

A Psychodynamic Treatment for Severe Personality Disorders: Issues in Treatment Development

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We describe a psychodynamic treatment modified for patients with severe personality disorders identified as borderline personality disorder in DSM-IV, Axis II, and understood as borderline personality organization from a psychoanalytic perspective. This treatment is labeled *transference-focused psychotherapy* (TFP) in order to highlight the centrality of working with these patients in the here-and-now treatment interaction. The empirical development of TFP is described, including the generation of a treatment manual, the utility of various methods to teach the treatment, and preliminary data on efficacy. The latest step in the development of this treatment is an ongoing randomized clinical trial comparing the efficacy of TFP to a cognitive-behavioral and a supportive treatment.

SINCE THE EARLY 1980S, THE BORDERLINE PSYCHOTHERAPY RESEARCH Project at the Personality Disorders Institute at New York–Presbyterian Hospital–Weill Medical College of Cornell University, headed by Drs. John Clarkin and Otto Kernberg,¹ has been systematizing and

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investigating a particular psychodynamic psychotherapy for borderline patients called *transference-focused psychotherapy* (TFP). We have generated several volumes of a treatment manual (Kernberg et al., 1989; Clarkin, Yeomans, and Kernberg, 1999; Yeomans, Clarkin, and Kernberg, in press) that describes this treatment, and companion volumes that detail the contract-setting phase of the treatment (Yeomans, Selzer, and Clarkin, 1992) and negotiating difficult aspects of treatment (Koenigsberg et al., 2000). We have also empirically explored a number of clinical issues related to the treatment of borderline patients including the development of treatment manuals for borderline personality disorder (BDP) (Hurt and Clarkin, 1990; Kernberg and Clarkin, 1993), the treatment process in terms of factors related to early dropout (Smith et al., 1995; Yeomans et al., 1994), symptom response (Hull, Clarkin, and Kakuma, 1993), and covariates that influence outcome (e.g., antisocial traits; Clarkin et al., 1994).

Development of a Treatment Manual

Psychotherapy researchers have been advocating the use of treatment manuals designed for specific disorders for many years (Clarkin, 1998). However, psychodynamic researchers have lagged far behind in this area. Luborsky's pioneering work is an exception in publishing empirical studies of his supportive-expressive dynamic therapy for specific DSM disorders (Luborsky, 1984; Luborsky, Mark, et al., 1995; Luborsky, Woody, et al., 1995). 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 (Crits-Christoph and Mintz, 1991). However, manuals may limit psychotherapy benefits by restricting the flexibility of therapists (Seligman, 1995). Nevertheless, a recent meta-analytic study found the studies that used treatment manuals had larger effect sizes when compared with studies that did not use treatment manuals (Anderson and Lambert, 1995).

There are three special difficulties in the manualization of a psychodynamic treatment for character pathology: (1) lack of consensus concerning

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the nature of psychodynamic treatment, (2) describing a treatment of long duration, and (3) describing a psychodynamic treatment that gives a great deal of initiative in the treatment to the patient.

The essential aspects in the psychodynamic treatment of character pathology are debatable. Psychodynamic therapists are seen as thoroughly trained to use their creative intuition in approaching every individual patient in a unique way. While there is no doubt that every patient is unique, and each patient–therapist dyad develops its unique interaction and trajectory over time, in order to develop scientific knowledge of the treatment of various disorders we must examine the effects of treatments that have common features with clearly identified patient types. In order to investigate a clearly defined psychodynamic treatment for a specific group of patients (i.e., those with borderline personality organization), we needed to articulate the treatment in a written manual.

A first step in this process was the decision as to *which* dynamic treatment to develop, as there are many psychodynamic treatments for character pathology. We have chosen to focus on only one psychodynamic formulation of personality organization and pathology, and one approach to the treatment of these patients, and that is according to the theorizing of Otto Kernberg. The object relations approach based on Kernberg's clinical theorizing (Zittel and Westen, 1998) was selected because we were fortunate to have Kernberg as a colleague and could get him to expose this treatment to scrutiny via the viewing and rating of videotaped sessions. In addition, this dynamic theory of character pathology was well articulated and had a match to the DSM-IV Axis II description.

