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Transference-Focused Psychotherapy

John F. Clarkin, Nicole Cain, Mark F. Lenzenweger,
and Kenneth N. Levy

Transference-focused psychotherapy (TFP) is a theory driven, manualized, empirically supported treatment for patients with the categorical diagnosis of borderline personality disorder (BPD) and for the broader group of patients with borderline personality organization. Since many treatments are effective with patients with BPD, it is generally accepted that there are important common elements across these treatments and psychotherapeutic treatments in general (Laska, Gurman, & Wampold, 2013). In this chapter, we emphasize those aspects of TFP that go beyond the common therapeutic elements.

Origins, Scope, and Focus

Object relations theory, deriving from Kleinian, as well as American object relations influences (Jacobson, 1964; Kernberg, 1984; Klein, 1957; Mahler, 1971), posits that the basic human drives and biological systems are always experienced in relation to a specific other, an object. TFP, a treatment approach based on object relations theory for patients with personality disorder (PD) was first manualized in 1999 (Clarkin, Yeomans, & Kernberg, 1999), and with further clinical and research experience we have expanded and refined the treatment (Clarkin, Yeomans, & Kernberg, 2006), and recently ex-

plicated the application of principles of treatment with multiple case examples (Yeomans, Clarkin, & Kernberg, 2015).

A major focus in the development of TFP has been on treatment of patients with severe PDs, especially BPD, as described by DSM-III (American Psychiatric Association [APA], 1980) and its successors. However, given the dysfunctions that cut across the PD categories and the resulting rampant comorbidity among these disorders, we have also focused on the aspects of treatment that are relevant across the less severe PDs (Caligor, Kernberg, & Clarkin, 2007). In fact, we have focused equally on the specific categories of PD as defined in DSM-5 (APA, 2013), and are concerned about the severity of key dimensions related to personality pathology that lead to levels of personality organization (neurotic and high- and low-level borderline organization).

Overview of the TFP Treatment Model

Clinicians across treatment orientations as diverse as cognitive (Pretzer & Beck, 2004), metacognitive (Dimaggio, Semerari, Carcione, Procacci, & Nicolo, 2006), interpersonal (Benjamin, 2003; Cain & Pincus, 2016), attachment (Bateman & Fonagy, 2006; Levy, 2005; Meyer & Pilkonis, 2005), and object relations

perspectives (Clarkin, Levy, Lenzenweger, & Kernberg, 2007) emphasize patients' representations of self and others as central to guiding interpersonal behavior. The conceptualizations of mental representations of self and others are variously referred to as cognitive–affective units, schemas, interpersonal copies, internal working models, and internalized object relations dyads, and in process terms such as reflective functioning. These self–other representations constantly appear either explicitly or by implication in therapy exchanges in which patients describe their relationship patterns with others to the therapist, and in patients' descriptions of their feelings and thoughts about the therapist.

In contrast to the general agreement about the centrality of mental representations of self–other and related interpersonal behavior, the manner in which psychotherapeutic treatment addresses these mental cognitive–affective units varies in important ways. Dialectical behavior therapy (DBT; Linehan, 1993) uses a predominantly instructional and cognitive approach to patient skills development. The mentalization-based treatment (MBT; Bateman & Fonagy, 2006) approach emphasizes the need to temper patient affect in therapy sessions. In contrast, the TFP model provides a treatment frame that allows the emergence of affect-driven perceptions of self and others (including the therapist). This model acknowledges the necessity of affect arousal in the sessions to provide a safe opportunity to modify extreme cognitions and related affects in the "hot" and immediate experience of others. This approach is consistent with current understanding of primitive affects and their contribution to numerous forms of psychopathology. As stated by Panksepp and Biven (2012, p. 445) emotion-focused therapeutic approaches are more effective than cognitive-behavioral approaches in promoting more lasting change: "The intense re-experiencing of emotional episodes opens up new treatment possibilities because it provides therapists an emotional 'closeness,' especially within a secure therapeutic alliance, that is optimal for therapeutic change." Key features of the contemporary object relations treatment model, known as TFP, include initial contract setting, a focus on disturbed interpersonal behaviors, both in the patient's current life and in relationship to the therapist, and the use of the process of interpretation (Caligor, Diamond, Yeomans, & Kernberg, 2009).

Diagnosis, Assessment, and Formulation

The diagnosis of PD, both in general and in terms of specific categories, has undergone an evolution since DSM-III (APA, 1980). PDs in DSM-III were described using criteria that were a mixture of attitudes, emotions, and behaviors, with the clear intent of staying close to phenomenology in order to increase reliability of assessment. This phenomenological approach, admittedly very thin on theory, resulted in the often-noted problems and difficulties of transition from DSM-III to DSM-IV. The problems and shortcomings of the polythetic approach to the diagnosis of supposedly 10 distinct PD categories are largely captured in the excessive heterogeneity within a single specific PD among patients in one diagnostic category (see Lenzenweger, Clarkin, Yeomans, Kernberg, & Levy, 2008) and high levels of "comorbidity" (perhaps best described as co-occurrence or co-variation) across the PD.

