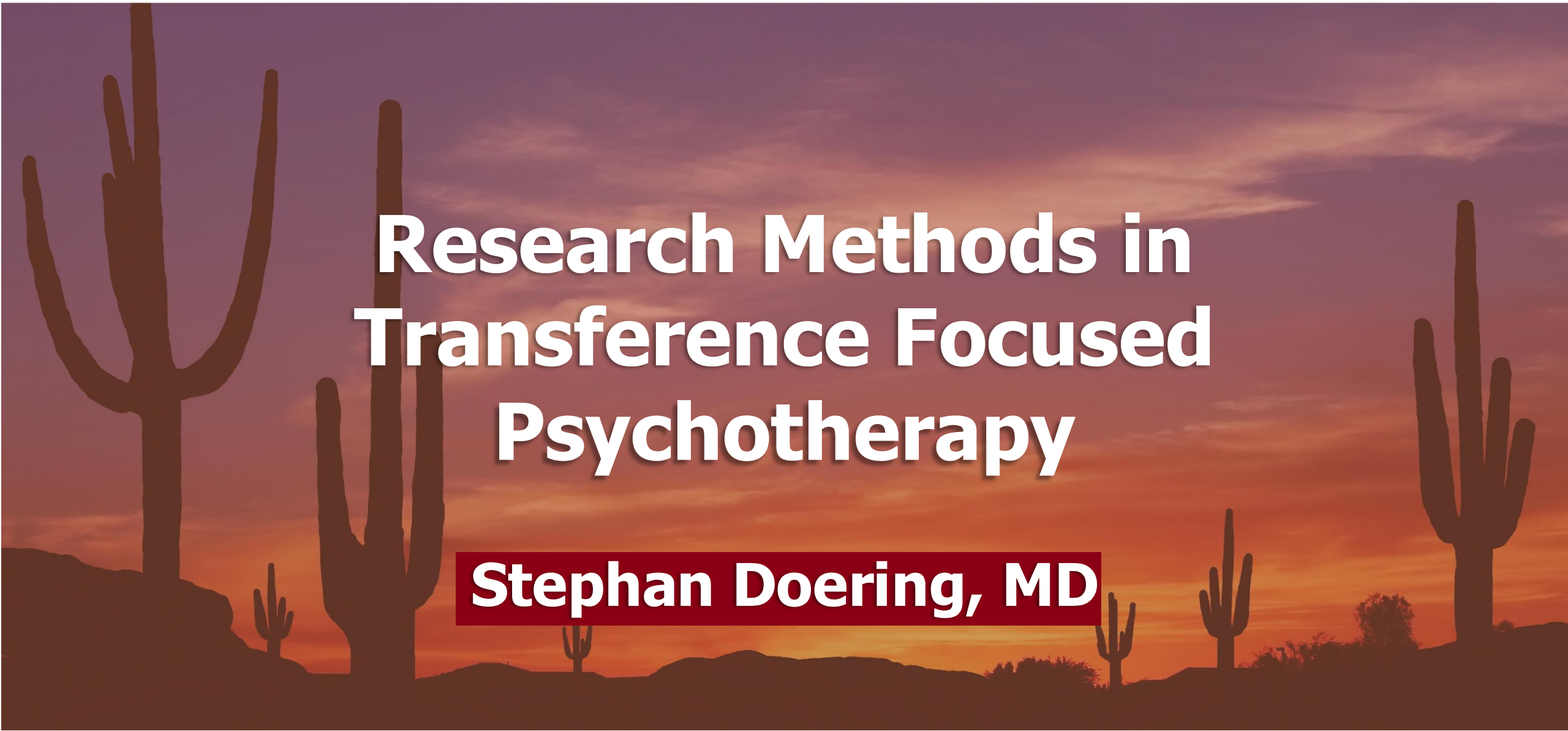
THE UNIVERSITY OF ARIZONA
COLLEGE OF MEDICINE TUCSON
Psychiatry