Most current psychotherapy manuals describe a brief treatment of some 15 to 20 sessions. With such brief duration, the treatment can be described almost literally session by session, in a way that is not possible for a treatment of some 100 or more sessions. In addition, cognitive-behavioral treatments have set strategies that are applied to each patient within a specific diagnosis. These techniques (e.g., exposure, problem solving) are applied with little regard to the individual characteristics of the patient with the particular diagnosis that sets the symptom reduction goals of the treatment. In sharp contrast, psychodynamic treatments typically provide space and time for the individual patient to start the treatment session and reveal what is bothering them at that time.

Transference-Focused Psychotherapy

Our treatment rationale is based on the (a) psychodynamic theory of personality organization and its relationship to symptoms and (b) the need to modify psychodynamic treatment in order to address the behavior of those individuals with borderline personality organization.

TFP is a structured psychodynamic treatment based on Otto Kernberg's (1984) object relations model. Central to Kernberg's model are 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 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 goal of TFP is 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. In this treatment, focusing on the transference is the primary vehicle for transforming primitive object representations (i.e., split, polarized) into more advanced ones (i.e., complex, differentiated, integrated).

TFP begins with explicit contract-setting with the patient which clarifies the conditions of therapy, the method of treatment and the respective roles of patient and therapist. The primary focus of TFP is on the predominant affect-laden themes that emerge in the relationship between borderline patients and their therapists in the here-and-now of the transference.

During the first year of treatment, TFP focuses on a hierarchy of issues: the containment of suicidal and self-destructive behaviors, the various ways of destroying the treatment, and the identification and recapitulation of dominant object relational patterns, as they are experienced and expressed in the here-and-now of the transference relationship. Therapists are instructed to steer away from exploring past relationships and to eschew interpretations that link the here-and-now with past relationships. Premature interpretations of this kind have been observed to foster regression in borderline patients (Kernberg et al., 1989), who

tend to experience transference distortions as real, and thus, have difficulty understanding and integrating the linkages between current difficulties and early pathogenic relationships during the early stages of treatment.

As the TFP therapist applies the strategies repeatedly over time, the patient begins to show behavioral manifestations of structural change. The patient becomes aware of previously unrecognized parts of self that are behaviorally manifested in the interaction with the therapist. Split off, persecutory parts of self are recognized. As these split off object representations are identified, they are slowly integrated into a more coherence sense of self and others. Thus, defensive splitting and projective identification are reduced, and the identity becomes more coherent, with fewer affect storms and integration of affects.

Construction of a Treatment Manual

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 videotapes of senior clinicians doing the psychodynamic treatment with BPO 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 different situations with different individual patients.

To detail the treatment coherently among ourselves, and to teach the treatment to psychology fellows and residents in psychiatry, we struggled with the task of isolating important principles of treatment while recognizing the uniqueness of each patient–therapist dyad and the personality styles of the different therapists. We were not describing the treatment as done by one individual therapist with a particular personality style, but a set of treatment principles that applied in the treatment of all patients with BPO.

Initially, we spent a great deal of time and effort in clarifying how to set the treatment contract with the patient at the start of treatment after taking some clinical history. Some in the group tended to rush over the details of the treatment contract, whereas others were more perfectionistic and wished to have absolute clarity in the contract as negotiated with the patient before proceeding to treatment per se. The clarification over

this issue resulted in an early book describing the treatment contract in detail (Yeomans et al., 1992), with special emphasis on the patients' self-destructive behavior and how these are negotiated in the treatment contract.

The resulting treatment manual (Clarkin, Yeomans, and Kernberg, 1999) 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 practicality. The manual describes the elements of the treatment (strategies, tactics, techniques) and the phases of treatment from beginning to middle and termination. We have also written about the contract-setting process in TFP (Yeomans et al., 1992) and about the typical complications in the treatment (Koenigsberg et al., 2000).