In the progression from DSM-IV to DSM-5, there has been a perceptible shift in emphasis from categories of PD to dimensions of dysfunction. The movement behind the generation of DSM-5 was informed by focus on the biological underpinnings of psychiatric disorders suggestive of dysfunction at various levels of severity that span the diagnostic categories (Hyman, 2011). In order to capture domains of dysfunction, the architects of DSM-5 Section III introduced dimensional ratings of self- and other functioning and dimensional trait assessment.

We have long taken the dimensional approach to the specification of the primary domains of dysfunction in PD psychopathology. Our approach to the assessment and diagnosis of PD is consistent with but divergent somewhat from the approach taken by DSM-5 Section III. Based on the structural organizational approach to personality pathology advanced by Kernberg (1984), we have articulated a nosology of personality pathology with a related method of clinical assessment. Object relations theory combines a dimension of severity of pathology with a categorical or prototypical classification of three levels of personality organization (Clarkin et al., 2006; Kernberg & Caligor, 2005) (see Figure 32.1 and Table 32.1). This approach has the advantage of utilizing both the severity of personality pathology (by assessing the dimensions of identity, quality of object relations, defensive operations, social reality testing, aggression, and moral values), and categories of personal-

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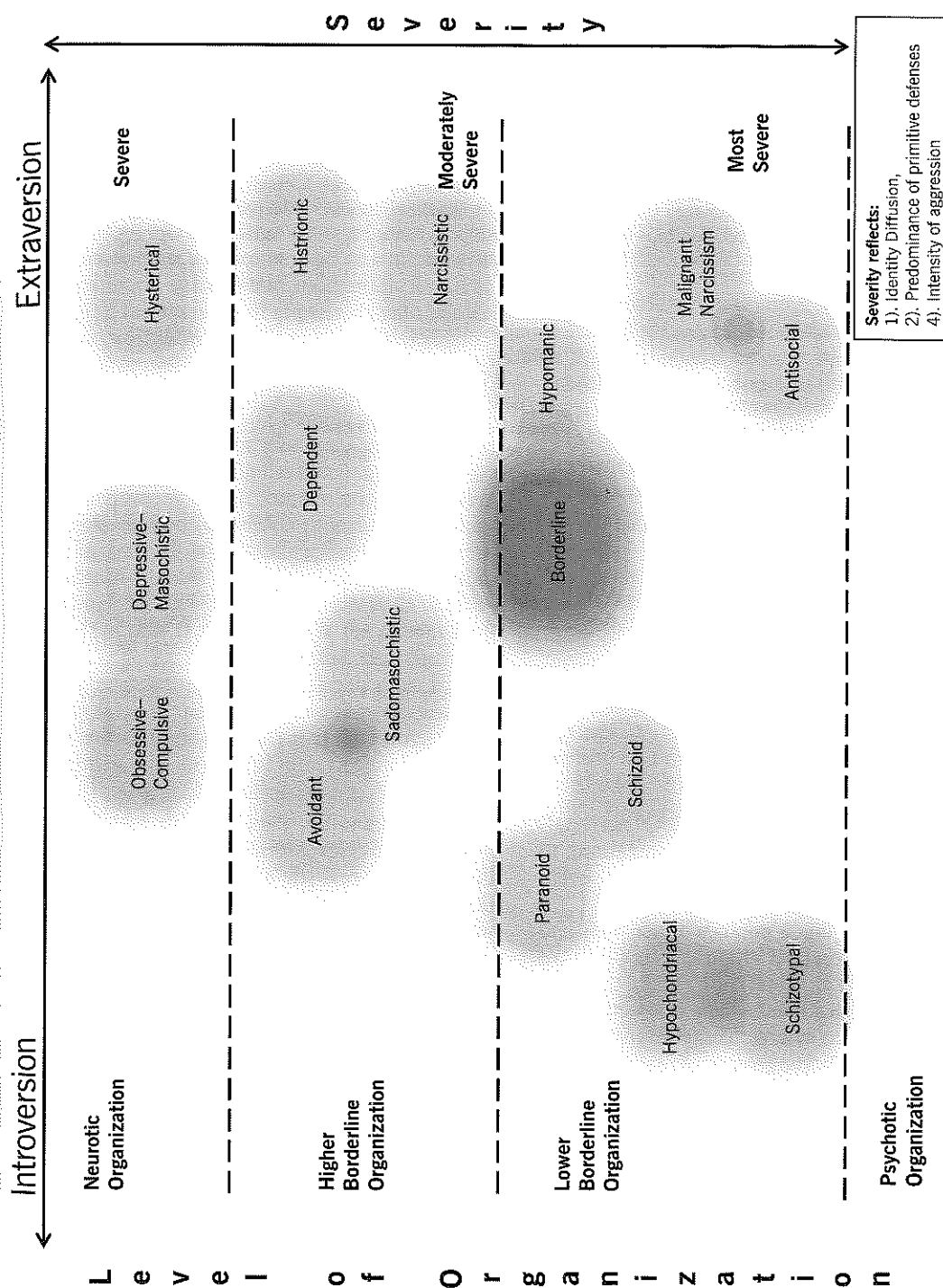sting, aggression,
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FIGURE 32.1. Structural organization of PD psychopathology. From Yeomans, Clarkin, and Kernberg (2015). Copyright © 2015 American Psychiatric Association. Reprinted by permission.

