# III

# COMMON FRAMEWORKS TREATING PERSONALITY PATHOLOGY

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# Transference-Focused Psychotherapy

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Transference-focused psychotherapy (TFP) is an evidence-based modified psychodynamic psychotherapy designed for use with patients suffering from severe personality disorders (PDs), most prototypically borderline and narcissistic PDs (Yeomans et al., 2015). TFP is based on Otto Kernberg's object relations model that integrates object relations theory with psychoanalytic ego psychology and aspects of Sigmund Freud's drive theory (O. F. Kernberg, 1984). Kernberg articulated his theory of PDs based, in part, on his experiences with the Menninger Foundation's Psychotherapy Research Project (O. F. Kernberg et al., 1972). Drawing on his clinical observations and data coming from the project, he began modifying standard psychodynamic psychotherapy. Kernberg initially described this treatment as exploratory or expressive psychotherapy, distinguishing it from psychodynamic psychotherapies that had a more explicitly supportive dimension and that were beginning to be articulated (Wallerstein, 1986; Wallerstein et al., 1956). Kernberg's (1967) articulation of the developmental psychopathology underlying severe PDs as well as his clinical experience treating those with severe personality pathology served as the basis of this novel treatment. TFP was still further elaborated in a series of treatment manuals written by Kernberg and his colleagues at the Personality Disorders Institute of Cornell University (in chronological

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Portions of this chapter are based on "Transference-Focused Psychotherapy (TFP)," by K. N. Levy, N. Draijer, Y. Kivity, F. E. Yeomans, and L. K. Rosenstein, 2019, *Current Treatment Options in Psychiatry*, *6*, pp. 312–324 (https://doi.org/10.1007/s40501-019-00193-9). Copyright 2019 by Springer. Adapted with permission.

https://doi.org/10.1037/0000310-010
*Personality Disorders and Pathology: Integrating Clinical Assessment and Practice in the* DSM-5 *and* ICD-11 *Era*, S. K. Huprich (Editor)

order: O. F. Kernberg et al., 1989; Yeomans et al., 1992; Clarkin et al., 1999; Koenigsberg et al., 2000; Clarkin et al., 2006; Yeomans et al., 2015; Diamond et al., 2021).

As the name implies, TFP focuses on the transference, with the *transference* conceptualized as "a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribed to other relationships" (Levy & Scala, 2012, p. 392; see also Levy, 2009). Transference can occur in an array of relationships, including in the relationship between therapists and patients, particularly with patients with PDs. Although patients with PDs may perceive aspects of their therapist in realistic ways, transference is the product of the patient's distortions, in varying degrees, within their interpersonal schemas. These distortions are based on the impact of the patient's internal mental representations of other that stand in the way of an accurate perception of others. Thus, transference may be more or less amenable to reality testing by the therapist, as the patient's awareness of these distorted representations of others fluctuates, varying at different times and with different emotional states.

Transference may also overlap or coexist with real elements of others. Real aspects of an individual's presentation may "pull" for certain transferences (e.g., older men may pull for father transferences). Even in such cases, it is important to remember that the internal images are not literal representations of the past but larger than life images that have been influenced by unconscious fantasies, fears, and desires. At other times, though, patients may subtly provoke others to behave in ways that are congruent with their transferential expectations (e.g., finding a way to provoke anger that seems to confirm the expectation of another's harsh criticism of them). An important feature of transference is that some aspects are unconscious and related to conflicts and defensive processes. In neurotic individuals, irrelevant or distorted representations are quickly modified based on new experience, or what Gelso (2014) called the *real relationship*. However, in those with borderline personality disorder (BPD), this process is slower and less guaranteed. In the therapy, therapists focus on the patient's affective experience for identifying and explicating their dominant relational patterns as they are experienced and expressed in the here and now of the relationship with the therapists (conceptualized as the transference relationship). The therapist's timely, clear, and tactful interpretations of the dominant, affect-laden themes and patient enactments in the here and now of the relationship between the two are hypothesized to lead to the resolution of the tendency toward rigid and distorted transference.

Several studies have revealed that TFP leads to both symptom and personality change within controlled trials and in comparison to community experts treating BPD. Recent meta-analyses and Cochrane Collaboration reviews have found that TFP and other empirically supported treatments are likely equally effective and equally efficacious in general (Cristea et al., 2017). Given the efficacy and effectiveness of TFP in these studies, several prominent treatment guidelines, including the Society of Clinical Psychology Committee on Science and Practice, the United Kingdom's National Institute for Health and

Care Excellence guidelines, the German Society for Psychiatry, Psychotherapy, and Psychosomatics's (2009) *Treatment Guidelines for Personality Disorders*, Australia's National Health and Medical Research Council Clinical Practice Guidelines, the Swiss Association for Psychiatry and Psychotherapy, and the Netherlands' Multidisciplinary Directive for Personality Disorders, recognize TFP as an empirically supported treatment. TFP is recognized as one among the "big four" specialized therapies for treating BPD, alongside dialectical behavior therapy (DBT), mentalization-based treatment, and schema-focused therapy (SFT).

In this chapter, we describe the underlying theoretical framework for TFP; the goals, structure, and techniques of the treatment; and its indications. We also summarize the existing body of empirical studies on symptom and personality change in TFP as well as recent innovations and novel clinical uses for TFP. We conclude the chapter with a discussion conceptual and empirical relationships between the Alternative *DSM-5* Model of Personality Disorders (AMPD) in Section III of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013) and the object relations model of personality pathology central to TFP.