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 professionals, psychiatric residents, and fellows in psychology. Videotaping of actual treatment sessions is seen as a procedure essential to viewing the treatment as actually done (not just described) by senior clinicians and modeling the treatment for others. We have found that many psychoanalytic institutes and psychoanalysts and psychodynamic therapists have intense negative reactions to the videotaping of therapy sessions. The arguments against videotaping are familiar and oft repeated. In order to do psychotherapy research, however, one must be able to observe the therapy first hand, as the therapy is the dependent variable in the research design.

It has been our experience over more than 20 years that the videotaping quickly becomes an expected and accepted part of the treatment. The patients accept the taping with little concern, and the therapists who have the most difficulty with the procedure get accustomed to it as they become more comfortable in revealing their work to colleagues.

A library of videotapes of senior clinicians doing TFP, both effectively and at times with difficulty and mistakes, provides an important model for those learning TFP. The ability to see the details of moment to moment interaction between therapist and patient is a very meaningful learning procedure. We have 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 videotape 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.

We have had the experience of teaching TFP to clinicians at other sites over an extended period of time. This teaching of TFP has occurred with colleagues in Montreal, Canada; Mexico City, Mexico; Maastricht, Holland; and Munich, Germany. Each site has invited us to provide training in TFP in somewhat different formats. The usual approach is to provide a seminar on TFP which includes the reading of the treatment manual by the participants. This beginning instruction is followed by supervision of an actual case treated by the trainee.

Preliminary Data on the Efficacy of TFP

Our group received a National Institute of Mental Health (NIMH) treatment development grant (Treatment Development for Borderline Personality Disorder Project, John F. Clarkin, principal investigator; NIMH MH-53705-02) in order to develop a treatment manual for TFP, as well as a methodology for teaching and supervising TFP, and tools for assessing therapist adherence and competence in the delivery of TFP. To this end, we were funded to provide treatment for 10 BPD patients over a one-year period. No funding was awarded for a control or comparison group. In addition to the 10 subjects who completed the study as part of the NIMH grant, we continued to recruit and study patients treated with

TFP mostly by trainees and new staff interested in learning TFP. We continued to utilize the methodology from the grant study. An additional seven subjects were recruited and completed 12 months of treatment. In the NIMH grant study and our continuation study a total of 35 patients was evaluated and met the study inclusion criteria. Seventeen subjects completed the planned one year of treatment, nine dropped out of the study during the contracting phase, and four dropped out prematurely after some four to eight months of treatment. Two additional patients were discharged early in the treatment and referred elsewhere due to a judgment by the clinical research staff as to their inability to adhere to the TFP contract. Three subjects declined to participate after having begun the evaluation process.

We examined the effects of one-year outpatient treatment of borderline patients with TFP. Our goal was to examine the initial efficacy data for TFP. We are most interested in both symptom and structural change, but we decided to focus on behavioral change in this preliminary study of TFP. With borderline patients, who act on their impulses without reflection, behavioral change is important in its own right, and may occur early in treatment before structural change can begin. Without the demonstration of behavioral change, there would be no interest in TFP in the pragmatic context of the current health care system in the United States. Symptom and behavioral change are easy to assess and quantify as compared to structural change. With these considerations in mind, we focused on the assessment of changes in self-destructive behavior, symptoms, social and work functioning, and in the utilization of the health care system. It was hypothesized that subjects would show a significant reduction in suicidal and self-injurious behavior as well as a significant reduction in its severity, and decrease in the physical harm resulting from suicidal and self-injurious behavior. In addition we believed that subjects would show a significant reduction in suicidal ideation, hopelessness, and a significant increase in reasons for living and show a significant reduction in distress, depression, anxiety, and anger. It was expected that subjects would show a significant reduction in the number of criteria met for the diagnosis of BPD as well as the severity for each of the individual BPD criteria and a significant reduction in service utilization in terms of emergency room visits, hospitalizations, and number of days hospitalized. Finally, it was hypothesized that subjects would show a significant increase in social adjustment and global functioning.