SOUTHWEST PSYCHOANALYTIC SOCIETY



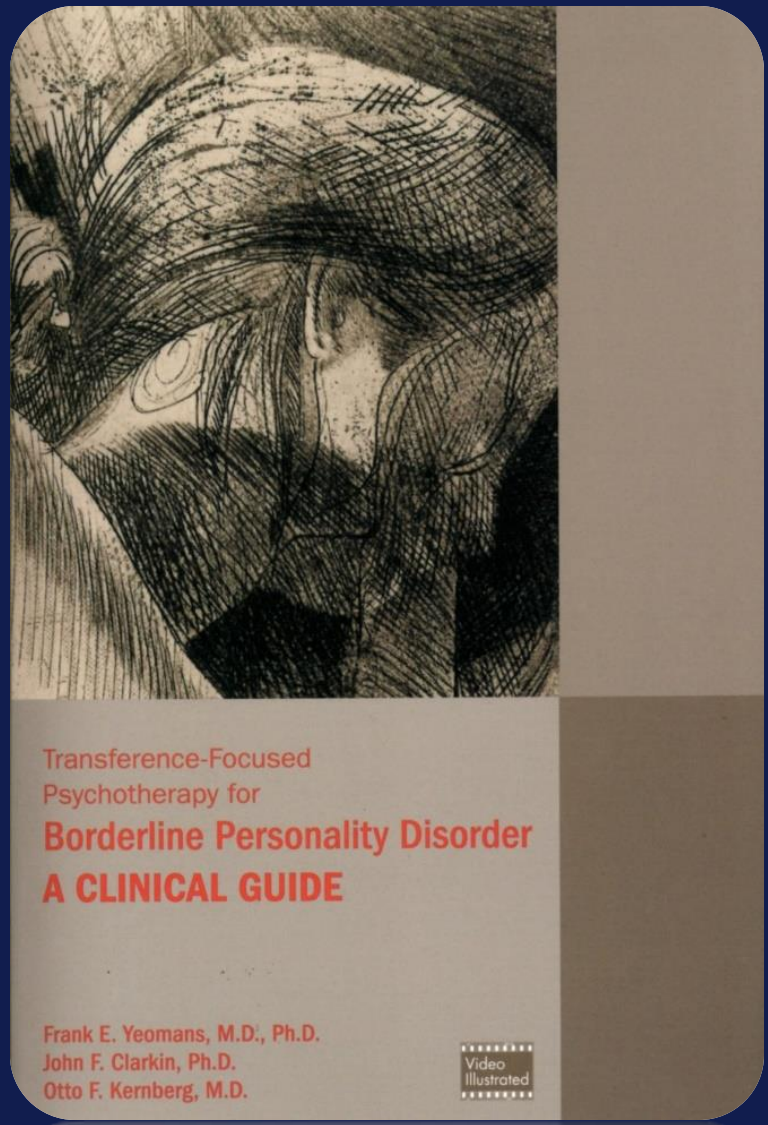
Research Methods in Transference Focused Psychotherapy

Stephan Doering, MD

October 5, 2024

Research Methods in TFP

Stephan Doering, M.D., Professor and Chair
Department of Psychoanalysis and Psychotherapy
Medical University of Vienna, Austria



Part I: Diagnosis

Structural interview, STIPO, IPO

Structural Interviewing

*Otto F. Kernberg, M.D.**

Summary of previous work

In earlier work,[3] I proposed that an understanding of the intrapsychic structural characteristics of patients with borderline personality organization can contribute to the differentiation of borderline disorders from the symptomatic neuroses and neurotic character pathology on the one hand, and from the psychoses, particularly schizophrenia and manic depressive illness, on the other. Structural diagnosis, that is, the diagnosis of an overall intrapsychic organization that provides stability, continuity, and sameness throughout time, is facilitated by a special type of clinical interview—a "structural interview"—that focuses sharply on the relation between the interaction of patient and diagnostician, the patient's interpersonal functioning in general, and the history of the present illness.