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TABLE 32.1. Dimensions and Categories of Personality Pathology

	High-level (neurotic) personality organization	Borderline personality organization	Low-level borderline personality organization
Identity	Investment in productive work or studies; coherent sense of self and others	Variable investment in work; superficial, vague, conflicted sense of self and others	Shifting, variable sense of self; poor sense of others; inability to invest
Quality of object relations	Friendships with depth of involvement; capacity for combining romance and sexuality; relationships that are reciprocal and enduring	Friendships are conflicted, at times superficial; intimacy limited by conflicts; views relationships in terms of need fulfillment	Friendships superficial, conflicted, chaotic; superficial attempts at intimacy or lacking; inability to combine romance and sexuality
Level of defenses	Advanced defenses	Primitive defenses such as splitting	Primitive defenses
Social reality testing	Relative accuracy in perceptions of self and others; accurate mentalization	Variable and at times inaccurate perceptions of self and others; lack of insight in how others see oneself	Variable and inaccurate perception of self and others
Aggression	Modulated and integrated anger	Verbal aggression	Verbal and potential physical aggression
Moral values	Integrated moral code; moral behavior	Some variability in moral behavior	Defective moral code to amoral; possibility of behavior against the law

ity organization going from high-level personality organization (i.e., neurotic organization), to middle or borderline organization, and to severe or low-level borderline organization.

This typology that combines dimensions and categories has received empirical support. We (Lenzenweger et al., 2008) utilized the theoretical model with an advanced latent structure statistical method known as "finite mixture modeling" to identify subgroups of patients with BPD. Three identified subgroups were characterized by different combinations of paranoid and suspicious orientation to others, aggressive attitudes and behavior, and antisocial behaviors and traits. These results have since been replicated (Hallquist & Pilkonis, 2012; Yun, Stern, Lenzenweger, & Tiersky, 2013), which suggests that the subtypes may be important to guide further efforts to understand underlying endophenotypes and genotypes.

The severity of the personality disorganization is as important as categorical diagnosis to treatment planning. Patients with PDs with a mild (neurotic) level of severity have a complex but generally realistic and accurate representation of self and others that enables them, albeit with some conflicts, to relate realistically to others and moderate their affect in interpersonal relations (see Table 32.1). In contrast, patients at a borderline level of PD severity have a biased internal representation of self and others, which leaves them with difficulties accurately perceiving the intentions of others, and confusion in goal-oriented self-direction. Patients with severe PD at low-level borderline organization not only have "identity diffusion," that is, polarized and distorted perceptions of self and others, but this is also combined with a more aggressive disposition, and minimal internal moral coherence. Treatment planning depends on the severity level of major domains of personality functioning in conjunction with the particular categorical level of personality organization.

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Clinical Assessment

The structural interview (Kernberg, 1984) is a clinical interview that combines a standard psychiatric assessment with an assessment of current personality functioning in order to arrive at a structural diagnosis. The structural interview begins with an exploration of the patient's symptoms and motivation for treatment. In listening to the patient's response to these opening questions, the interviewer develops an impression of the patient's mental state, extent and severity of symptoms, and an indication of the patient's attitude and motivation for treatment. In the assessment of patients with borderline organization, careful evaluation of suicidal and other self-destructive behaviors, eating disorders, substance abuse, and the nature and extent of depression are complicated and have direct implications for treatment selection. The interviewer then shifts the focus to the patient's representations of self, others, and relationship patterns with others. This process is informative in the evaluation of the presence or absence of identity consolidation or identity diffusion. Throughout the interview, the clinician is interested not only in the content of the patient's answers (e.g., patient is depressed, describes self as without intimate relations) but, most importantly, also in the form of the answers and any difficulties in responding that the patient demonstrates. The structural interview does not follow a totally predetermined order. Although the beginning and end are clear, the ways in which the interview develops and the diagnostic elements that become evident are less rigidly established, but depend on what emerges in the patient's self-presentation, and the diagnostician's response to this presentation.

Semistructured Interview

To assist clinicians in utilizing this interview and ensure reliability for research purposes, the structural interview has been transformed into a semistructured interview, the Structured Interview of Personality Organization (STIPO; Horz, Clarkin, Stern, & Caligor, 2012; Stern et al., 2010), which consists of standardized questions and follow-up probes. As described by object relations theory, six domains of functioning are covered in the STIPO: identity (capacity to invest in work and recreation, sense of self, sense of others), quality of object relations (interpersonal relations, intimate relations and sexuality, internal working models of relationships), primitive defenses, coping and rigidity, aggression (self-directed and other-directed), and moral values.

The clinical usefulness of the STIPO can be compared to that provided by more conventional semistructured interviews of personality pathology such as the Structured Clinical Interview for DSM-IV Axis II (SCID-II), which is an almost literal review of the criteria for each PD that enables one to make a reliable DSM diagnosis (or diagnoses). In contrast, the STIPO provides dimensional ratings of six domains of personality functioning, with an indication of how these areas of functioning are reflected in the individuals' current life circumstances. Scores on these six domains provide a profile of the patient's functioning, with areas of adequate to inadequate functioning. The resulting profile can help the interviewer assess the closeness of the patient to prototypical descriptions of patients at a neurotic, high-, or low-level borderline organization.