Procedure

Subjects 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. After referral for evaluation, patients were interviewed and assessed by trained evaluators for inclusion in the study. At the time that subjects were invited to participate in the study, written informed consent was obtained after all study procedures had been explained. Potential subjects were screened with both clinical and semistructured interviews. Women who met the following selection criteria were eligible for the study: (1) five or more DSM-IV criteria for BPD as measured on the SCID-II; (2) presence of at least two incidents of suicidal or self-injurious behavior in the past five years; (3) do not meet DSM-IV criteria for schizophrenia, bipolar disorder, delusional disorder, organic pathology, or mental retardation; (4) are between the ages of 18 and 50 years of age; and (5) agree to the study conditions, including termination from other individual psychotherapy. On admission to the study, patients were given a number of additional assessment instruments and were reevaluated at four, eight, and 12 months while participating in the study.

Subjects

Thirty-two subjects were evaluated and judged appropriate for treatment. Seventeen patients completed the planned one year of treatment. This group had a mean age of 32.7 years and 76.5% were Caucasian. Ten were single and never married, 4 were married, and 3 divorced. Eight of the 17 were unemployed.

Therapists

The therapists ranged from experienced, senior individuals (four men and two women) with at least 10 years of experience, to six (three men and three women) faculty/staff psychologists and postdoctoral trainees in psychology, all of whom had two or more years of experience treating BPD patients with psychodynamic treatment and training in TFP. All therapists selected for this phase of the study were judged by independent

supervisory ratings to be both competent and adherent to the TFP manual. All therapists regularly viewed videotaped sessions. 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, M. Stone, and P. Foelsch).

The therapists ranged from very experienced individuals with analytic training to postdoctoral psychology fellows who were learning TFP during this study. The range of therapist experience enabled us to examine in a preliminary way the relationship between therapist experience, competence in doing TFP, and outcome, albeit with a small N and basically on an impressionist level.

Findings Regarding Adherence and Competence. After the completion of all treatment in the study, three senior supervisors rank-ordered the therapists for TFP adherence and competence. The range was purposefully truncated, as all therapists were consistently supervised to adherence during the treatment period. With this limited range of competence, we found no relationship between the rank order and patient outcome.

Some therapists were easier to supervise in TFP than others, and this did not favor either the more experienced or younger therapists. There was a small number of problems that kept reappearing in the supervision that are worthy of note. Therapists were keenly aware of the dominant object relations played out in the session, but seemed relatively inactive in the face of the patient's behavior. When queried about their relative passivity, therapists were unsure of their interpretive formulation, and often they felt that the patient was not prepared and might react with antagonism to the interpretation. Several therapists, when faced with crises in the treatment, would resort to supportive techniques of advice or suggestions for action which invariably was of no assistance.

Retention–Attrition. For those completing the treatment contract, the one-year attrition rate was 19.1% (four of 21 of patients dropped out of treatment) and no patient committed suicide. Two patients dropped out early in the treatment after four months, while two dropped out after eight months of treatment. The two patients who dropped out after eight months of treatment were improved, and decided that they no longer needed the treatment. Two other subjects were administratively discharged due to protocol violations. These results compare well with those

of Linehan and colleagues' (1991) study (4 of 24, 16.7%, one suicide, 4%), Stevenson and Meares's (1992) study (16%), and Bateman and Fonagy's (1999) study (21%). Interestingly, in our study nine subjects declined to enter treatment during the contracting phase prior to beginning treatment. There was a tendency for the decliners to live farther from the institute, although this difference did not reach statistical significance. Thus, 57% of the subjects referred from area inpatient units, day hospitals, and outpatient clinics completed 12 months of TFP treatment. None of those completing the treatment deteriorated or were adversely affected by the treatment. Therefore, it appears that TFP is quite well tolerated.

