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**Transference-Focused Psychotherapy
for BPD:**

Moving Beyond Symptom Change

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Transference Focused Psychotherapy (TFP)

The first manualized **psychodynamic** treatment for borderline personality disorder

Combines structure and limit-setting with psychodynamic approach

Twice-weekly outpatient therapy (with the option of auxiliary treatments to target specific problems)

“Top down” and “bottom up” approach

TFP – Focus on the intrapsychic

- Why bother working at this level?
 - Symptom Change
 - Change in underlying psychological functions
 - Change in sense of self and experience of the world
 - Goal of psychological integration...”full” life
 - Satisfaction in love and work

Who Is TFP For?

Patients with personality disorders at the **borderline level of personality organization**, including:

Borderline PD

Narcissistic PD

Histrionic PD

Dependent PD

Avoidant PD, etc.

These are all characterized by lack of a clear identity, which we refer to as **Identity Diffusion**

What is the Core Feature of these Borderline-Level Personality Disorders? - 1

I. Identity Diffusion. Sense of self and others is fragmented, distorted and superficial.

This leads to:

- Difficulty “reading” others... and self
(Donnegan et al, 2003; Wagner and Linehan, 1999)
- Sense of emptiness; lack of continuity in time.

In this model, BPD is seen as both a problem of Emotion Dysregulation and of an incoherent Sense of Self and Others

What is the Core Feature of these Borderline-Level Personality Disorders? - 2

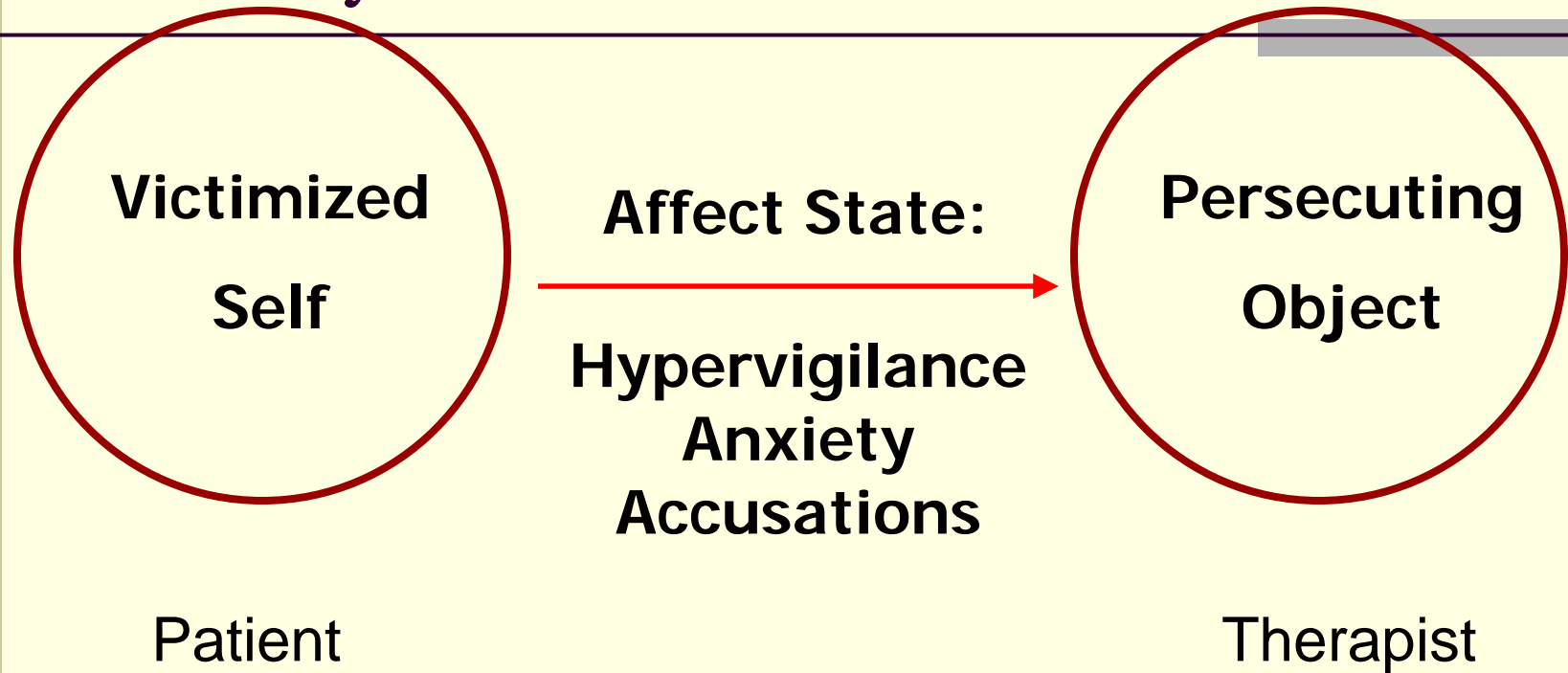
II. Primitive Defenses: intolerable and unacceptable thoughts are split off from the rest of the self and either acted out or projected on others