## GOALS OF THE TREATMENT

The overarching goals for patients undergoing TFP are—in helping an individual move from a fragmented sense of self to an integrated one—to build a greater capacity for self-control; to have less impulsive behaviors; to better process and regulate intense emotions; and to foster a greater capacity for closeness, pleasure and intimacy in relationships. In addition, TFP aims to help patients achieve a greater level of functioning such that appropriate life goals that patients desire can be met. In regard to symptom domains as well as domains of functioning that are more specific to BPD, patients' suicidal and parasuicidal behaviors, angry outbursts, and impulsive behaviors are targets for improvement in the treatment. From the perspective of TFP, change in these specific difficulties leads to less hospitalization, fewer emergency services, and fewer difficulties in relationships. In the TFP model, the integration of disparate, contradictory, and incoherent internal mental representations of self and others leads to these significant improvements in BPD symptoms. Otto Kernberg (O. F. Kernberg, 1984) referred to this as the *resolution of identity diffusion* or, conversely, *the achievement of identity consolidation*.

*Identity*, or one's sense of self, is defined as one's represented experience of themselves as well as one's represented experience of others; it includes both one's representation of oneself in interaction with others and the affect that characterizes these representations of self and others. Although the content and valance of these representations of self and other are important, more relevant are the structural aspects of these representations. By *structural aspects*, we are referring to the degree of differentiation, integration, and hierarchical organization of representations. This way of thinking about representations

of self and others is central to many psychodynamic thinkers going back to Sigmund Freud but is also consistent with developmental psychologists like Piaget, Vygotsky, and Werner. By *degree of differentiation*, Otto Kernberg was referring to the number of discrete aspects of representations as well as the representational integrity or boundary of these aspects. By *degree of integration*, Kernberg was referring to the connections between discrete representations so that there is contextualization through the relation of these aspects to one another. By *hierarchical organization*, Kernberg, like Werner's (1957) elaboration of the orthogenetic principle, suggested that as development proceeds, representations of self and others move from global and integrated states to more hierarchically integrated ones in which more important specific information is nested in superordinate structures. This organization allows for more relevant information to be accessed when needed. Impairments in these structural aspects of self and other representations and defenses against integration are seen as central and as underlying the difficulties experienced by those with severe PDs. In more typical and healthy development, the individual is supported in and learns to integrate disparate, contradictory, and incoherent internal mental representations of self and others.

The object relations model underlying TFP posits that BPD derives from a failure to develop internal representations of self and others that are complex, realistic, and characteristic of adaptive psychological functioning. Complex representations of self and others facilitate a person's capacity to reflect on interactions with others. While these representations support one's understanding of one's own thought processes and beliefs, and ultimately allow one to behave in a thoughtful and purposeful manner, those with more fragmented or unintegrated representations may struggle in these domains. Patients with fragmented representations experience difficulties seeing others in complex ways that account for contradictory aspects, such as considering mental states that integrate positive and negative elements. Thus, they experience themselves in incongruent ways—for example, punishing and gratifying, or frustrating and satisfying, or fragile and exploiting aspects of others are dynamically held apart in conscious experience such that only one aspect of these representations is present in awareness at one time. Becoming momentarily aware of both aspects in one person or in oneself, what is typically required for accurate and meaningful reflection on someone's mental states, may initially leave those without complex representations confused rather than in a state of clarity.

In addition, without integrated representations of self and others, and the capacity for complexity that comes with them, extreme positive emotions can quickly shift into negative ones, further impeding an individual's perception of day-to-day interactions. Within a cognitive behavior framework, Beck referred to this process as *black and white thinking* (Beck & Freeman, 1990), and from an SFT perspective, Young referred to this as *schema flipping* (Kellogg & Young, 2006). In the TFP model, the inconsistent sense of self and others and the

vacillation or oscillations between these mental states are together referred to as "identity diffusion," which is analogous to identity disturbance defined in *DSM-III* (3rd ed.; American Psychiatric Association, 1980) and is captured nicely in the *DSM-5,* Section III, AMPD Criterion A description of self-functioning. In addition, this formulation is consistent with the psychological processes regarding identity formation described by Blatt (1974; Blatt & Blass, 1990), Erikson (1950), Marcia (1966), and McAdams (2001), among others.

In the TFP model, difficulty regulating emotions derives directly from identity diffusion. The treatment therefore attempts to bring together diffuse aspects of the patient's representations of self and other as well as the affect that links them. This integration is hypothesized to generate new and more nuanced ways of experiencing emotions and the world. Bringing together and clarifying these disparate representations allows patients to think more flexibly about the therapist, significant others, and themselves. Therefore, making patients aware of their contradictory experiences of self and others, and particularly of the therapist, is the main method by which internal representations become integrated (Levy et al., 2006).

## INDICATIONS

Conceptually, TFP is indicated for the outpatient treatment of severe PDs, including borderline, histrionic, narcissistic, and antisocial PDs as described in Section II of *DSM-5*. From the perspective of the *DSM-5* AMPD, TFP is indicated for severities above 0 (*little or no impairment*) from Level 1 (*some impairment*) to Level 4 (*extreme impairment*) with Borderline, Narcissistic, Antisocial, Schizotypal, and Avoidant PD types. When using the World Health Organization's (WHO; 2019) *International Statistical Classification of Diseases and Related Health Problems* (11th ed.; *ICD-11*), TFP is suitable for those with moderate or severe PDs, particularly when the borderline pattern specifier is specified. In addition, when using the Psychodynamic Diagnostic Manual–Version 2 (PDM-2; Lingiardi & McWilliams, 2017), TFP is suitable for those in the borderline level of personality organization and with personality syndromes of borderline, narcissistic, psychopathic, and histrionic. Common to all of these disorders is what Otto Kernberg referred to as a *borderline organization of personality structure*, a structure characterized by identity disturbance; intact reality testing that can become impaired with severe levels of stress; and the use of maladaptive defenses to cope with strong emotions, especially the use of splitting. An adapted form of TFP, called TFP–Extended (TFP-E; Caligor et al., 2007, 2018) has recently been articulated and is more suitable for individuals with less severe personality pathology, such as obsessive-compulsive (Section II and III, *DSM-5*; American Psychiatric Association, 2013; and PDM-2; Lingiardi & McWilliams, 2017), dependent (Section II, PDM-2), or avoidant PDs (Section II, PDM-2). Likewise, recent modifications have been suggested when treating

