 3.7% per year and four active treatment studies for mixed personality disorders (with 53% having borderline personality disorder) produced a recovery rate of 25.8% per year.

Given the relative infrequency of suicidal acts, suicidal behavior was not a primary measure of outcome in this study.

Overall, the major finding in this study is that patients with borderline personality disorder who were treated with TFP showed marked reductions in the severity of parasuicial behaviors, and fewer emergency room visits, hospitalizations, and days hospitalized. The effect sizes were large and no less than those demonstrated for other BPD treatments [4,22,25]. Although we were encouraged by these results, we were aware of the inherent limitations in the study's design—namely that the improvements may have been attributable to the effects of time, rather than the treatment itself. Without a comparison group, it was impossible to eliminate this possibility. In order to address this limitation, we designed a study to examine patients treated with TFP's as compared to patients treated in other modalities.

## 7. Comparison study

We compared the results of patients diagnosed with BPD and treated with TFP to the results of a group of borderline patients who received one year of treatment as usual (TAU) in the same setting and system [26]. Significant differences between the TFP-treated group and the TAU group would greatly increase confidence in the benefits of TFP and support the undertaking of a randomized controlled trial of the treatment.

Participants continued to be recruited from all treatment settings within NYPH. In addition to the data previously collected on the participants in the pre-post study, we collected data from nine additional patients for the TFP condition. The additional nine patients were treated with TFP in accordance with the same methodology as the original group of seventeen. In addition to these 26 patients in the TFP condition, a comparison group of 17 women diagnosed with BPD was later identified as a treatment as usual group. The participants for the comparison group were initially assessed as part of evaluations provided by the Personality Disorder Institute for various reasons (e.g. clinical purposes or as part of other ongoing studies, etc.). There were no significant differences between the treatment group and the comparison group in terms of demographic or diagnostic variables, severity of Axis II BPD

symptomatology, baseline emergency room visits, hospitalizations, days hospitalized, or GAF scores.

Of the 17 patients in the comparison group, six patients entered once-weekly individual psychotherapy (three with private therapists affiliated with Cornell and three with therapists working in the NYPH Outpatient Department), seven patients entered treatment in a NYPH day program (five in Dialectical Behavioral Therapy, one in psychodynamic, and one who spent 6 months in psychodynamic and 6 months in DBT), and four patients were in and out of various treatments both at NYPH and outside the Cornell system. None of the TAU patients were discharged from the out-patient department. Individual psychotherapy was provided at the NYPH for all but two TAU participants. Both patients in psychotherapy outside NYPH's out-patient department were seen by therapists trained and with clinical appointments at Cornell Medical College. Overall, the TAU therapists represented a multidisciplinary group of therapists whose experience level generally falls somewhere between the first and second cohorts of therapists in the experimental condition.

The retention–attrition rate of the original seventeen TFP patients is discussed previously. None of the additional nine TFP patients, and none of the seventeen TAU patients, dropped out. Overall, of the 32 patients who completed the treatment contract and started TFP, six did not complete the 1-year treatment (23.1%). No patient suicided.

## 8. Comparison study results

We examined the percent of patients with psychiatric ER visits and psychiatric hospitalizations within each group (TFP vs. TAU) as a function of time (baseline and end of treatment). For the TFP treated group, 20 (76.9%) of the 26 patients visited the ER in the year prior to treatment but only seven (26.9%) had ER visits during the treatment year. This difference was significant. For the comparison group, 13 (76.4%) of patients had ER visits in the year prior to evaluation and 14 (82.4%) had ER visits during the year period that followed. This difference was not significant. Additionally, the difference between the TFP and TAU was not significant at baseline but was significant at the end of treatment.

With regard to the percent of subjects hospitalized, for the TFP treated group, 20 (76.9%) of the 26 patients were hospitalized in the year prior to treatment but only nine (34.6%) were hospitalized during the treatment year. This difference was significant. Whereas for the comparison group, 14 (82.4%) of patients were hospitalized in the year prior to evaluation and 11 (68.8%) were hospitalized during the year period that followed, a non-significant change. Again, the difference between the TFP and TAU groups was not significant at baseline but was significant at the end of treatment. Significant differences between the two treatments were evident in both the intent-to-treat group as well as the completers.