Building Identity



The Self-Other Dyad

Gabbard: Some neurobiological support for this theory

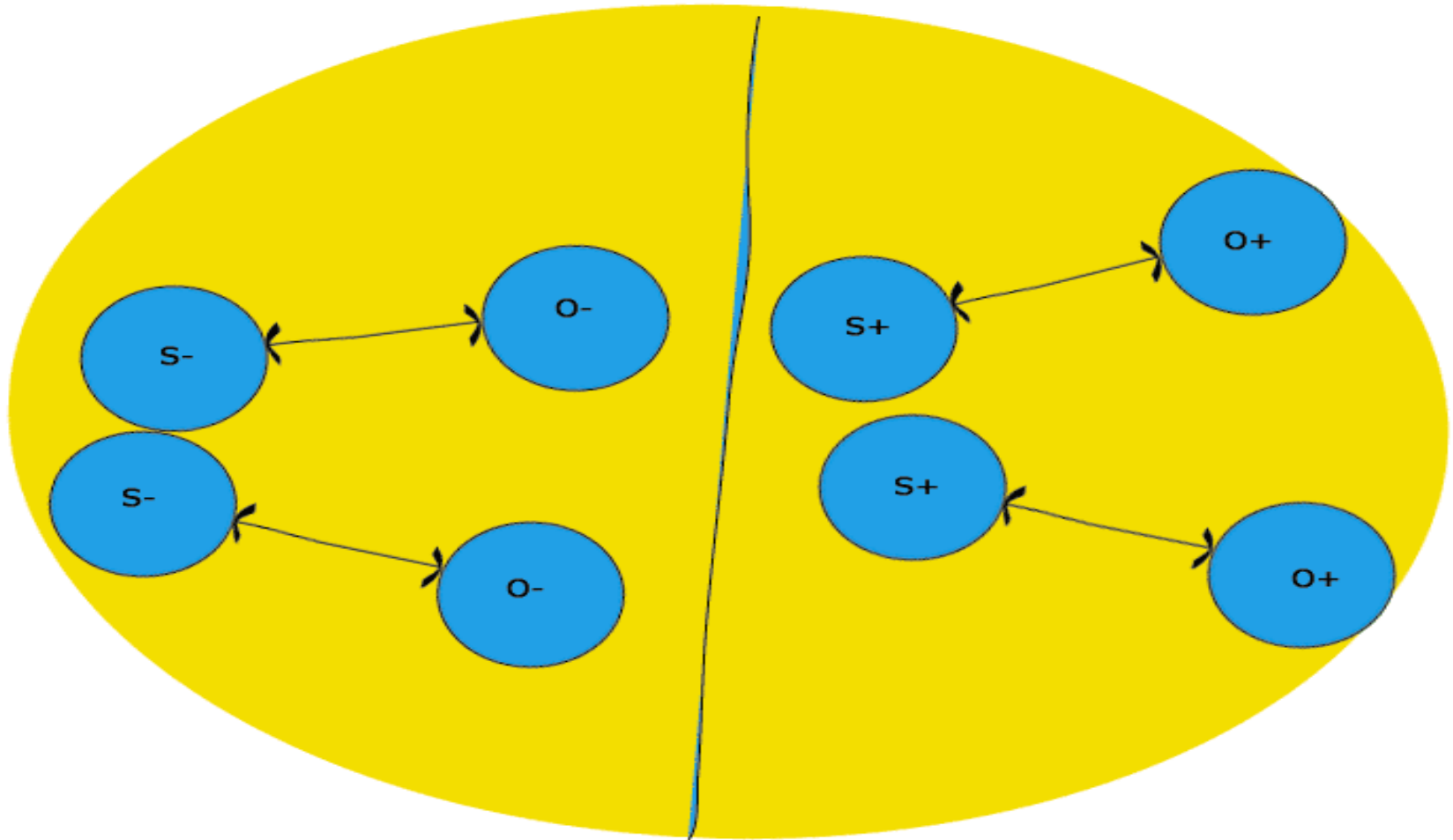


The affect state of anxiety and hypervigilance associated with HPA hyperreactivity is linked to a specific internal object relationship involving a persecuting object and a victimized self.

Dyads as Building Blocks

- Dyads of similar affective charge aggregate
 - In early development
 - In BPD
- The identification is with **the entire relationship**, not just with the self-representation or the object representation

Split Organization:

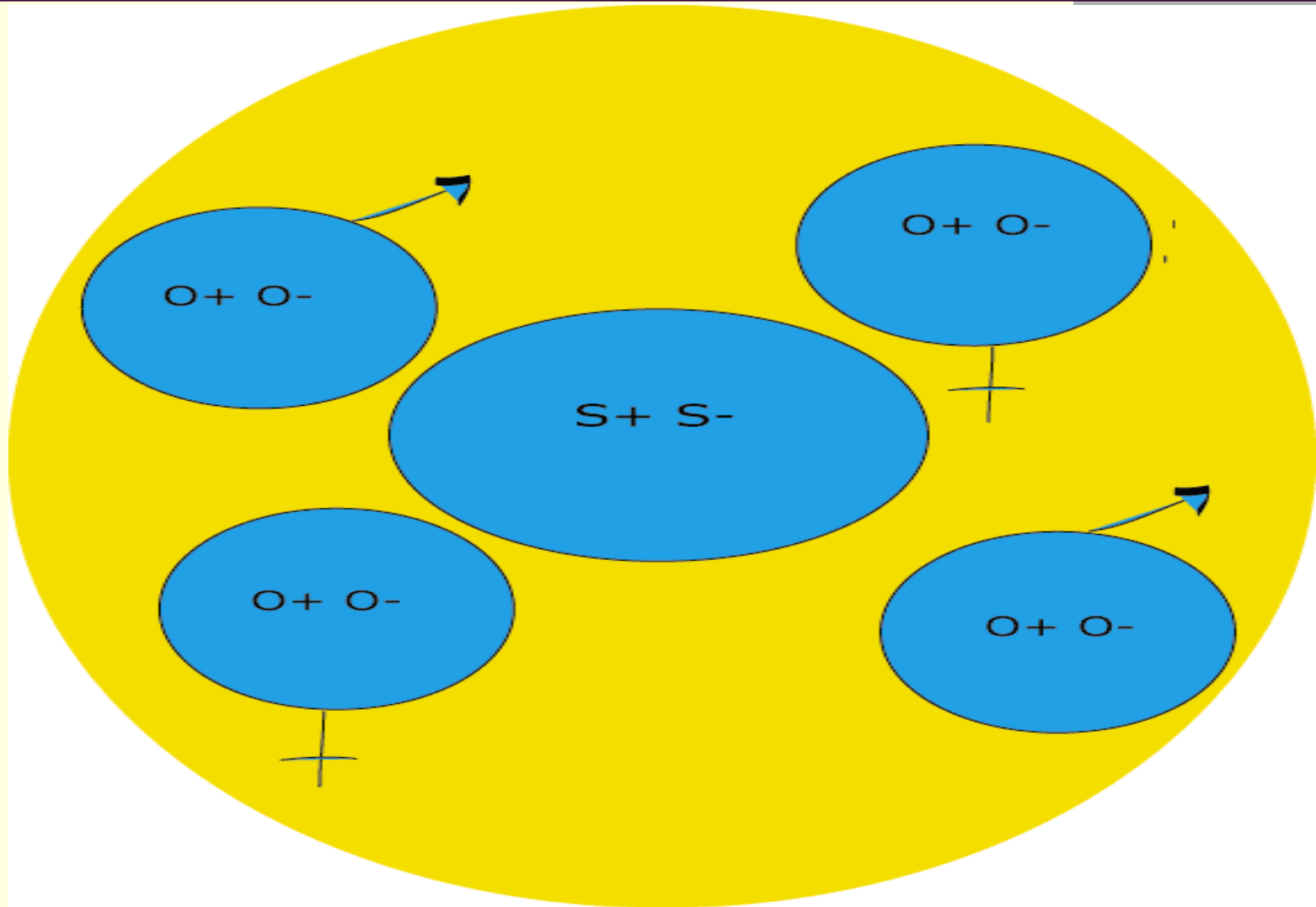


THE DEVELOPMENT OF PSYCHOLOGICAL STRUCTURE IN THE INTERNAL WORLD - 1

In normal infant development:

1. In peak affect states, the infant internalizes a memory of self in relation to other.
2. These experiences coalesce into those with pure positive affect and those with pure negative affect. At this stage, self and others are perceived in extreme, absolute terms.
3. In **normal development**, the extreme positive and negative segments of the mind become integrated into more complex and nuanced representations of self, others, and affects. Ambivalence, acceptance, flexibility and the notion of “good enough” guide the individuals perceptions of self and others.

Normal (Integrated) Organization: Consciousness of Integration/complexity



THE DEVELOPMENT OF PSYCHOLOGICAL STRUCTURE IN THE INTERNAL WORLD – 2 THE PERSISTENCE OF THE SPLIT STRUCTURE

Borderline pathology develops when:

4. Under the stress of maltreatment or aggressive constitutional loading, the negative experiences outweigh the positive experiences.
5. The negative experiences remain isolated and split off from the positive experiences, **preventing integration and leading to the fixation of the originally normal developmental split**. This perpetuates perceiving self and others in extreme, absolute terms.

Evolution of treatment

From the **Split Organization** to the
Integrated Organization

From polarized intense experiences of self and other to more complex and better modulated experiences



"I'm neither a good cop nor a bad cop, Jerome. Like yourself, I'm a complex amalgam of positive and negative personality traits that emerge or not, depending on circumstances."

How to Accomplish this Goal?

Within the secure treatment structure, observe and reflect upon the whole array of internal images of self and other as they are experienced at different times in the relationship with the therapist (the transference)