PDs characterized by narcissism; these modifications are described later in the section "Recent Clinical and Theoretical Developments and Advances."

## THEORY UNDERLYING TFP

In the object relations framework of TFP, BPD is understood to be based in incomplete, incoherent, and distorted psychological or representational structures, in particular narrow, extreme, and disconnected internal mental representations of self and others. As such, those with BPD have difficulty evoking internal representations of one's self and others that are complex, integrated, and realistic. Without complex representations, patients suffer from impaired psychological functioning, particularly under times of stress or during ambiguous interpersonal situations. O. F. Kernberg (1984) referred to this undifferentiated and unintegrated representational state as *identity diffusion*. Patients struggling with identity diffusion vacillate between exclusively negative or exclusively positive representations of themselves and others, and these quick shifts are hypothesized to undergird extreme negative and extreme positive emotional reactions characteristic of BPD. These reactions tend to distort everyday interactions with others, leading to severe interpersonal difficulties.

In TFP, the therapist tries to work through and integrate the patient's incoherent representations of others by both clarifying the patient's experience and maintaining a reflective position despite the patient's affectively charged representation of the therapist. Within this reflective stance, the patient's contradictory representations are repeatedly brought into awareness within the holding environment of the session, and identity diffusion eventually resolves or reduces. Following successful treatment and the reduction of identity diffusion, the patient will approach others and the self with flexibility and openness, experiencing others as generally more benign and with multiple aspects. This greater complexity and realistic perception of others fosters relationships that are significantly more fulfilling and that are based in more stable and enduring feelings that can now coexist and integrate with disappointments and irritations. Following the reduction of identity diffusion, the patient will likely have a greater capacity to temper self-destructive impulses and have a greater ability to function autonomously in work and life in general.

## STRUCTURE AND TECHNIQUES OF TFP TREATMENT

In its original and typical form, TFP is a twice-weekly, individual, face-to-face, outpatient psychotherapy. Similar to other therapies for PDs, TFP is a long-term treatment that lasts at least 12 to 18 months. Experienced therapists, trained and certified by the International Society for Transference-Focused Therapy (ISTFP; https://istfp.org/) or who are in training and under supervision by an approved ISTFP supervisor (ISTFP, n.d.), are permitted to deliver TFP.

TFP has four treatment phases: (a) assessment, (b) the establishment of the treatment frame or contract, (c) the active treatment phase, and (d) termination.

## Assessment

TFP begins with a thorough assessment to establish a clear diagnosis and to better understand the patient's difficulties and life structure. The assessment phase tends to last between one to three sessions, each session running about 1 hour, and may require collateral information from previous treatments and family members. This assessment is used to help the therapist establish a diagnostic understanding and develop a case formulation (Levy et al., 2019).

This understanding and formulation are shared with the patient to provide them with an understanding of their difficulties and include not only diagnostic feedback but an explanation of the differential diagnosis and the patient's interpersonal dynamics related to perception of self and others. The provision of such feedback requires transparency and tact and must be done collaboratively rather than seen as an imposition to the patient. Once the therapist and patient agree on the conceptualization of the patient's difficulties, this information can be used to collaboratively establish the treatment goals and set the treatment frame, including explicating the roles and responsibilities of both the patient and therapist in the treatment.

## Establishment of a Treatment Frame

The treatment contract, or "treatment frame," as it is called in TFP, establishes the conditions or frame of the therapy in a way that emphasizes the experiencing of emotions and curbs the expression of emotions in the form of impulsive behavior, such as cutting, abusing substance, or having risky sex. This contract or treatment frame, in the case of inactive or socially isolated individuals, also encourages individuals to become involved with other people through a structured activity, such as employment or volunteer work. The treatment frame articulates the expectations and responsibilities for both patient and therapist. The patient's responsibilities typically include attending session, working toward the treatment goals, and reducing impulsivity and self-harm behaviors. The treatment frame also includes expressing oneself without censoring or screening and reflecting on thoughts and feelings as well as the therapist's comments. The sharing of thoughts and feelings without censorship is modified from the classical sense in psychoanalysis and is more focused on the problems that bring the patient to therapy. Therapist responsibilities typically include logistical responsibilities, such as scheduling appointments; monitoring the time; articulating policies about absences, rescheduling, vacations, missed sessions; and clarifying boundaries and the limits of the therapist's involvement. Most importantly, the therapist is responsible for attending to the patient's communications and making every effort to understand and, when useful, to comment to the patient.