With respect to global functioning, there was a significant time by treatment group interaction—patients who completed TFP treatment showed an increase in global functioning whereas the TAU group did not. With regard to BPD criteria, we were only able to compare the TPF treated group and the TAU group at baseline and examine change in the TFP treated group because the participants in the TAU condition were not given diagnostic interviews at the end of the treatment year. Independent *t*-test analysis revealed that the mean number of BPD criteria met were not significantly different between the two groups at Time 1 (baseline). A paired *t*-test revealed the decrease in the number of criteria met in the TFP treated group was significant from baseline to 1-year time point for both intent-to-treat and completer analyses.

All of the within-subjects and between-subject effect sizes for the TFP treated participants indicated favorable change. The within-subject effect sizes ranged from 0.73 to 3.06 for the TFP-treated participants, with an average effect size of 1.19, placing. This effect size is in the high end of the large range as defined by Cohen [27]. In contrast, four of the eight within-subject effect sizes for the TAU group indicated deterioration, with the two positive effect sizes for number of psychiatric hospitalizations (for intent-to-treat and completer analyses, respectively) falling in the low end of the medium range. The between subject effect size ranged from 0.48 to 1.87, with an average effect sizes of 1.08. This effect size is also in the large range [27].

Although our study was not specifically designed to examine cost-effectiveness, and without data on the exact cost savings between the year prior and the treatment year, the dramatic reduction in service utilization in terms of ER visits, hospitalizations, and length of stays in the hospital suggests a substantial cost savings associated with our treatment. Even estimating a conservative $1000 per day for inpatient treatment, the TFP-treated group would have utilized $1,000,000 less during the treatment year than in the year prior to treatment, whereas the TAU group utilized more services during the treatment year than in the year prior.

The major finding in this study is that BPD patients treated with TFP showed marked reductions in emergency room visits, hospitalizations, days hospitalized, as well as increases in global functioning as compared to the treatment-as-usual cohort. Both within group and between group effect sizes were large and no less than those demonstrated for outpatient DBT, inpatient DBT, and a psychodynamic day treatment [4,22,28].

Given the comparison with a relevant study group, the findings of this study are an advance over our previous findings and suggest the value of further research on TFP. Nevertheless, the lack of randomization in the design limits the conclusions about efficacy. A randomized clinical trial

of TFP would constitute a more stringent test of the efficacy of this treatment.

## 9. Randomized clinical trial

Encouraged by the positive results obtained in the comparison study, we are embarked on a randomized clinical trial of TFP [7]. The primary purpose of the study is to compare the efficacy of TFP to an active treatment and a control. A cognitive–behavioral treatment called Dialectical Behavior Therapy (DBT) [29], which has received preliminary empirical support for its effectiveness, was selected as the active comparison treatment. The mechanisms of change in these two treatments are conceived in very different ways. DBT is hypothesized to operate through the learning of emotion-regulation skills in the validating environment of the treatment [29]. TFP is hypothesized to operate through the integration of conflicted, affect–laden conceptions of self and others via the understanding of these working models as they are actualized in the here-and-now relationship with the therapist. A third treatment, supportive treatment [30], was used in contrast to these two active treatments as a control for attention and support.

This treatment study of BPD patients is unique and goes beyond existing treatment studies in a number of ways: [1] this is the first BPD treatment study to include males; [2] this study includes not only borderlines with suicidal behavior, but all who meet the diagnosis; [3] this is the first study to compare two forms of active treatment to a supportive treatment; [4] therapists are not located at a university clinic or hospital but in their private offices in the community; [5] medication is carefully delivered, when needed, by an algorithm; patients with and without medication provide a contrast in the data analysis, [6] outcome measures involve not only symptom change, but also changes in organization of the personality at the psychological and neurocognitive levels.

The BPD patients were recruited from the New York City and adjacent Westchester County, referred by private practitioners, clinics, family members and self-referred. They are males and females between the ages of 18 and 50. Patients with comorbid schizophrenia, schizoaffective disorder, bipolar disorder, delusional disorder, and/or delirium, dementia, and amnestic and other cognitive disorders were *excluded* because of the influence of brain pathology and thought disorder on the ability to provide meaningful self-report data and complicated response to treatment. In addition, patients with substance dependence were excluded, although substance abuse was not an excluding factor. We include patients with other comorbid Axis I disorders, as issues of comorbidity across time with these Axis I disorders are a focus of investigation.

Patients were assessed with a number of semi-structured interviews and self-report instruments to establish the diagnosis. Assessment instruments were chosen to reflect important domains that might show change in treatment such as symptoms, behaviors, attention, positive and negative affect, affect regulation, work and social functioning, identity and identity diffusion.