Transference means the transfer of internalized images from the past onto a present situation. **It is universal:** you can either use it, try to dispel it, or be confused by it.

An integrated identity: Healthy Object Relations

- Stable and realistic sense of Self and Others
- People and their personalities are appreciated as complex and nuanced, rather than caricatured and simplistic
- Positive and negative personality traits and characteristics can co-exist – (one can maintain loving feelings for a partner who also causes temporary frustration and anger)
- Intense emotions are tempered by these qualities
 - complex, multi-layered emotions are present (e.g., ambivalence, guilt, gratitude, remorse, realistic self-esteem)

Identity Diffusion and Primitive Defenses Lead to Borderline Object Relations and Sx

- Intense affects: Polarized, intense emotions and mental states (“black and white” perceiving and feeling)
- Superficial, underdeveloped understanding of the mental life of self and others, poor capacity to *reason* about the mental states
- Disturbed interpersonal relations
 - Rapidly shifting, polarized, and rigid views of self and others
 - Difficulty with sexual functioning (“all or nothing”)
- Self-destructive actions
- Emptiness/hollowness
- Moral rigidity or absence of moral code
- Difficulty with commitments to love and work

Strategies of TFP - 1

- I: Initial phase - the reduction of suicidal and self destructive behaviors through an explicit framework for treatment

Strategies of TFP - 2

- II: Core of the treatment - the development of a coherent identity that brings together extreme emotional and cognitive experiences of self and other. This is done through focusing on the patient's experience with the therapist (**the transference**) in order to:
 - 1) Foster awareness of mental states of self and other, and
 - 2) Integrate polarized emotions, motivations, & beliefs as they are experienced in the moment with the therapist

Therapist attitude

- accepting, concerned, curious, emotionally attuned, and reflective attitude toward the patient