## Active Phase of Treatment, or the Implantation of the Treatment

Following the assessment, the patient and therapist jointly discuss the therapist's diagnostic impressions, and the frame is collaboratively set and agreed

on; the active phase of therapy begins. The patient begins the treatment, as outlined in the treatment contract, with what is on their mind, and this prompt reminds the patient to bring to the foreground of the session the most relevant issues and thoughts that characterize their most recent and pressing difficulties. Three primary directives guide the patient toward the most relevant therapeutic tasks in session: (a) maintaining the integrity of the treatment and discussing life-threatening difficulties, such as suicide, homicide, or behaviors that compromise the patient's or therapist's safety; (b) making every effort to apprehend the patient's inner representations as they are elaborated in the patient's experience of the therapist (the "transference" of internal mental material to the external situation); and (c) discussing the patient's experience of others and day-to-day difficulties that occur outside session.

Within session, repetitive relational themes are brought into the patient's awareness, especially as they pertain to the patient's transference. The therapist closely follows the patient's emotions and helps articulate their experience, especially unconscious and unintegrated aspects of their experience. Over the course of one or more sessions, the therapist first helps to clarify and reflect the patient's subjective experience (Caligor et al., 2009). The therapist then tactfully makes the patient aware of discrepancies between what the patient is saying, doing, or communicating nonverbally, and encourages the patient to reflect on those discrepancies. In TFP and many psychodynamic therapies, this is called a *confrontation*. Obviously, this kind of confrontation does not feel "in your face" or abrupt. Rather, this approach sheds light on information that is being disavowed or dissociated, makes the patient more aware of maladaptive defensive maneuvers intended to keep difficult content out of awareness, and allows for exploration and integration. Confrontation should be done with tact so as to make the unintegrated information more palatable.

Once these discrepancies in the patient's experience are noted, a broader process of interpretation of relational patterns with the therapist and outside treatment begins. Interpretations should be delivered in a timely, clear, and tactful way and address the patient's continued representations of others in polarized or incoherent ways Interpretations may involve pointing out that a patient strongly wants to separate positive aspects of themselves and others in their life from ones that are negative in an effort to protect the good aspects from the bad. Interpretations may introduce aspects of a patient's experience that are disavowed and that feel threatening, and therefore appropriate timing within the here and now immediate moment of the patient's experience must be balanced with tact, finesse, and empathic understanding. Interpretations should therefore build over time, should feel relatively palatable to the patient, and should contain material that is already close to the patient's present awareness. This maximizes the emotional impact of the interpretation and the likelihood that it might be received by the patient. In addition, while they are always hypotheses that are responsive to feedback and correction, interpretations should be delivered with some conviction and without unnecessary trepidation. Such a process promotes improved reflective ability, richer and more positive perceptions of self and others, and improvement in intimate

relationships. In this way, interpretations are not so much an isolated intervention but part of a broader hermeneutical endeavor that seeks to capture and reflect the full nuance of the client's experience of themselves and others, a process that equally includes clarification and confrontation.

## Advanced Phase of Treatment, Evolution of the Therapy, and Planned Termination

As the treatment progresses and the patient improves, either the patient or therapist, or both, may begin thinking about the termination of the therapy. This process may begin as early of 6 months into the treatment, or it could take years. Poor prognosis indicators, such as antisocial, paranoid, and narcissistic features, may result in longer time frames. Regardless, the process is often not linear and may proceed in starts and stops, and there may be regressions to earlier levels of functioning after steady improvements. With improvement, two things can happen. First, the patient's better functioning leads them to participate in life in a way that often results in challenges. A patient who was previously unable to date emotionally available partners now is required to delve into deeper intimacy. Likewise, a patient who was previously unable to work at positions consistent with their intellect and capacities may find themselves in a job that requires more responsibility and commitment. These kinds of situations can be challenging and may require additional therapeutic work to meet the demands of increased commitments in the patient's life. Second, as patients become more integrated, they often realize their own role in their difficulties. The reduction in externalizing defenses and in splitting lead them to be aware of difficulties within themselves, and with more realistic views of self and others comes the challenge of dealing with having to integrate contradictory views and feelings.

Several markers indicate that the patient may be ready for the therapy to end or to transform into a therapy more typical of neurotic process. As the therapy progresses, the patient begins to experience events less concretely and at a more abstract or representational level. More frequently, they recognize the self and other representational dyads, can observe their vacillation, and tolerate these interchanges, including with the therapist. The transference moves from more primitive and paranoid ones to more depressive ones that resemble the kinds of transference seen in neurotic patients. Paranoid transferences become transient, resolve quickly, and can be discussed more easily. Enactments have decreased and even disappeared, although they may resurface during the termination phase. However, the patient can more readily reflect on these enactments and see them as part of the termination process. As this happens, the relationship with the therapist is deepened and becomes more reality based, with increased gratitude. The patient is more autonomous in session and is increasingly able to use free association and present coherent narratives that can be reflected on.

The patient's reaction to discussions of termination is an indicator of readiness for ending the therapy. Patients may experience intense anxiety and fear

of abandonment during the termination phase. These feelings, along with experiencing the therapist's absence as an attack, complete with reactive rage toward the therapist, can be expressed overtly but may also include missing sessions, which limits the discussion of terminations. These may be indicators that there is more work to be done. However, the capacity to tolerate, reflect, discuss, and resolve these events may suggest that termination is warranted. The narcissistic patient may decide unilaterally to end therapy abruptly, like ripping a bandage off a scab. The patient may declare themselves better. In doing so, they may deny the importance of the therapy and the therapist. This reaction is often called a "flight into health," which is thought to be defensive and brittle. A skilled therapist will sense this possibility in a narcissistic patient, predict that the patient may feel this urge, and emphasize the value of additional work in such a situation. Healthier reactions to termination, including contained sadness, awareness of loss, and overt mourning, as well as the capacity for gratitude, are clear indicators of readiness for termination.