Three broad structural organizations correspond to neurotic, borderline, and psychotic disorders. Such structural organization constitutes a stabilizing function of the mental apparatus, mediating between etiologic factors and direct behavioral manifestations of illness. Regardless of the relative contributions of genetic, constitutional, biochemical, familial, psychodynamic, or psychosocial factors to etiology of the illness, the effects of them all are eventually reflected in the type of overall psychic structure. The psychological functioning of the individual is stabilized in terms of this structure, which then becomes the underlying matrix from which behavioral symptoms develop.

I described three overriding structural characteristics: (1) identity integration versus identity diffusion (and the related overall quality of object relations), (2) a constellation of advanced or primitive defensive operations, and (3) presence or absence of reality testing. Jointly, these characteristics differentiate neurotic, borderline, and psychotic structural organization. Individuals with neurotic personality structure present an integrated identity, in contrast to those with borderline or psychotic structures. Individuals with neurotic personality structure also present a defensive organization centering

*Medical Director, The New York Hospital-Cornell Medical Center, Westchester Division; Professor of Psychiatry, Cornell University Medical College; Training and Supervising Analyst, Columbia University Center for Psychoanalytic Training and Research, New York, New York

1981, Psychiatric Clinics of North America 4(1): 169-195

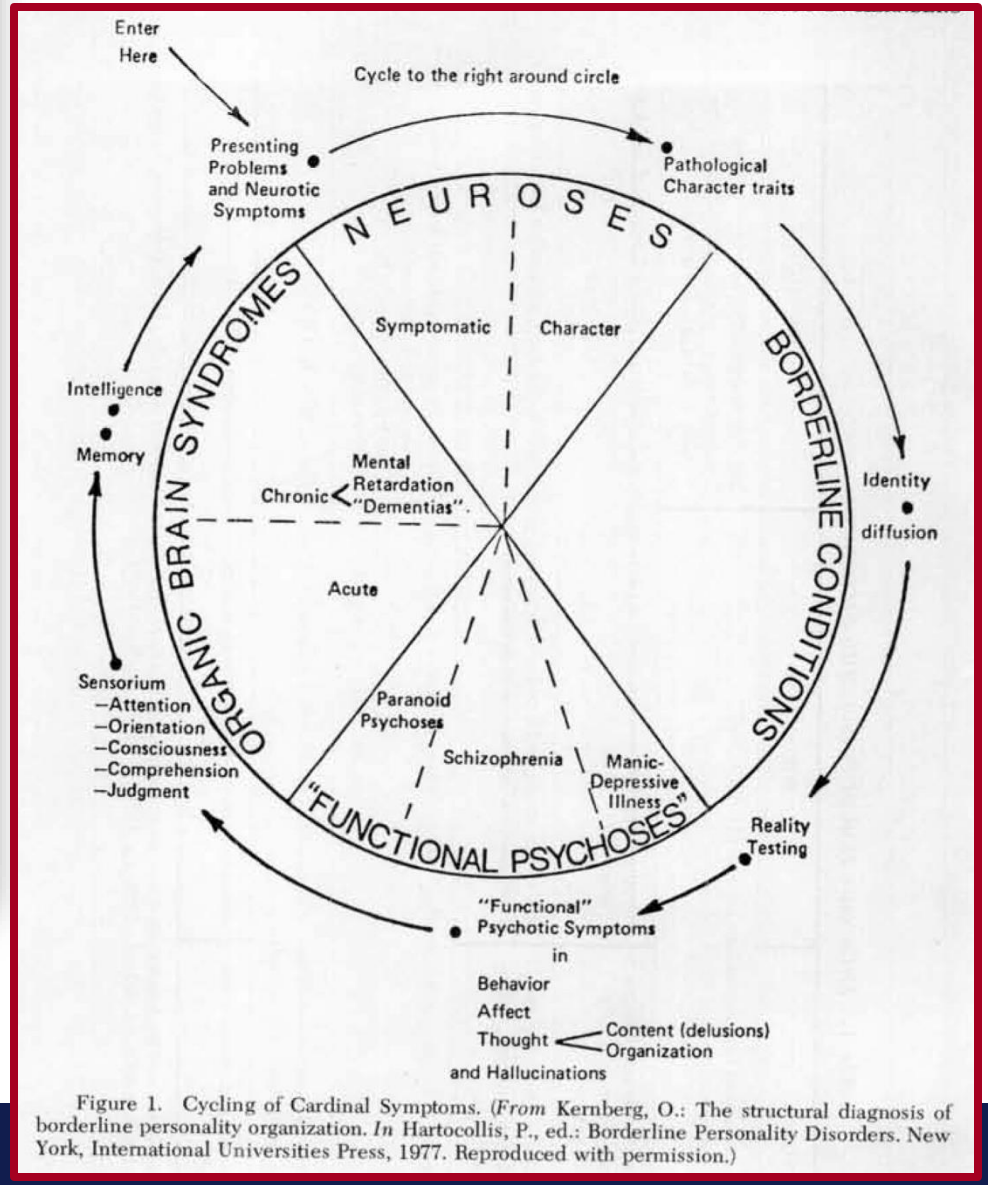


Figure 1. Cycling of Cardinal Symptoms. (*From* Kernberg, O.: The structural diagnosis of borderline personality organization. *In* Hartocollis, P., ed.: Borderline Personality Disorders. New York, International Universities Press, 1977. Reproduced with permission.)

Otto Kernberg (*1928)

p. 172

STRUCTURED INTERVIEW OF PERSONALITY ORGANIZATION-R: STIPO-R