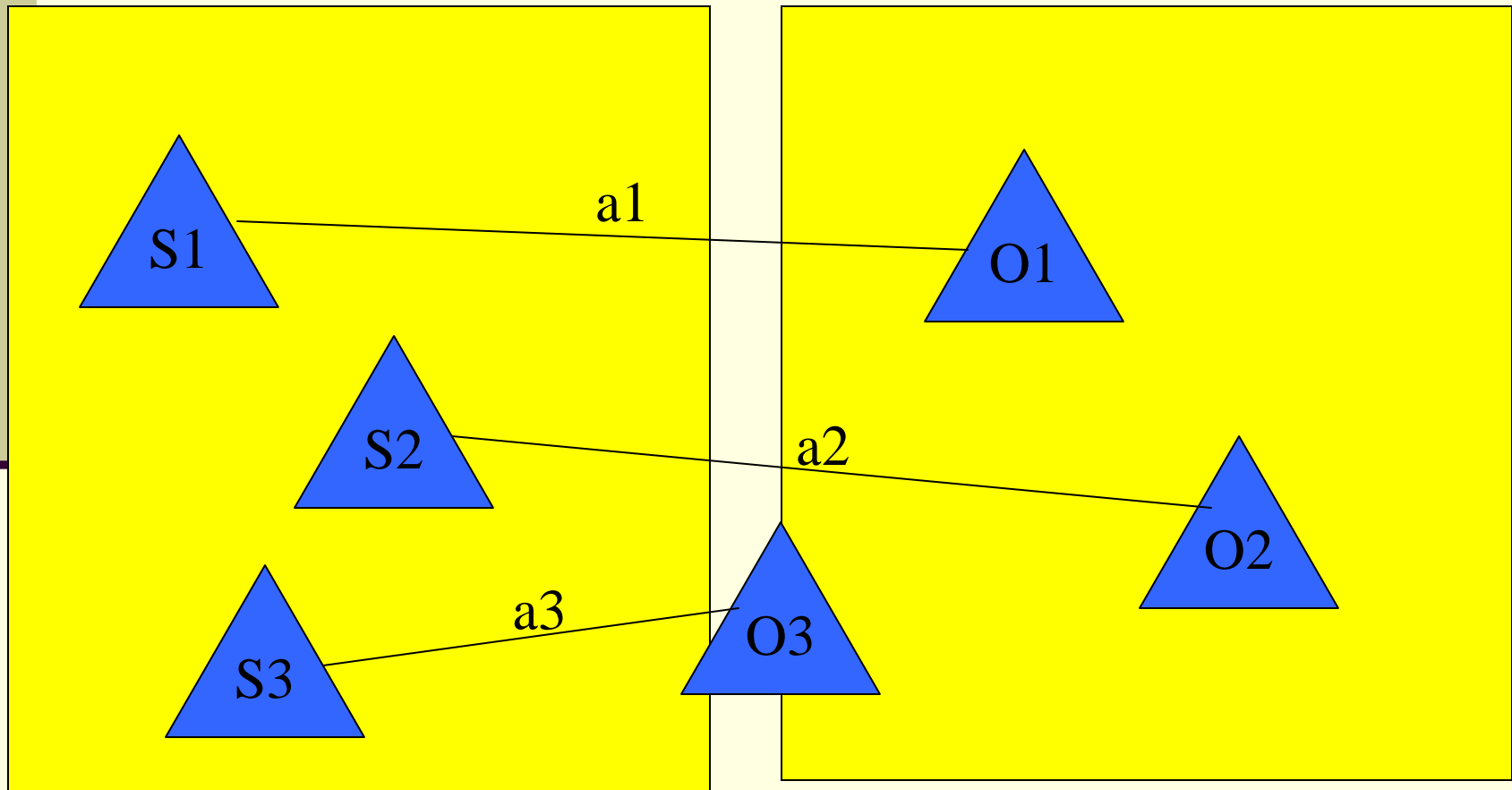
Why Focus on the Transference?