Pre-Post Psychotherapy Changes

Suicidal and Self-Injurious Behavior. Our study did not limit entry to borderline patients with a suicidal act within the past year, as was the case in the Linehan et al. (1991) study. However, it was a requirement to entry that all patients in our study had a suicidal act in the prior five years. Given the relative infrequency of suicidal acts, suicidal behavior was not a primary measure of outcome in this study. However, there was a significant reduction in the number of patients who attempted suicide in the year prior to treatment (53%) and those who made an attempt during the one year of treatment (18%). In addition, there was an important trend for reduction in the number of suicide attempts and the medical risk of these acts. Suicidal ideation did not decrease, but there was a significant increase in reasons for living. One possible interpretation of the combination of these data elements, which is congruent with clinical lore, is that during the first year of treatment there is the beginning of containment of action while suicidal ideation remains. In this context, there is a growing awareness of satisfactions in life and reasons to live.

The number of self-injurious behaviors did not decrease during the treatment year, but importantly, the medical risk and the physical condition associated with both the most serious and the average of all self-injurious behaviors were significantly reduced.

Symptoms. There was a significant decrease in global symptomatic distress (BSI) and state anxiety (STAI state scale). Additionally, there

was a trend toward significance for diminution in both depression (BDI) (Beck et al., 1961) and trait anxiety (STAI trait scale). There were no significant changes in terms of self-reported state and trait anger.

Changes in Borderline Criteria. The most obvious way to assess change in our study group was to examine whether patients still met criteria for BPD at the end of the treatment year. Whereas all 17 subjects met criteria for BPD at the time of entry into the study, only eight continued to meet criteria for BPD after 12 months of treatment. Thus, 52.9% of subjects no longer met criteria for BPD. This difference was highly significant, $F(1) = 12.24, p < .001$.

At baseline, the treatment group ($N = 17$) had a dimensional score of 3 (out of 6) or more on all BPD criteria as measured on the SCID-II Borderline Dimensional Interview except suspiciousness/depersonalization. A score of three meets threshold for the presence of a particular criterion. The average number of criteria met was 7.65 ($SD = 1.22$). The mean dimensional summary score for the group was 35.53 (out of a possible maximum score of 54, and a minimum score for borderlines of 15; $SD = 5.08$). At completion of the treatment year, there was a significant diminution on eight of the nine symptom criteria as well as both the number of criteria met and the dimensional summary score. Only anger did not change significantly during the one-year treatment, although there was a trend toward significance. Two criteria, unstable interpersonal relationships and affective lability, were not reduced to a mean below threshold (rating below 3).

Perry, Banon, and Ianni (1999) note that naturalistic follow-up studies of patients with BPD yield an estimated recovery rate of only 3.7% per year, whereas four active treatment studies for mixed personality disorders (with 53% having BPD) produced a recovery rate of 25.8% per year. Stevenson and Meares (1992) found that 30% of patients in their study no longer met criteria for DSM-III BPD at a one-year follow-up. We also examined the number of subjects no longer meeting DSM-IV criteria for BPD after 12 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 Stevenson and Meares and with the model derived by Perry and coworkers. Perry and coworkers estimated that it would take 10.5 years of naturalistic follow-up to obtain a comparable recovery rate for individuals with BPD.

Social Functioning. We evaluated areas of social adjustment on the SAS-SR. There was a significant improvement in friendships and work functioning and management of finances. There were no significant changes in relationship to family of origin, sexual functioning, and housework. There was a trend for improvement in family relations and legal issues. There were significant improvements ($p < .001$) on the Global GAS and GAF ratings of functioning.

Service Utilization. With data from the Treatment History Inventory (THI) (Linehan, 1987), we examined the patients' service use in the year prior to TFP treatment as compared to the use of services during the year of treatment. The nonparametric Wilcoxon signed rank test comparing baseline ratings from the THI with ratings after one year of treatment showed a significant reduction in emergency room visits (55% reduction), psychiatric hospitalizations (67%), and days of inpatient hospitalization (89% reduction; 39.2 vs. 4.5 days). Additionally, whereas 11 (64.7%) of patients were hospitalized in the year prior to treatment, only five (29.4%) were hospitalized during the treatment year. This difference was significant.