## EMPIRICAL SUPPORT

A growing body of literature has elucidated the efficacy and effectiveness of TFP, including its underlying mechanisms of change as well as personality changes that are unique to TFP and that map onto associated brain regions. In this section, we review the current empirical literature on TFP and recent modifications to the frame of treatment that make it indicated for a range of personality disorders that can be conceptualized with the AMPD.

### Evidence for the Underlying Theoretical Assumptions of TFP

From a TFP perspective, identity diffusion is the central mechanism that underlies BPD and therefore underlies the core symptoms and traits typical in BPD, including emotional dysregulation and suicidality. A burgeoning literature currently is examining the importance of identity in the characteristic difficulties of those with BPD.

In a series of complementary studies, Levy and colleagues have attempted to better understand identity and representations of oneself and others (Beeney et al., 2016; Ellison et al., 2020; Levy et al., 2010; Levy, Steiner, et al., 2022; Scala et al., 2018; Steiner et al., 2021). Levy et al. (2010) found that vacillations in mental states about the self and others (including the therapist) predicted the quality of the observer-rated therapeutic alliance in a subset of patient–therapist dyads from the Clarkin et al. (2007) randomized clinical trial (RCT). Beeney et al. (2016) found anomalies in the neural basis of self and other processing for those with BPD. Greater activation in the precuneus and posterior cingulate was found for those with BPD within both self-reflection at baseline and other-reflection at baseline contrasts, whereas the control group evidenced greater activation in the self–other contrast in the angular gyrus (all results $p < .005$, $k = 24$, equivalent to family-wise error correction, $p < .05$).

Behaviorally, BPD patients showed more fragmented, unintegrated, fluctuating, and negative self-concept on a self-concept card sorting task completed twice over a 3-hour period. In Scala et al. (2018), those with BPD were compared to patients with anxiety disorders in an intensive repeated measurement design collecting both random and event contingent data via smartphones over 21 days. Patients recorded data 12 times per day on average. The authors found that affect regulation deficits, operationalized as a repeated experience of negative affect during the day, predicted suicidal urges. However, this association was only significant when patients were in identity diffuse mental states. Although BPD patients scored significantly higher and experienced more identity disturbance, negative affect, and suicidal urges than those with anxiety disorders, consistent with a transdiagnostic approach, the process worked similarly across both groups.

In an unpublished study, Levy, Steiner, et al. (2022) examined the capacity of those with BPD traits to form accurate visual self-images. In a series of 300 presentations, participants were tasked with choosing between two faces as to which one looked more similar to themselves. Two images were generated using a reverse correlation method: one based on all the images selected as more similar to the participant and the other, the rejected image. The self-relevant generated image was then computer compared to the participant's actual image, and a similarity score was generated. BPD traits were negatively related to the accuracy of the generated self-image. The greater the number of BPD traits and symptoms, the more diffuse the self-image ($b = -.29$, $p < .02$). In contrast, Steiner et al. (2021) found that although narcissistic traits, similar to BPD traits, also predicted less accurate self-images, those higher in narcissism generated images of the self that were significantly more likely to be rated by independent assessors as more attractive than the participant's actual photograph. Thus, those participants with greater BPD traits tended to create more diffuse self-images, whereas those with greater narcissistic traits and symptoms tended to create more enhanced self-images.

## Treatment Effectiveness and Efficacy

TFP's effectiveness and efficacy have been demonstrated in multiple pre–post studies (Clarkin et al., 2001; Clarkin & Levy, 2003; Cuevas et al., 2000; Perez et al., 2016), a quasi-experimental study (Levy, Clarkin, et al., 2022), and three RCTs completed by separate research teams across four countries (Clarkin et al., 2007; see also Doering et al., 2010; Giesen-Bloo et al., 2006; Levy et al., 2006).

In the first RCT, Clarkin et al. (2006) compared TFP, DBT, and supportive psychodynamic therapy. All of these treatments led to improvements in depression, anxiety, functioning, and adjustment; however, those in the TFP arm of treatment also improved in a broader number of domains, particularly anger and aggression. In another study, TFP was compared to treatment in the community by therapists experienced in treating BPD (Doering et al., 2010). In that study, the authors found that those in the TFP arm of treatment experienced a reduction in suicide attempts, fewer admissions to a psychiatric

department, and fewer patients unexpectedly leaving treatment. The TFP arm also had significantly fewer borderline symptoms, significantly better psychosocial functioning, and healthier personality organization when compared to the other arm of treatment at termination. Patients treated in either group showed similar improvements in depression and anxiety. Arnoud Arntz and colleagues' RCT compared schema therapy (ST) with TFP conceptualized as a control group (Giesen-Bloo et al., 2006). Both treatments were effective, producing large effect sizes. Although ST showed better results in the intent-to-treat analyses, the completer analyses showed no differences between the treatments (Giesen-Bloo et al., 2006; Levy, Wasserman, et al., 2009; Levy et al., 2012). Differences in nonrandom dropout between treatment arms explain the discrepancy between ST and TFP. There were also various indications that the randomization had failed in the trial. For example, patients in the TFP group scored higher on measures of self-destructiveness than patients in the ST group and thus had more severe difficulties than the ST group. This greater severity has been shown to be related to worse outcome in treatment for BPD. It is also important to realize that despite these issues and others (see Yeomans, 2007), differences between groups did not emerge until Year 3.

### Meta-Analytic Studies

A number of meta-analytic reviews have examined TFP in relation to other treatments (Binks et al., 2006; Cristea et al., 2017; Kliem et al., 2010; Oud et al., 2018; Stoffers-Winterling et al., 2012). These studies have consistently found that there are no reliable differences in overall effect sizes between psychodynamic treatments, including TFP and other treatments, when compared with DBT. This finding is consistent with the effect sizes found in individual studies and those that directly compare DBT with TFP (Clarkin et al., 2007) and with other treatments (Doering et al., 2010; Giesen-Bloo et al., 2006).