- Assumption: Emotions are embedded within internalized interpersonal relationships that get repeated with new people in the patient's life... whether or not they fit the new situation
- Letting the internal relationship images emerge with the therapist allows helps achieve an understanding of them that frees the patient to be open to new, richer relationship experiences

← TRANSFERENCE,
and the power of Internal World
over External Reality Ex:RB →

■ Experience of Self

■ ...and of Therapist



Understanding Interpretation

- Interpretation is attuned to the *here-and-now* experience of the patient
- Interpretation takes the patient one step beyond her/his current level of awareness of
 - What he/she is feeling
 - What is motivating the feeling
- This process leads to integration of split-off feelings

Steps of Interpretation - I

- Understand/Identify self state in the moment (first level of mentalization)
- Elaborate understanding of the therapist
- If necessary, offer the patient a version of how the therapist experiences the moment

Steps of Interpretation - II

- **Put the moment in a broader context:** Contrast the immediate experience of self and of therapist with that seen through other channels or at other times (second level of mentalization - address splits/conflicts)
- Consider reasons for splits
- Put the above in the context of other relations

Principle: A person needs an integrated self concept to reflect on a current state. Otherwise, the person feels they **are** what they feel in the moment - and nothing more.

Empirical Support for Efficacy of TFP in 4 Studies

■ **Study 1: Patients as own controls**

17 patients who completed one year of TFP; functioning during treatment year compared with functioning during year prior (Clarkin, Foelsch, Levy, Hull, Delaney & Kernberg, 2001, *Journal of Personality Disorders*)

■ **Study 2: TFP compared to TAU**

26 patients who completed TFP treatment compared with 17 subjects who had been evaluated for the same treatment but who did not enter into TFP Treatment. (Levy, Clarkin & Kernberg, in review)

Empirical Support

- **Study 3: Randomized Controlled Trial (RCT)**

90 patients in three manualized treatments:

TFP, DBT and Supportive Treatment (Clarkin, Levy, Lenzweger & Kernberg, 2007, *American Journal of Psychiatry*; Levy, Meehan, Kelly, Reynoso, Clarkin, Lenzweger & Kernberg, 2006, *Journal of Consulting and Clinical Psychology*)

Funding from the Borderline Personality Disorder Research Foundation

- **Study 4: RCT**

104 patients randomized to TFP or to Experienced Community Therapists (Doering et al., under review)

Study 3

Overall Study Aims

- To assess the efficacy of Transference Focused Psychotherapy (TFP) and Supportive Psychotherapy (SPT) compared with Dialectic Behavioral Therapy (DBT) for patients with Borderline Personality Disorder
(Clarkin, Levy, Lenzweger & Kernberg, 2007, *American Journal of Psychiatry*;
Levy, Meehan, Kelly, Reynoso, Clarkin Lenzenweger & Kernberg, 2006, *Journal of Consulting and Clinical Psychology*)

RANDOMIZED CONTROLLED TRIAL

- Male and female BPD, ages 18 to 50
- Inclusion criteria: Axis II BPD
- Exclusion criteria: Schizophrenia, Bipolar Disorder, Eating Disorder and Substance Dependence
- Randomized to one of three treatments
- If indicated, medication by algorithm
- Assessment at four points in time during one year of treatment

Patients

- 90 patients (83 Women and 7 Men)
- Mean Age = 30.9 (S.D. = 7.85)
- Marital status:
 - 7.7% Married, 12.2% Living with partner, 44.4% Divorced, 23.3% In relationship
- Education:
 - 4-year college degree (any college) 32.2% (63.3%)
- Employment:
 - Employed (fulltime) 64.4% (33.3%)
- Ethnicity/Race:
 - 67.8% Caucasian, 10.0% African-American, 8.9% Hispanic, 5.6% Asian, 3.3 % mixed ethnicity/race, 4.4% other

Sample characteristics and context

■ Mean Axis I = 3.8

- MDD: 48%
- (any mood): 78%
- Anxiety: 55%
- (PTSD): 16%
- Eating d/o: 34%
- Substance: 38%
- Suicide
- Attempts 57%
- Self destructive 64%
- Either 83 %

■ Mean Axis II = 2.5

- Par: 26%
- Szd: 0%
- Szt: 3%
- Asp: 21%
- His: 24%
- Nar: 18%
- Avd: 31%
- Dep: 11%
- O-C: 14%