In a second study funded by the International Psychoanalytic Association (Kenneth Levy, principal investigator), we showed that patients who completed TFP treatment not only showed a significant decrease in the mean number of hospitalizations and length of time hospitalized, but also were significantly different from the comparison group at the end of a one-year period (the TFP-treated group went from 39.2 days to 4.5 days hospitalized, whereas the non-TFP-treated group went from 41.1 days to 38.7 days hospitalized). These findings are very promising and suggestive of the value of TFP as a treatment for BPD.

In terms of number of patients hospitalized, for the TFP-treated group, 16 (70.0%) of the 23 patients were hospitalized in the year prior to treatment but only five (21.7%) were hospitalized during the treatment year. This difference was highly significant. Whereas for the comparison group, 11 (80.0%) of patients were hospitalized in the year prior to evaluation and nine (60.0%) were hospitalized during the year period that followed. This difference was not significant.

There was a time-by-treatment group interaction, with respect to the number of hospitalizations. Subjects who completed TFP treatment

showed a decrease in the mean number of hospitalizations while the mean number of hospitalizations for the non-TFP-treated group decreased some but not significantly and essentially remained level. Statistical analysis revealed that the decrease in the number of hospitalizations in the non-TFP-treated group was not significant, but that the decrease in days hospitalized in the TFP-treated group was significant. Further analyses revealed that the number of days hospitalized was not significantly different between the two groups at Time 1 (baseline), but, they were significant at Time 2 (the one-year time point). Subjects who completed TFP treatment not only showed a significant decrease in the mean number of hospitalizations and length of time hospitalized, but also were significantly different from the comparison group at the end of a one-year period (the TFP-treated group went from 39.2 days to 3.3 days hospitalized, whereas the non-TFP-treated group went from 41.1 days to 38.7 days hospitalized).

Structural Change. In addition to the symptom and behavioral data on the sample of 17, we collected data that relates to structural change on some selected cases. Our efforts in this regard have focused on the attachment style of the patient as assessed on the Adult Attachment Interview (AAI) (George, Kaplan, and Main, 1985) and changes in the attachment style over the course of the treatment. In addition we have adapted the AAI to measure the attachment between the patient and therapist, and have named this instrument the Patient–Therapist Attachment Interview (PTAAI). We summarize here preliminary data on a few patients in this study that investigate change in patient attachment style, and the nature of the attachment between therapist and patient across one year of TFP (Diamond et al., 1999; Diamond, Clarkin, Levine, et al., in press; Diamond, Clarkin, Stovall-McClough, et al., in press). On the small number of patients for whom we have this data, selected patients do show changes in attachment style, moving from insecure attachments to secure attachments. These changes in attachment style are related to other changes in symptoms and social functioning in these patients. Most exciting is the relationship between the changes in patient attachment style and relationship between patient and therapist as assessed on the PTAAI.

Comment

We examined the treatment outcome for patients diagnosed with BPD who were treated in a one-year modified psychodynamic outpatient psychotherapy. The major finding in this study is that patients with BPD who are treated with TFP showed marked reductions in emergency room visits, hospitalizations, days hospitalized, and increase in global functioning. The effect sizes were large and no less than those demonstrated for outpatient DBT, inpatient DBT, and a psychodynamic day treatment (Linehan et al., 1991; Bateman and Fonagy, 1999; Bohus et al., 2000). The findings of the current study are an advance over our previous findings, given the comparison with a relevant study group. Nevertheless, a randomized controlled trial of TFP would constitute a more stringent test of the efficacy of this treatment and with the positive results presented here, we are proceeding to such a study.