Patients were also assessed using neurocognitive tasks known to tap executive functioning and attention. A subgroup of patients underwent functional imaging (fMRI) prior to and following one year of treatment. Upon completing the assessment, patients were randomized to one of the three treatment conditions for one-year outpatient treatment.

We interviewed 207 individuals for at least one evaluation session. Of these 207, 109 were eligible for randomization. Of the 109 eligible for randomization, 90 were randomized to treatment. There were no differences in terms of demographics, diagnostic data, and severity of psychopathology between those randomized to treatment and those not.

Patients were randomized to one of the three treatment conditions for one-year outpatient treatment. The three treatments were delivered with attention to preserving the integrity of each treatment under investigation. Therapists in each of the three treatment conditions were selected based on prior demonstration of competence in the treatment. In order to ensure on-going therapist adherence and competence, all treatments were supervised on a weekly basis by experts in each treatment. Barbara Stanley, PhD, an acknowledged expert in DBT and NIMH-funded researcher in this area, is the supervisor for DBT. Otto Kernberg, a psychoanalyst of international stature, is the supervisor of TFP. Ann Appelbaum, expert therapist, is supervisor of the supportive treatment.

## 10. Domains of outcome

The domains of outcome in a psychotherapy study are determined by the goal of the treatment (what patient changes does the therapy intend), and the hypothesized mechanisms of change (predictors, mediators, and moderators). Thus, in our ongoing treatment study we assess the influence of treatment in reference to the central temperamental features of negative affect (i.e. lowered negative affect) and effortful control (i.e. increased effortful control/constraint), in addition to the changes in the BPD Axis II criteria themselves. The advantage of assessing change in these two key temperamental dimensions is their close relationship to underlying neurobehavioral systems of the organism on the one hand, and their obvious impact on everyday functioning on the other. We postulate that a decrease in negative affect (or change in the balance of positive and negative affect) and an increase in effortful control would be features of any successful treatment of BPD patients. Focus on these variables provides a context in which we can judge the relative success of different types of psychosocial treatment. It also provides us with a unique

opportunity to determine if there are specific gains that maintain or accrue with each of the three treatments. For example, there may be notable gains associated with one of the three treatments in one area of psychosocial functioning, which are themselves seen in correlation with changes in negative affect or effortful control. We also assess the third crucial variable of conceptualization of self and others, as it is through the conceptualization of the interpersonal world that the individual controls and modulates affect.

The variables of primary interest in this study were assessed at four time points, namely at baseline, 4-months, 8-months, and 12-months (termination of treatment). Thus, each study subject will have been measured on the same variables at roughly the same intervals at four points in time.

## 11. Preliminary results

All psychotherapy sessions have been completed, and data are currently being analyzed. Some preliminary analysis has been completed on three assessment measures - Reflective Function (RF), coherence, and attachment [31]. Preliminary findings indicate that RF increased most dramatically for the TFP-treated group, but did not change significantly in either the DBT or supportive treatment groups. Coherence increased significantly for all three groups. Overall, there was a significant change among patients in terms of attachment style. At baseline, 92% of patients were judged to be insecure in their attachment, and only 8% were judged secure. At 12-months, only 64% of patients were judged insecure, while the number of secure patients increased to 36%. This difference is significant at the $P < 0.03$ level. A change in unresolved/resolved status with regard to trauma or loss was also clear. At baseline, 36% of patients met criteria for an Unresolved attachment classification. By 12-months, the percentage had dropped to 9%, a change that is significant at the $P < 0.004$ level. The data have not been analyzed by treatment group yet, so differences among treatments have not been determined.

## 12. Conclusion

Accumulating evidence indicates that Transference Focused Psychotherapy may be an effective treatment for Borderline Personality Disorder. As more data from the RCT is assessed, we will have a better understanding of how the treatment performs under more stringent experimental conditions. Because the RCT better controls for unmeasured variables through randomization, and offers controls for attention and support, and compares TFP to an already established, well-delivered, alterative treatment, its outcome will be a strong indicator of the treatment's efficacy and effectiveness. In addition to assessment of outcome, the RCT has also generated process-outcome studies designed to assess the hypothesized mechanisms of action in TFP that results in the changes seen in these patients [32]. Additionally, in the future, evaluating the long-term effectiveness through 2-, 3-, and 5-year follow-up data is crucial to establish the long-term significance of a treatment for a chronic disorder [3].

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