Theoretical Foundations

Theory of the Disorder

There is growing consensus that the essential features of PD involve difficulties with self-identity and interpersonal dysfunction (Bender & Skodol, 2007; Gunderson & Lyons-Ruth, 2008; Horowitz, 2004; Livesley, 2001; Pincus, 2005). While a rather recent addition to the field via DSM-5 (Section III), this view has long been espoused in object relations theory (Kernberg, 1984). Several aspects of object relations theory contribute to its clinical usefulness. The theory addresses both the internal mental representations of self and other, and the related symptoms and observable behaviors. The theory provides a description of both normal and dysfunctional levels of personality organization. The relative strength and weaknesses across the domains of functioning contribute to tailoring intervention to the individual patient.

A major focus of object relations theory is real-time functioning, especially as the individual interacts with others. This focus on real-time functioning is consistent with advances in social-neurocognitive science (Clarkin & De Panfilis, 2013), and contributes to the understanding of the interpersonal dynamics between patient and therapist in the treatment situation.

Central to the object relations view of personality pathology is the interaction between observable behavior and internal mental structures representing self and others.

Fundamental Theoretical Constructs

"Personality" is the integration of behavior patterns with their roots in temperament, cognitive capacities, character, and internalized value systems (Kernberg & Caligor, 2005). "Psychological structure" refers to a stable and enduring pattern of mental functions that organize the individual's behavior, perceptions, and subjective experience. "Internalized object relations" are the building blocks of psychological structures, and serve as the organizers of motivation and behavior. Internalized object relations dyads comprise a *representation of the self and a representation of other, linked by an affect* that provides focus and motivation. The internal representations of "self" and the "object" in the dyad are neither assumed to be totally accurate representations of the entirety of the self or the other nor are they totally accurate representations of actual interactions in the past. Rather, they are representations of self and other as they were experienced at specific, affectively charged moments in the past and processed by internal forces such as primary affects, defenses, and fantasies. Individuals with borderline personality organization are minimally aware of contradictory aspects of these representations, especially when they guide their behavior in peak moments of affective arousal.

The individual with a functional and satisfying personality organization operates with an integrated and coherent conception of self and significant others. With normal personality organization, the individual functions with a sense of continuity over time with self-esteem, a capacity to derive pleasure from relationships with others, and from commitments to work. There is a capacity to experience a range of complex and well-modulated affects without the loss of impulse control. A coherent and integrated sense of self contributes to the realization of one's capacities, desires, and long-range goals. Likewise, a coherent and integrated conception of others contributes to relations with others involving a realistic evaluation of others, empathy, and social tact. The healthy individual can "mentalize," that is, understand self and others in terms of intentions, motivations, and emotions. In addition to the ability to mentalize

in general, the healthy individual can mentalize under peak affective states, and place momentary affect stimulation and related stimuli into a larger context that helps him or her maintain affect regulation and behavioral control in the moment. The combination of an integrated sense of self and of others contributes to mature interdependence with others, a capacity to make emotional commitments to others, while simultaneously maintaining self-coherence and autonomy.

In contrast, patients with PDs of varying degrees of severity manifest a combination of observable behaviors that are interpersonally disruptive, with internal symbolic representations of self and others that are dominated by extreme conceptions of self and others (i.e., sharp division of good and bad evaluations with extremes of affect; Lenzenweger, McClough, Clarkin, & Kernberg, 2012). The level of personality organization as it relates to the severity of PDs—from normal to neurotic to borderline to psychotic—is largely dependent on the degree of integration of the sense of self and others.

Object relations theory posits, as do the models maintained by many others (Fonagy, 1998; Gunderson & Lyons-Ruth, 2008; Paris, 2005; Zanarini & Frankenburg, 2007), that the combination and interaction of early social influences and genetic vulnerability are important etiological factors in BPD. The destructive effects of early sexual abuse occur in the history of some patients with BPD. However, the additional factors of caregiver neglect, indifference, and empathic failures have profound deleterious effects (Cicchetti, Beeghly, Carlson, & Toth, 1990; Westen, 1993). Children reared in these disturbed environments form insecure attachments with their primary caregivers that interfere with the development of capacities for effortful control and self-regulation. The internalization of conceptions of self and other are compromised by intense negative affect and defensive operations that distort the information system in an attempt to avoid pain and preserve islands of positive affect.

The link between early harsh treatment and later BPD has been confirmed by prospective studies (Carlson, Egeland, & Sroufe, 2009; Crawford, Cohen, Chen, Anglin, & Ehrensaft, 2009). Early maltreatment, maternal hostility, attachment disorganization, and family stress are predictive of social-cognitive difficulties at age 12, including disturbed repesentations of self. These disturbances in early adoles-

cent self-representation were in turn linked to borderline symptoms at age 28. The study of 11,000 pairs of twins followed from birth to age 12 provides a prospective study of the diathesis–stress model of BPD (Belsky et al., 2012). The combination of genetic vulnerability, captured by family history of psychiatric illness, and the experience of early maltreatment was highly predictive of adult BPD status.

Principles of Change

Prior to addressing the central question of therapeutic intervention and the possibility of change, one must consider the areas of stability in personality functioning, and the forces that contribute to this stability. It is commonly assumed that there is continuity between personality functioning and personality dysfunction. Although early evidence for this view was derived solely from correlational relationships between psychometric measures of normal personality and PD, today we have more integrated theories that posit underlying continuities between the domains of personality and PD using a neurobehavioral framework rooted in neurobiology (Depue & Lenzenweger, 2005; Lenzenweger & Depue, 2016). From this point of view, an empirically supported theory of personality functioning is a necessary foundation for progressing to a comprehensive understanding of personality dysfunction.