### Changes in Personality

Although symptom change is important, and especially for BPD, given that the consequences of untreated BPD symptoms are grave, TFP aspires for structural change within a patient's personality, a more extensive and ambitious outcome. Changes in deep personality structures have therefore been a main interest within psychotherapy research on TFP. Although these changes are especially important for personality pathology given that personality difficulties are hypothesized as being rooted in personality proper, current research on these more ambitious outcomes in specialized treatment for BPD has been neglected. However, within RCTs of TFP, structural changes have been assessed, and TFP has reliably demonstrated specific benefits in this domain. In two RCTs and a pre–post study on TFP, patients in these studies demonstrated unique and significant increases in attachment security and mentalizing (the ability to make sense of one's and others' mental states) when compared with

non-TFP control groups (Buchheim et al., 2017; Fischer-Kern et al., 2015; Levy, Diamond, et al., 2022; Levy et al., 2006). Levy et al. (2006) found that almost a third (29%) of patients in the TFP condition adopted secure attachment styles following a year of TFP. By comparison, none of the patients in the control treatments was securely attached by the end of treatment. Similarly, Buchheim and colleagues (2017) found that 12 of the 38 (31%) patients in the TFP arm of the Doering et al. (2010) study showed improved scores in terms of attachment security, whereas no participant in the control group showed significant improvements in attachment security. Levy, Diamond, et al. (2022) also found significant changes in attachment security following 1 year of treatment, particularly that 30% of the patients treated in TFP became securely attached.

With regard to mentalizing abilities in patients following treatment, the pre–post effect size in all three studies (Fischer-Kern et al., 2015; Levy, Diamond, et al., 2022; Levy et al., 2006) demonstrated similar improvement even though the studies were conducted on two separate continents; at three separate cohort times; and with a set of different therapists, interviewers, and coders. These findings suggest improved relationships, greater awareness of one's own motivations, and more accurate inference about other people's intentions and behaviors as well as the potential for more satisfying interpersonal relationships. These unique findings for TFP are central to research on BPD treatment; from the perspective of TFP, patients sustainedly cope better with internal conflict, relationships, and major life events as a result of these unique changes in personality.

### Changes in Brain Functioning

Perez et al. (2016) conducted a pilot study on neural correlates of improved emotion regulation and improved impulsivity after TFP treatment. Using a within-subjects design, they examined pre–post treatment neural changes using functional magnetic resonance imaging (fMRI) scans in 10 women reliably diagnosed with BPD who were treated in 1 year of TFP by trained, supervised, and adherent therapists. During the scans, a BPD-specific, emotional-linguistic, go/no-go task was used to assess the relation between negative emotional processing and inhibitory control. Perez et al. found fMRI measured brain changes that were associated with variation in outcome. They found that brain changes were significantly related to symptom changes from TFP treatment. Specifically, there was relative increased dorsal prefrontal (dorsal anterior cingulate, dorsolateral prefrontal, and frontopolar cortices) activation and relative decreased ventrolateral prefrontal cortex and hippocampal activations following treatment. Clinical improvement in constraint was positively associated with relative increased left anterior-dorsal anterior cingulate cortex activation. Clinical improvement in affective lability was positively associated with left posterior-medial orbitofrontal cortex/ventral striatum activation, and negatively with right amygdala parahippocampal activation.

## RECENT CLINICAL AND THEORETICAL DEVELOPMENTS AND ADVANCES

In the mid-1960s, Otto Kernberg began describing his treatment approach for patients with borderline personality organization (BPO) based on his work at the Menninger psychotherapy project (O. F. Kernberg et al., 1972). Following that early articulation, Kernberg and colleagues have continually clarified and elaborated the theory and techniques in TFP. In 1989, the first TFP manual was published (O. F. Kernberg et al., 1989) and followed up by updates in 1999 (Clarkin et al., 1999), 2006 (Clarkin et al., 2006) and 2015 (Yeomans et al., 2015). Along the way, important supplements were published on contracting (Yeomans et al., 1994) and on dealing with difficult patients and clinical situations (Koenigsberg et al., 2000), and a primer was published (Yeomans et al., 2002).

Although these manuals outlined a treatment intended primarily for patients with BPD, Kernberg always envisioned that the ideas underlying the TFP model had broader relevance. In Kernberg's view, all manifestations of a more general category of pathology that he identified as BPO might benefit from TFP principles. The concept of BPO was articulated before the narrower definition of BPD adopted by *DSM-III* (American Psychiatric Association, 1980), *DSM-IV* (4th ed.; American Psychiatric Association, 1994), and *DSM-5* (American Psychiatric Association, 2013), and has a similar focus as the AMPD, particularly an emphasis on levels of self- and interpersonal functioning. The concept of BPO includes BPD but also several other personality styles or disorders, including narcissistic PD. Consonant with this broader perspective on personality organization and pathology, Kernberg had interests in narcissism coexisting with his broader interest in borderline pathology (O. F. Kernberg, 1975/1985, 2004, 2007), and, as mentioned previously, some preliminary evidence supports TFP as a uniquely efficacious treatment for NPD when compared with DBT and a supportive psychotherapy (Levy, Kivity, et al., 2022). Nevertheless, Kernberg and a number of clinical researchers have recently written about a modified TFP treatment frame for patients experiencing significant narcissistic pathology primarily to address differences in the way personality style in NPD and BPD impact treatment process (Caligor et al., 2015; Diamond & Yeomans, 2008; Diamond et al., 2011, 2021; O. F. Kernberg, 2014; Levy, 2012; Levy, Chauhan, et al., 2009; Stern et al., 2013, 2017; Yeomans et al., 1994, 2013).