Our study has several other limitations. First, this was an open trial. Subjects, therapists, and raters were not blinded to mode of treatment. Second, the sample in the present study was a relatively homogeneous group of severely disturbed, chronically self-destructive, borderline women. It is unclear if our results would generalize to less severely disturbed borderline individuals or whether the treatment would be as effective for borderline men. Another important issue regarding ability to generalize concerns the fact that none of our treated patients were currently abusing substances at the time of entry into the study. A number of studies have found a high prevalence of alcohol and substance use in individuals with BPD (Skodol, Oldham, and Gallaher, 1999; see Trull et al., 2000, for a review). It should be noted that although none of our patients met criteria for alcohol or substance dependence at the beginning of treatment, half of our treatment completers ($N = 11$) had significant drug use/abuse histories. Therefore, while our findings may not generalize to patients with current alcohol or substance abuse or dependence, certainly our findings are applicable to borderline patients with significant histories of drug or alcohol abuse.

Despite the limitations noted above, the positive results presented here clearly suggest that additional research on the efficacy of TFP is warranted. In addition to a randomized controlled trial of TFP, future research studies should include both expanded assessment of outcome and include process-outcome studies designed to assess the hypothesized

mechanisms of action in TFP that results in the change seen in these patients.

Foci for Future Research

Process Research

While outcome studies like those by Linehan (Linehan et al., 1991; Linehan et al., 1999) and Clarkin and colleagues (Clarkin et al., in press; Levy et al., in preparation) are important in determining the effectiveness of a particular treatment, the probative value of such studies for treatments underlying theoretical constructs is indirect and limited. Understanding what promotes therapeutic change requires more direct study of treatment processes. Moreover, process research, more than comparative outcome studies or even experimental tests, is likely to be useful in providing evidence for or against the theoretical propositions that guide different psychological treatments. Despite support for the effectiveness of existing treatments for BPD, researchers are still confronted with a high degree of uncertainty about the underlying processes of change. Gabbard and colleagues contend that transference interpretations are very high risk interventions (Gabbard, 1991). In contrast, Kernberg (1984) maintains that early interpretative work with the negative transference is necessary to prevent premature termination and therapeutic stalemates. These questions can be answered best through process research. Validation for a treatment and its propositions occurs to the extent that the proposed mechanisms of change are actually related to the effectiveness of the treatment.

Randomized Clinical Trial

With funding from the Borderline Personality Disorder Research Foundation (BPDRF) we are in the process of conducting a randomized clinical trial of the treatment of patients with BPD. Patients receive appropriate medication, when needed, according to an algorithm. In addition, patients are randomized to one of three treatment approaches (supportive treatment, a cognitive behavioral treatment, or TFP) which they receive over a one-year duration in an outpatient setting.

A major feature of this study is the extensive assessment of BPD patients before and after treatment in terms of genetics, temperament, neurocognitive functioning, and brain systems with the fMRI. This perspective on the disorder puts a new light on the treatment of these individuals. In this ongoing treatment study we are measuring affect, attention behavior, and examining the relationship of affect and affect regulation at the brain level with fMRI. Both TFP and cognitive-behavioral treatments of borderlines approach the issues of negative affect and effortful control, but in different ways. TFP enters the complex interaction of pathology at the level of representations of self and the other in the here-and-now interaction of therapist and patient in the treatment room. Cognitive behavioral treatment instructs the patient in the development and practice of skills of self-control. Further research will clarify the relative effectiveness and roles of these two approaches.

Follow-Up Research

Follow-up data is imperative to establish the long-term significance of these findings. Studies over time are crucial to evaluating the short- and long-term efficacy of treatments, since gains made in therapy may dissipate with time. The severity and chronicity of BPD suggest that follow-up evaluations after treatment trials are especially important for this population. In addition, the follow-up findings concerning the course of treated subjects have important implications for refining treatment approaches and identifying areas that are particularly intractable. For these reasons, the follow-up study of our subjects remains a central investigative tool for examining the course and effects of treatment for patients with BPD.

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