Assessing Change in Psychotherapy

■ Clinical Outcome

■ Primary outcome domains

- Suicidality, aggression, and impulsivity

■ Secondary outcome domains

- Social Adjustment (Love and Work)
- Depression, anxiety, irritability (phenomenological distress)

■ Mechanisms of Change

- Change in reflective function

Change in 6 Domains: Effect Sizes

(Clarkin et al, 2007, Amer J Psychiatry)

	Suicidality	Anger/ Aggression	Impulsivity	Anxiety	Depression	Social Adj
TFP	0.33 (0.01)	0.44 (0.001)	II: 0.36 (0.005)	0.37 (0.004)	0.50 (0.001)	0.28 (0.03)
DBT	0.34 (0.01)	NS	NS	0.50 (0.001)	0.38 (0.003)	0.44 (0.001)
SPT	NS	0.28 (0.05)	III: 0.31 (0.02)	0.48 (0.001)	0.49 (0.001)	0.59 (0.001)

What happens to the person that results in change? (Clarkin & Levy, 2006)

- Bateman & Fonagy's mentalization-based therapy (MBT): The development of mentalization or reflective function
- Linehan's dialectical behavior therapy (DBT): Development of new skills and increased "mindfulness"
- Schema Therapy (Young): Reparenting and understanding schemas
- TFP: Increased integration and differentiation of sense of self and others; more accurate view of self and others (Reflective Function as a proxy for this)