There are also other approaches to linking personality to PD (see Lenzenweger & Clarkin, 2005). One approach that we have found useful in considering linkages between normal personality and PD is the cognitive–affective processing model (CAP) of Mischel and Shoda (2008), an integrative model of personality functioning with empirical support. The model has been articulated in an effort to understand both the consistency of personality and the creativity of the individual in the specific situation. Central to this process model are distinct cognitive–affective units that capture an individual's encoding and construal of situations, beliefs about the world, affective tendencies, goals and values, and self-regulatory competencies. These cognitive–affective units are seen as existing in a structured network that mediates between the environmental situation and the individual's behavioral response. This theoretical model is able to capture intraindividual, interindividual, and group differences in personality, making it a compelling model for personality dysfunction.

There are some striking similarities between the CAPS model that grew out of the academic study of personality and personality functioning, and the object relations model that has emanated from the clinical evaluation and treatment of patients with difficulties in personality functioning. Most relevant to the present discussion of treatment of PDs is the central hypothesis of both theories that the mental representations of self and others are central to understanding behavioral consistency within a particular person–environment interaction.

In view of the crucial effects of disturbances in representations of self and other, with related negative effects in patients with borderline personality organization, the focus of TFP is on the systematic examination and eventual change in the self–other representations that the patient brings to the relationship with the therapist and is reflected in his or her current relationships. The goal of TFP is achievement of patient integration, that is, to arrive at representations of self and others that are balanced in the salience of positive and negative cognitions, accompanied by modulated rather than extreme affects, and balanced in terms of cooperative interpersonal behavior with others. This internal state of identity consolidation promotes emotion regulation and contributes to a cooperative, positive relationship with others.

Principal Intervention Strategies and Methods

Kernberg (2016) has described four intervention strategies that are common to all psychodynamic treatments as interpretation, transference analysis, therapist stance of technical neutrality, and countertransference analysis. TFP is the application of these basic interventions modified specifically for patients with borderline personality organization. The goal of TFP is achieved by therapeutic interventions that are conceptualized as strategies, techniques, and tactics (see Table 32.2). *Strategies* are the overall approaches defining the sequential steps in the process of interpreting object relations that are activated in the transference. They describe the overall intentions of treatment and are best observed over the entire session or blocks of successive sessions. The *techniques* are the interventions used in the moment-to-moment interactions in the session. Finally, the *tactics* of TFP are the maneuvers that the therapist uses to lay the groundwork for using the process of interpretation.

TABLE 32.2. Strategies, Tactics, and Techniques of TFP

Strategies

- Defining the dominant object relations
- Observing and interpreting role reversals
- Observing and interpreting linkages between object relations dyads that defend against each other.
- Working through patient's capacity to experience a relationship differently in the transference and in current significant relationships

Tactics

- Negotiating the treatment contract
- Maintaining the frame of the treatment
- Choosing and pursuing priority themes to address in the material the patient is presenting
- Maintaining balance between expanding incompatible views of reality between patient and therapist, and establishing common elements of shared reality
- Regulating the intensity of affective involvement

Techniques

- Interpretive process
- Transference analysis
- Maintenance of technical neutrality
- Use of countertransference

Treatment begins with the negotiation of a verbal contract that enables the patient and therapist to create a consistent setting in which the relationships with others and their internal representations can be examined for their lack of reflection, polarized and affect laden extremes, and gaps in understanding. The focus of discussion and change is on the present, the current relationship with the therapist, and the here-and-now condition of the patient's daily life.

Interpretation is a major technique imbedded in the overall structure of the treatment. The stereotyped, oversimplified version of insight in a dynamic treatment is that the therapist interprets the patient's behavior, and the patient responds with sudden, astonished understanding and subsequent change in behavior. Nothing could be further from reality, as we describe later. Interpretation is a process carried out over time, titrated to the rise and fall of the patient's affective state, with the goal of expanding the patient's ability to put momentary perceptions of self and others in intense affective states into the larger context of the relationship pattern.

The patient's self and object representations are integrated through a process in which these representations are identified and labeled by the therapist, and traced as they contribute to the patient's experience of interpersonal relationships. When the patient has begun to recognize characteristic patterns of relating, and contradictory self and object images begin to reemerge in the relationship with the therapist, the therapist explores the patient's active effort to keep them separated and disruptive in interpersonal behavior.

Treatment Relationship

TFP begins with several treatment contracting sessions in which the therapist describes the responsibilities of both therapist and patient if treatment is to be successful. Patient responsibilities include coming to scheduled sessions on time and talking as freely as possible about what is on the patients' mind. Therapist responsibilities include listening intently to the patient, and making comments when appropriate to assist the patient's understanding of self and others. In view of the fact that many patients with BPD are not involved in meaningful work, we have now included in the contracting process negotiation with the patient to obtain some form of work, even if it is voluntary work, to structure his or her day and potentially add to self-definition. In addition to these general aspects of contracting, there are specific ones based on the individual patient's clinical state and history of treatment. These especially involve potential suicidal acts and ways prior treatments have been aborted.