Summary of Measure

Identity	15 items
Capacity to invest	4 (1-4)
Sense of self	7 (5 - 11)
Representation of other	4 (12 - 15)
Object relations	14 items
Interpersonal relationships	4 (16 - 19)
Sex and intimacy	5 (20 - 24)
Internal investments in others	6 (25 - 30)
Lower-level "Primitive" Defenses	6 (31 – 36)
Higher-Level Defenses	4 (37 – 40)
Aggression	9 items
Self directed	4 (41 - 44)
Other directed	5 (45 - 49)
Moral values	6 items (50 - 55)

Narcissism item #'s - 11 items

1. 3 Capacity to invest in work / school - satisfaction
2. 9 Sense of Self - need for admiration
3. 11 Sense of Self - fluctuation in self-esteem
4. 25 Object relations, Internal Working Model of Relationships – self centeredness
5. 26 Object relations, Internal Working Model of Relationships – boredom
6. 29 Object relations, Internal Working Model of Relationships – economic view
7. 30 Object relations, Internal Working Model of Relationships – empathy
8. 32 Primitive Defenses - Idealization / Devaluation
9. 36 Primitive Defenses – Narcissistic Fantasy
10. 46 Aggression - Envy
11. 55 Moral Values – Exploitation

1. Identity
   - 1.A. Capacity to invest
   - 1.B. Sense of self
   - 1.C. Sense of others
2. Object relations
   - 2.A. Interpersonal relationships
   - 2.B. Sex and intimacy
   - 2.C. Internal investments in others
3. Lower level „primitive" defenses
4. Higher level defenses
5. Aggression
   - 5.A. Self-directed
   - 5.B. Other-directed
6. Moral values

John Clarkin

http://istfp.org/publications/diagnostic-instruments/

STRUCTURED INTERVIEW OF PERSONALITY ORGANIZATION-R: STIPO-R

Summary of Measure

Identity	15 items
Capacity to invest	4 (1-4)
Sense of self	7 (5 - 11)
Representation of other	4 (12 - 15)
Object relations	14 items
Interpersonal relationships	4 (16 - 19)
Sex and intimacy	5 (20 - 24)
Internal investments in others	6 (25 - 30)
Lower-level "Primitive" Defenses	6 (31 – 36)
Higher-Level Defenses	4 (37 – 40)
Aggression	9 items
Self directed	4 (41 - 44)
Other directed	5 (45 - 49)
Moral values	6 items (50 - 55)