TFP was originally conceptualized within a developmental psychopathology framework based in identify diffusion and polarized representations of others and the self that cut across PD categories, and authors have therefore noted that other styles and levels of severity of personality pathology may benefit from TFP principles (Caligor et al., 2007, 2018). The application of TFP principles have now been described for working with college students (Hersh, 2013), prescribing psychiatric medication (Hersh, 2015), treating patients in acute clinical care settings (Hersh et al., 2017; Zerbo et al., 2013), working with traumatized patients (Draijer & Van Zon, 2013), treating complex depression

(Clarkin et al., 2019), and training psychiatric residents (Bernstein et al., 2015). Integrating TFP with other treatments has also been explored: Good psychiatric management (McCommon & Hersh, 2021), supportive psychotherapy (O. F. Kernberg, 2022), behavioral activation (Levy & Scala, 2015; Yeomans et al., 2017), and modular treatments (Clarkin et al., 2015) have all been considered as potential modalities for integration.

TFP principles have also been considered within child and adolescent treatments (Biberdzic et al., 2018; Ensink et al., 2015; Normandin et al., 2014, 2015, 2021), and these modifications were largely inspired by Paulina Kernberg's work (P. Kernberg et al., 2000).

## TFP APPLIED TO *DSM-5* AMPD AND *ICD-11*

Several authors stress that Otto Kernberg's conceptualization of personality organization, with its focus on linking self and other representations to self- and interpersonal functioning and the overall severity of personality pathology not only predated the AMPD but was influential in its architecture (Bender et al., 2011; Clarkin et al., 2020; Natoli, 2021; Waugh et al., 2017; Yalch, 2020). Bender et al. (2011) noted that Kernberg's object relations model, the concept of personality organization that is the basis for the TFP model, was one of the first to articulate a model of personality types arrayed along a continuum of severity. First articulated in the late 1960s, Kernberg proposed a model for understanding a range of PDs along two dimensions: severity and internalizing versus externalizing (O. F. Kernberg, 1967; O. F. Kernberg & Caligor, 2005). Various PDs could be arrayed along this two-dimensional space. Consistent with recent research (Sharp et al., 2015; Wright et al., 2016), Kernberg conceptualized the severity dimension in terms of level of borderline functioning. The progression from lower levels of severity in personality pathology to higher levels of severity is tied to more impaired and maladaptive self—other representations and functioning. Thus, in Kernberg's model, the central BPD symptoms—abandonment fears, unstable relationships that alternate between idealization and devaluation, affect instability, identity disturbance, paranoid ideation, chronic feelings of emptiness, and angry outbursts—arise from an individual's impaired and distorted internal images of self and other, what Kernberg called identity diffusion. The data from Sharp et al. (2015) and Wright et al. (2016) are consistent with this idea. This conceptualization is also consistent with the AMPD in Section III of *DSM-5* (American Psychiatric Association, 2013) in that borderline pathology is of central heuristic value for representing what is common to all personality pathology (Criterion A) and the severity model in the PDM-2 (Lingiardi & McWilliams, 2017).

Kernberg's model led to several dimensional rating scales of self-functioning and interpersonal functioning in measures, such as the *DSM-5* Level of Personality Functioning Scale (Bender et al., 2011), Level of Personality Functioning Scale–Self-Report (Morey, 2017), the Self and Interpersonal Functioning Scale

(Gamache et al., 2019), *DSM-5* Levels of Personality Functioning Questionnaire (Huprich et al., 2018), and Inventory of Personality Organization (Lenzenweger et al., 2001).

Kernberg's concept of personality organization provides a broad and comprehensive framework for an understanding of both typical or normal personality development and personality pathology that is consistent and interdigitates closely with the models proposed in the dimensional aspects of the AMPD and the *ICD-11* (WHO, 2019) as well as the PDM-2 (Lingiardi & McWilliams, 2017), HiTOP (the Hierarchical Taxonomy of Psychopathology; Kotov et al., 2017), and cognitive affective personality system (CAPS) framework (Mischel & Shoda, 1995). The concept of personality organization is based on several underlying dimensional constructs, such as identity, defense mechanisms used, and capacity for social reality testing.

*Identity* refers to one's representations of self and others and their degree of differentiation and integration. For Kernberg, similar to Anna Freud (1966) and Vaillant (1992), defenses can be conceptualized along a developmental continuum from more healthy and mature defenses through neurotic defenses; to more immature or primitive borderline defenses, such as splitting, projective identification, and omnipotent control; to psychotic or pathological level defenses. Reality testing can vary from generally intact to subtle and transient deficits in social reality testing, to frank deficits in physical reality testing (e.g., hallucinations). One's level of personality organization is based on the degree of identity consolidation or diffusion, the maturity or immaturity of defenses used, and the capacity for social reality testing that, taken together, can be arrayed along a dimension from relatively healthy or neurotic levels through high and low borderline levels to psychotic levels of personality organization. Those at a neurotic level of personality organization show mild impairments in self- and interpersonal functioning. Their identity is characterized by a consistent sense of self and others, is consolidated, and is thus resilient in the face of challenges. They generally rely on mature defenses, even when stressed, and their reality testing is intact. Those organized at a borderline level show more severity and impairment in self- and interpersonal functioning, with indications of identity diffusion as characterized by unintegrated and fragmented sense of self and others as well as use of immature or primitive defenses. Although reality testing is generally intact, these individuals can show deficits in social reality testing, particularly when under stress. Those at a psychotic level experience the most severe impairments in self- and interpersonal functioning.