Once the treatment contract has been negotiated and accepted by both parties, the basic stance of a TFP therapist is therapeutic neutrality, that is, to maintain a position that does not join with the forces involved in the patients' internal conflicts. Rather, the TFP therapist fosters the patient's observation and understanding of his or her own conflicts, and allies with the patient's observing self. The careful encouragement by the therapist of the patient's capacity to articulate, observe, and reflect on his or her own conflicts is a major goal of treatment aimed at decreasing reflex action and increasing reflective self-observation.

Technical neutrality is often misunderstood as directing the therapist to be passive and maintain an uncaring, noncommittal attitude toward the patient. On the contrary, the TFP therapist conveys an interest and curiosity in understanding the patient's experience, and an expectation that the patient can change in ways that lead to a

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more productive and satisfying life. The thera-
pist supports the healthy, self-observing part of
the patient. One of the major benefits of treat-
ment is an increase in the patient's ability to
observe and reflect on his or her own feelings,
thoughts, and behaviors.

The therapist's ability to diagnose, clarify,
and interpret the dominant active transference
paradigm at each point in the treatment is de-
pendent on maintaining the position as a neutral
observer. Since the dissociated affect-laden in-
ternal world of patients with BPD is complicat-
ed by extreme perceptions and affects, techni-
cal neutrality implies an equidistance between
self and object representations in mutual con-
flict. The therapist takes a stance equidistant
between mutually split off, all good and all bad,
object relations dyads. It is these representations
and dyads that become integrated in treatment.

Process of Treatment

The process of treatment can be seen from the
perspective of the progression of treatment in-
terventions, and, in parallel fashion, from the
perspective of the sequence of change in pa-
tients' behavior both in the sessions and in their
everyday life. Of course, these two aspects of
the process of the treatment are interactive and
depend on each other.

Process of TFP

The patient comes to treatment with not only
a history of disturbed interpersonal relations
but also a characteristic information-process-
ing bias that will likely be demonstrated in
the relationship with the therapist. TFP struc-
tures treatment in order to provide a safe set-
ting in which these biases can be manifested,
described in words, explored, understood, and
eventually modified. The contracting process is
crucial in creating this safe therapeutic space.
The contract implies the possibility of a coop-
erative, productive relationship between two in-
dividuals, one who needs help and another who
is willing to help. It is possible and very likely,
however, that given the information-processing
biases the patient brings to a new relationship,
disagreement and conflict will arise.

It is the process of interpretation within the
structure of the treatment frame that most de-
fines TFP. There are four discernable levels of
intervention in the interpretive process (Caligor

et al., 2009), even though these are abstract rep-
resentations of a complex process that is some-
what different with each patient. The first phase
is defining the dominant object relations, that is,
the implicit perceptions that the patient has of
him- or herself in relationship to others, includ-
ing the therapist. This dominant object relation-
ship often takes the form of victim in the hands
of a persecutor. The therapist brings attention to
vagueness, omissions, and contradictions in the
patient's depiction of self and others in conflict,
and this can lead to further affective reactions
on the part of the patient. Specific attitudes of
the patient toward the therapist emerge, and it
is the task of the therapist to put these confused
reactions into words. This is done without call-
ing into question the patient's experience. Done
well, the statement of the dominant object rela-
tionship of patient to therapist helps contain the
affect, and the patient feels understood.

The next phase in the interpretive process is
observing and identifying role reversals of the
object relations dyads exhibited by the patient.
If, for example, the patient's perception of vic-
tim in the hands of a victimizer later shifts, so
that the patient angrily attacks the therapist, the
therapist becomes the victim of the verbal at-
tack at the hands of the patient. It is the thera-
pist's role, while maintaining therapeutic neu-
trality, to point out these instances and help the
patient reflect on their meaning. Often, the pa-
tient is very aware of feeling like the victim in
the hands of others but is not consciously aware
of victimizing the other. By pointing out the
role reversal, the therapist is introducing a new
and different perspective on the patient's expe-
rience, inviting the patient to go beyond the im-
mediate, concrete experience, to form cognitive
connections between dimensions of experience
that have been dissociated. This is a first step in
suggesting to the patient that there is a represen-
tation of a relationship in his or her mind. This
second phase enables the patient to appreciate
that his or her transference experience is inter-
nal and symbolic, an invitation to the patient to
observe the way his or her mind works and how
it influences behavior.

In the third phase of interpretation, the con-
nection between two contradictory object rela-
tions (typically, idealized and persecutory expe-
riences of self and other) has been defensively
dissociated. The therapist invites the patient to
observe and reflect on the polarized and contra-
dictory aspects of the experience. In the fourth
phase, the therapist provides hypotheses about

the meaning of the patient's transference experience.

Process of Patient Change

There are discernable stages in the TFP treatment of BPD. Following assessment of both diagnostic criteria and level of personality organization, treatment contracting sets the stage for the early treatment phase in which threats to premature dropout, serious and potentially lethal behaviors, and patient criticism of the therapy and the therapist are common. Reduction in out-of-session self-destructive behavior is necessary for the major efforts to shift to understanding the intense underlying conflicted self–other representations that become salient in the therapeutic relationship.