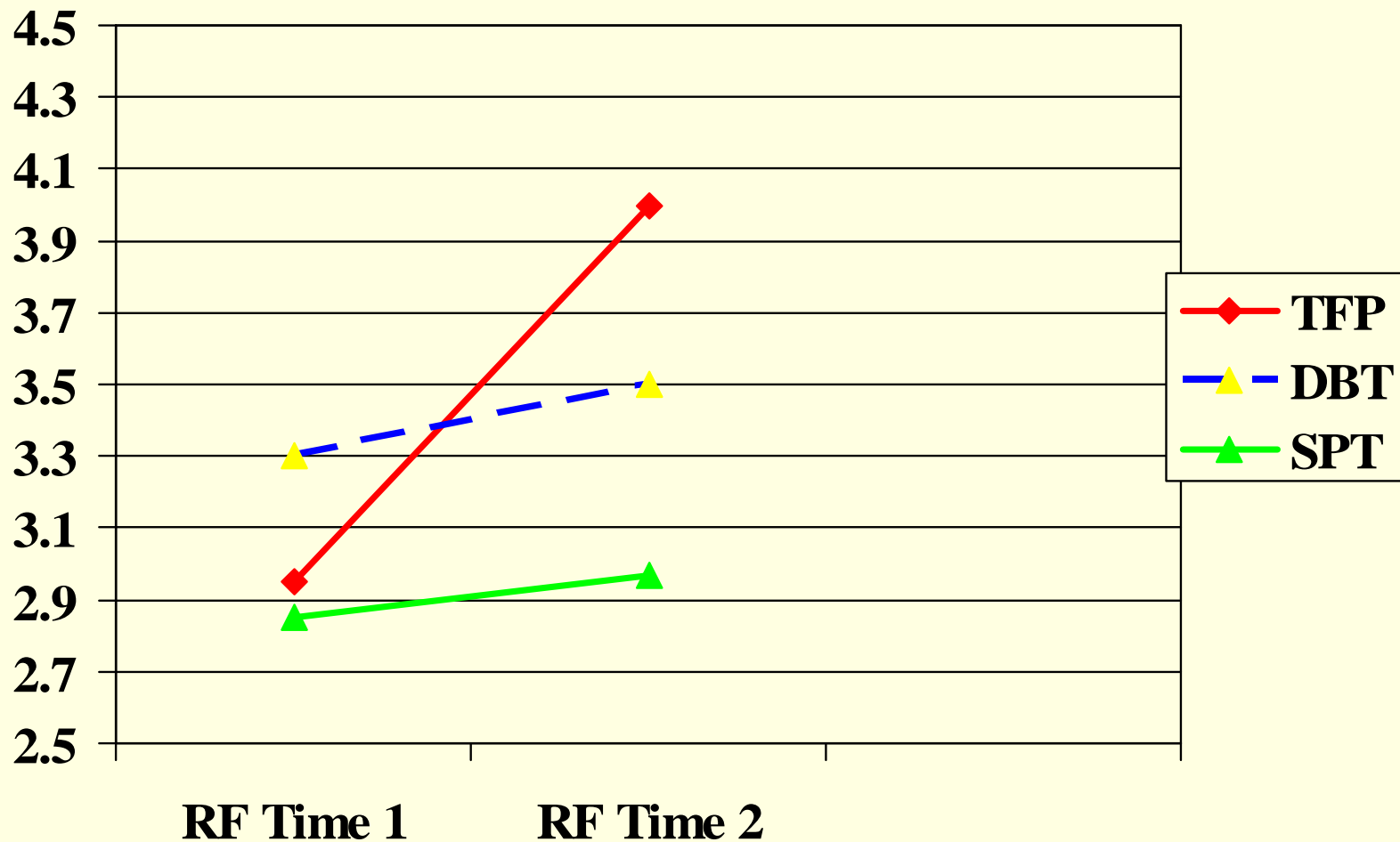
Reflective Function Scale

(Fonagy, Target, Steele, Steele, 1998)

- 1 Negative
 - Rejection, totally barren, grossly distorted, overly concrete, unintegrated, or inappropriate RF
- 1 Disavowal, distorted/self-serving
- 3 Naive simplistic or over-analytic/hyperactive
- 5 Ordinary or inconsistent
 - model of mind is fairly coherent, but somewhat one dimensional or simplistic
- 7 Marked
- 9 Exceptional
 - unusually complex, elaborate or original reasoning about mental states

Change in RF as a Function of Time and Treatment

(Levy et al, 2007, J of Consulting & Clin Psychology)



Why is Reflective Function Important?

- It is intimately linked with identity integration
- Fonagy and colleagues: AAI's of BPD's show:
 - Higher ratings for lack of resolution of trauma
 - Lower ratings for reflective function
- Further studies:
 - Low RF associated with insecure attachment
 - High RF associated with secure attachment, which is associated with optimal personality, psychosocial and cognitive functioning as well as quality of intimate relations

Summary of Research to Date

- Preliminary evidence in non-randomized clinical trials that TFP changes patient symptoms and behavior; reduces hospitalization and ER visits
- RCT contributes to effectiveness issue, domains of outcome, specific effects
- The 3 structured treatments are all related to significant change in multiple domains
- TFP and DBT better in suicidal behavior
- TFP and Supportive Psychodynamic better with anger/aggression and impulsivity
- TFP leads to specific effects in reflective functioning, a possible mechanism of change and agent of maintenance of gains

Articles and Books related to TFP - page 1

Clarkin JF, Yeomans FE, Kernberg OF. *Psychotherapy for Borderline Personality: Focusing on Object Relations*. Washington: American Psychiatric Press (2006).

Clarkin, J.F., Levy, K.N., Lenzenweger, M.F., & Kernberg, O.F. (2007). Evaluating three treatments for borderline personality disorder: a multiwave study. *American Journal of Psychiatry*, 164, 922-928.

Levy, K. N.; Meehan, K. B.; Kelly, K.M.; Reynoso, J. S.; Clarkin, J. F.; Lenzenweger, M. F.; & Kernberg, O. F. (2006). Change in attachment and reflective function in the treatment of borderline personality disorder with transference focused psychotherapy. *Journal of Consulting and Clinical Psychology* 74:1027-1040.

Article and Books related to TFP – page 2

Levy KL, Clarkin JF, Yeomans FE, Scott LN, Wasserman RH, Kernberg, OF: The Mechanisms of Change in the Treatment of Borderline Personality Disorder with Transference Focused Psychotherapy. *Journal of Clinical Psychology* , 62(4), 481-502 (2006).

Silbersweig D, Clarkin JF, Goldstein M, et al: Failure of Frontolimbic Inhibitory Function in the Context of Negative Emotion in Borderline Personality Disorder. *American Journal of Psychiatry*, 164(12), 1832-1841 (2007)

Yeomans FE, Clarkin JF, Kernberg OF. *A Primer on Transference-Focused Psychotherapy for Borderline Patients*. Northvale, NJ: Jason Aronson (2002).