In the TFP model, this concept of level personality organization or functioning runs orthogonal to the dimension of introversion versus extraversion, which is similar to Blatt's (1974) concepts of introjective (self, agency) versus anaclitic (dependent, relatedness, communion) focus but also clearly maps well onto trait theories with their focus on introversion and extraversion. In addition, in TFP, there are several personality styles or types, many of which are consistent with Section II and III personality types and that can be arrayed along these two dimensions. Sharp and colleagues (2015) conducted

an exploratory bifactor analysis of the diagnostic criteria for six PDs. They found a general factor for personality pathology (*g*-PD) emerged with the BPD criteria loading solely on the *g*-PD factor. Specific factors (s-factors) also emerged with strong average loadings for three PD types: Antisocial, Schizotypal, and Narcissistic PDs. Sharp and colleagues proposed that the *g*-PD factor was a strong representation of the *DSM-5,* Section III, AMPD Criterion A. Wright and colleagues (2016) similarly found the evidence for a *g*-PD factor in a bifactor analysis of 10 PDs, noting that these findings were consistent with O. F. Kernberg's (1984) concept of BPO.

Interestingly, although Widiger (Widiger & McCabe, 2020; see also Sleep et al., 2021) has suggested that Criterion B can account for Criterion A of the AMPD, the TFP model more elegantly encompasses the main aspects of both Criterion A and Criterion B in an integrative and seamless manner. Criterion B represents maladaptive personality traits assessed through five broad trait domains of Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism that are further differentiated into 25 underlying facets. Although not readily apparent because these trait domains emphasize the maladaptive extremes, they also map onto the five-factor model (FFM) such that negative affectivity is conceptually similar to neuroticism, detachment to introversion, antagonism to low agreeableness, and disinhibition to low conscientiousness. Although psychoticism's relation to the FFM conception is more tenuous, Miller et al. (2018) suggested that it is related to openness, but the correlation is the lowest of such comparisons, it fits well with alternative trait models like Eysenck's (1987) that has found a psychoticism dimension. Obviously, the introversion–extroversion dimension maps to the same named dimension in the FFM and the detachment dimension of the AMPD.

In regard to the personality organization dimension, neurotic level of organization relates to moderate levels negative affectivity, and borderline level of organization relates to high levels of negative affectivity. High levels of disinhibition can be found in the impulsive PDs, typically at the borderline level of personality organization. Similarly, high levels of Antagonism would be found more typically at the borderline level of personality organization, while the psychotic level of personality functioning would be characterized by high levels of psychoticism in the AMPD. Thus, all five of the maladaptive trait dimensions are accounted for in a model that allows for differences in personality styles or types that are consistent with conceptualizations and empirical findings from various models. The TFP frame allows for responsivity to Criteria A and B by using recent adaptations. Consider, for example, that the presence of narcissism, either based on Criterion B traits or the diagnosis proper, may require modifications to the TFP frame and transference-based interventions as described in several papers (Caligor et al., 2015; Diamond et al., 2021; Levy, 2012). In contrast, impairments more characteristic of higher level functioning PDs may require modifications consistent with TFP-E (Caligor et al., 2007; Caligor et al., 2018).

With regard to the *ICD-11*, although not necessarily acknowledging its consistency with the TFP model, its dimensional focus, along with its focus on

severity of impairment in the areas of self- and interpersonal functioning and the retaining of borderline pattern descriptor, parallels aspects of the AMPD and is consistent with the most prominent aspects of the TFP model. Although the narrow focus on a general PD, the abandonment of other types of PDs, and the failure to consider defensive functioning is inconsistent with the TFP model, the *ICD-11* (WHO, 2019) inclusion of reality testing as a key dimension for assessing the severity of PD is conceptually closer to an important aspect of the TFP model than the AMPD's focus on psychoticism.

## CONCLUSION

TFP is a specialized psychodynamic psychotherapy for individuals with PDs that has been empirically demonstrated as effective for BPD. TFP aims to integrate diffuse identity, increase emotion regulation, and improve relationships, and is therefore ambitious in its intended goals of structural change. From the perspective of TFP, these changes allow patients the potential for intimate and satisfying love relationships as well as the development of sustained interests, commitments, and the capacity for investments requisite for a successful work life. Observation of and reflection on the relationship with the TFP therapist is the primary conduit of change, the foundation for exploring and integrating the patient's split and fragmented representations of self and others within the here-and-now moment of the patient's experience. Increased awareness and understanding of unintegrated experiences, emotions, and representations often result from this specialized treatment process. Multiple studies from separate countries and patient cohorts support the claim that TFP leads to improvements in both BPD symptoms as well as more structural changes in personality, such as security of attachment and capacity for reflecting on mental states in oneself and others.

We contend that the TFP model converges with the findings of a general psychopathology or "p" factor (Caspi & Moffitt, 2018), the AMPD, the recent findings within assessment of personality pathology about general ('g') and specific ('s') factors (Sharp et al., 2015; Wright et al., 2016), the main structure of the WHO (2019) *ICD-11* (Blüml & Doering, 2021; Tyrer et al., 2019), and the CAPS model (Mischel & Shoda, 1995; for reviews, see Clarkin et al., 2010, and Huprich & Nelson, 2015). These convergences show the TFP model is not only theoretically and clinically useful but has been absorbed into the main models in use today (Levy, 2020).

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