The TFP therapist monitors both the process of the relationship between patient and therapist, and the patient's current ongoing adjustment to the environment. There may be disparities between the two, such as when the sessions are calm and filled with trivial material, and at the same time the patient is engaging in self-destructive behaviors (e.g., fights with supervisor at work, endangering employment) in daily life. A sign of progress in TFP is when the daily life is operating effectively, and the patient's dysfunctional representations of self and other are manifested in a conflicted relationship with the therapist, where they can be actively examined.

The usual progression of change that we have observed clinically is reduction of problem behaviors, followed by the patients' growing recognition of aggressive affects that can be "owned" rather than projected onto others. Gradually, there is a further modification in the representations of self and others, especially as manifested in the transference in the therapeutic relationship, and growing productive involvement in work and relationships in patients' daily lives. The capacity for intimate relationships is often the last domain to develop.

Treatment outcomes are not simple success or failure; rather, they involve a number of domains of functioning, with the possibility of successful change in one domain, with minimal change in another. We have stressed the interaction of observable behavior, organization, and functioning of the mental life of the patient, and underlying neurobiological processing. Given this complexity, change can occur in behavior, with or without change in the underlying organization of identity and moral values. TFP as-

sumes the ambitious goal of not only bringing about symptomatic improvement but also increasing efficiency and satisfaction in work and profession, to help patients develop mature love relations in which eroticism and tenderness are integrated, and to enjoy a rich social life with friendship and social support.

Summary of Evidence

We have taken a stepwise approach (Kazdin, 2004) to the empirical development of TFP. Development of a treatment manual was based on principles of intervention used by senior clinicians treating patients with BPD. Our approach from the beginning was that a manual that specified exactly the same detailed interventions for all patients would not be practical given the individuality of patients with BPD. Rather, we combined treatment principles with clinical vignettes illustrating the application of the principles across diverse therapeutic situations.

Evaluation of TFP began with an examination of the feasibility of delivering the treatment over 1-year duration and the ability of the treatment to reduce borderline symptomatology (Clarkin et al., 2001). Most subjects ($N = 17$; mean age 32.7 years) had more than one Axis I symptom disorder, and comorbid narcissistic and paranoid PDs were common. The 1-year dropout rate was low (19.1%), there were no suicides, and none of the treatment completers deteriorated or were adversely affected by the treatment. Compared to the year prior to treatment, study patients had significantly fewer psychiatric hospitalizations, fewer days of inpatient hospitalization, and a reduction in the number of suicide attempts.

Randomized Controlled Trials

Based on these encouraging results we conducted a randomized controlled trial (RCT) that had elements of both efficacy and effectiveness studies. TFP was compared to DBT and a dynamically oriented supportive treatment (Clarkin et al., 2007). Like an efficacy study, patients were randomly assigned to treatments delivered by therapists trained in the respective treatments, with blind raters and reliably measured outcome variables. However, similar to effectiveness studies, patients with BPD with a range of severity were treated by community therapists in their own offices, and medication

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In view of the diversity of the patients with BPD and the different emphases of the three treatments, six domains of dysfunction were measured for change, with suicidality, aggression, and impulsivity as primary outcome domains, and anxiety, depression, and social functioning as secondary outcome domains. Individual growth curve analysis (Lenzenweger, Johnson, & Willett, 2004) was used to investigate change in the dimensions of symptoms and functioning over time. All three treatments showed significant change across multiple domains after 1 year of treatment, but some differences emerged among treatments. Both TFP and DBT were associated with improvement in suicidality. Only TFP was significantly associated with improvement in Barratt Factor 2 impulsivity, irritability, and verbal and direct assault. TFP had a broader scope of change: Significant change occurred in 10 of 12 variables across the six domains, in contrast to five of 12 variables for DBT, and six of 12 variables for supportive treatment.

In addition to symptom change, we hypothesized that TFP, with its therapeutic focus on perceptions of self and other, would result in changes in attachment organization and reflective functioning (RF; Levy et al., 2006). Patients receiving TFP improved significantly in narrative coherence on the Adult Attachment Interview (AAI), unlike those receiving other treatments. We also examined the influence of the three treatments on RF, the capacity to understand the behavior of oneself and others in terms of intentional mental states such as thoughts, feelings, and beliefs. As predicted, RF increased significantly in patients receiving TFT, whereas no change occurred with the other treatments.

The next step was to evaluate the effectiveness of TFP in a different cultural setting. Doering and colleagues (2010) conducted a two-site (Munich, Germany, and Vienna, Austria) RCT with efficacy and effectiveness components. Female patients with BPD ($N = 104$) were randomized to 1 year of either TFP or treatment by community therapists experienced in the treatment of BPD. The TFP psychotherapy group was significantly superior with regard to the number of DSM-IV BPD criteria at the end of treatment, with improvement in psychosocial functioning, reduction in suicide attempts, and number and duration of inpatient treatments

during the 1-year treatment and number of premature dropouts (67.3 vs. 38.5%). In addition, patients in TFP showed superior improvement over the comparison group in personality organization and functioning.

Empirically Derived Trajectories of Change

Using a subsample of the patients in the original RCT (Clarkin et al., 2007), we examined the domains of function as they changed across a treatment duration of 1 year (Lenzenweger, Clarkin, Levy, Yeomans, & Kernberg, 2012). Rather than focusing on endpoint/follow-up outcomes that do not capture the dynamic process of change, we examined baseline psychological predictors as they related to rates of change (i.e., change in variables measured multiple times on each patient during the course of 1 year of treatment) across domains of functioning. Selection of potential *predictors* of change was based on a neurobehavioral model (Depue & Lenzenweger, 2005), and an object relations model (Kernberg & Caligor, 2005) of severe personality pathology.

A principal component analysis (PCA) on the rate of change for 11 different dimensional measures of domains of change yielded three factors of change: aggressive dyscontrol, psychosocial adjustment (global functioning and social adjustment), and conflict tolerance (anxiety/depression and impulsivity). These results indicate that different areas of functioning and symptomatology change at different rates, and certain sets of variables change at the same rate (i.e., as a domain).

We examined the relations between baseline characteristics (predictors) and scores for each of the three domains of change. Lower pretreatment levels of negative affect and aggression were associated with more rapid clinical improvement in the domain of aggressive dyscontrol. Higher pretreatment identity diffusion was associated with more rapid clinical improvement in the global functioning domain. Lower initial levels of social potency were associated with more rapid improvement in anxiety/depression and impulsivity.

Neurocognitive Functioning as a Measure of Change

Psychotherapy research will advance as the mechanisms of change become the target of intervention at both the psychological level

(Kazdin, 2007) and at the level of neural functioning (Insel & Gogtay, 2014). The hypothesized mechanism of change for BPD in TFP is increased affect regulation achieved through mentalization, that is, the ability of the patient to put momentary affect arousal, especially in social interactions, into a more benign and broader context (Levy et al., 2006). We hypothesized that as the patient experiences dominant object relations infused with negative and intense affect in the TFP sessions, the gradual analysis of the perception of self and others would modify the extreme cognitive–affective perceptions. These changes would be consistent with enhanced modification of responses in the amygdala by the prefrontal cortex.

In our preliminary neuroimaging study of TFP,[1] we used an emotional linguistic go/no-go task to investigate the processing of negative stimuli by female patients with BPD prior to and after a 1-year treatment episode with TFP. The aim of the study was to identify links between the phenomenology and neurocognitive/neurobiological domains underpinning BPD pathology before and after 1 year of TFP. Patients ($N = 10$) met the DSM criteria for BPD and, in addition, had an indication of affective dysregulation as manifested by high negative affect, low positive affect, and low constraint on the Multidimensional Personality Questionnaire (MPQ). Measures of psychological functioning at multiple points during the 1 year of treatment were combined with assessment of neurocognitive functioning pre- and posttreatment.

In terms of psychological functioning, the patients exhibited significant change over the course of 1 year of TFP, including reductions in affective lability, interpersonal sensitivity, and paranoia. They reported less intrusive and vindictive interpersonal problems and displayed overall higher levels of interpersonal warmth toward others. Importantly, at the end of 1 year of treatment, all patients in the study were employed, with significant changes in work functioning.

In a comparison of pretreatment and posttreatment functional magnetic resonance imaging (fMRI) scans, patients with BPD manifest-

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[1] The imaging and treatment of patients in TFP was done at Weill Cornell Medical College, New York City, Principal Investigator (P.I.) John Clarkin. The processing of the imaging data was done by David Silbersweig and his neuroimaging laboratory at Brigham and Women's/Faulkner Hospitals, Boston.

ed a relative increase in activation in cognitive control regions (right anterior dorsal anterior cingulate cortex [ACC], dorsolateral prefrontal cortex [DLPFC], and frontopolar cortex [FPC]). Relative activation decreases were found in left ventrolateral PFC and hypocampus. These results demonstrated activation increases in emotion and cognitive control areas and relative decreases in areas associated with emotional reactivity and semantic-based memory retrieval. TFP may, in fact, mediate clinical symptom improvement in part by improving cognitive emotional control via increased engagement of dorsal ACC, posterior medial orbitofrontal cortex (OFC), FPC, and DLPFC activity. The effects of TFP may be mediated by top-down frontal control over limbic emotional reactivity and semantic memory processing systems. These results are consistent with those of other investigators (Goodman et al., 2014; Schnell & Herpertz, 2007) who have demonstrated the impact of DBT treatment programs for patients with BPD on neural functioning, consistent with an increase in emotion regulation.

Conclusion

The PD field is in the interesting situation of having treatments informed by different theories of personality disordered functioning, all of which show significant improvement for patients' symptoms, but with no significant differences in outcome between them (Levy, Ellison, & Khalsa, 2012), and little effect on patients' functional level in work and intimate relations (see McMain, Guimond, Streiner, Cardish, & Links, 2012). In this context, Bateman (2012) has called for an increasingly coherent theory of PD that can be translated into an understanding of mechanisms of change that, in turn, could inform a precise treatment program. Future research may explicate which patients with specific domains of dysfunction would optimally respond to one of the available treatments. In addition, this matching of optimal treatment to specific patient may depend on research isolating the mechanisms of change in the various treatments across specific domains of functioning that involve the integration of neurocognitive functioning, internal subjective states of mind, and observable behavior. In the meantime, we suggest that TFP is a developed methodology for utilizing the patient–therapist

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relationship in the exploration and change of patients' mental representations of self and other as they guide interpersonal behavior. Experience gained from the TFP methodology can be used in a total treatment approach or be integrated with other approaches in the treatment of patients with BPD (Clarkin, Yeomans, De Panfilis, & Levy, 2016).

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