Narcissism item #'s - 11 items

1. 3 Capacity to invest in work / school - satisfaction
2. 9 Sense of Self - need for admiration
3. 11 Sense of Self - fluctuation in self-esteem
4. 25 Object relations, Internal Working Model of Relationships – self centeredness
5. 26 Object relations, Internal Working Model of Relationships – boredom
6. 29 Object relations, Internal Working Model of Relationships – economic view
7. 30 Object relations, Internal Working Model of Relationships – empathy
8. 32 Primitive Defenses - Idealization / Devaluation
9. 36 Primitive Defenses – Narcissistic Fantasy
10. 46 Aggression - Envy
11. 55 Moral Values – Exploitation

SECTION 3: OBJECT RELATIONS

Interpersonal Relationships / Friendships

16. *Object Relations* *Friendships* *Presence*		**Do you have friends?** (Note: This question assesses the presence of friends, *excluding* spouses, girlfriends / boyfriends, and siblings, children.) **If yes,** Tell me about the one or two people you are closest to and what your relationship with them is like. Probe: for each of the friends identified, inquire about: Duration of the friendship; Mode and frequency of contact, e.g., by phone or in person; Consistency of contact over time, e.g., in and out of touch?	
		0=	*At least 2 friends, as characterized by duration, frequency / regularity of contact over past 5 year*
		1=	*No more than 1 friend who is not a family member, or presence of several relationships characterized as friendships that appear to be more like acquaintances, with impoverished descriptions according to the above criteria*
		2=	*No friendships meeting any of the qualities of duration, frequency of contact, as described above*

Note: This item is simply a measure of social connectedness versus isolation.

17. *Object Relations* *Friendships* *Closeness*		**You've mentioned your relationship with _____ and _____. Would you say that these are close relationships? In what ways are you "close"?** **Would you say that your relationship with ___ and ___ is characterized by intimacy and trust?** Can you open up and share important things with _____? Does ____ share important things about his/her life with you? Note: Probe these questions for up to two closest friends mentioned in #16. **Can / Could you depend upon _____?** If yes, in what ways do you depend upon ____? **Are your relationships with ____ and ____ filled conflict, volatility, and drama?**	
		0=	*Interdependence, intimacy, and disclosure; absence of drama, sustained conflict*
		1=	*Somewhat flawed sense of interdependence, intimacy, or disclosure; limited in terms of reciprocal nurturance and support*
		2=	*Significantly to severely flawed with respect to interdependence, intimacy and/or disclosure; highly superficial; volatile, chaotic*
		9=	*Question skipped – no friendships identified in question #16*

SECTION 4: LOWER-LEVEL ("PRIMITIVE") DEFENSES

31. *Lower-level Defenses* *Paranoia*		**Would you consider yourself someone who is cautious about what other people know about you; would you call yourself "guarded"?** Are you someone who is suspicious about other people, concerned about their motives, perhaps afraid that if you let down your guard you could be easily taken advantage of or hurt? **<u>If yes,</u>** Can you describe for me the ways in which you tend to be guarded or cautious? Is this because you are afraid that people will manipulate you or that the information you reveal will be used against you? Is this guardedness present across all or most relationships, or would you say that there are some relationships where this is not the case, where you are more open and less cautious?	
		0=	*Little to no sense of being unusually guarded; any fears of personal information being used against self are few and reasonable*
		1=	*Some discomfort with disclosure and openness in relationships in which it is typical to be unconcerned and unguarded, e.g., sibling, spouse, child; may be limited to specific relationships; motivation may be fear of being judged*
		2=	*Significant to severe / pervasive mistrust of others; significant difficulties being open and disclosing personal information to others; may be due to the fear that the information will be used against the self; score 2 for significant to severe guardedness, even if a fear of information being used against the self is not endorsed*

32. *Lower-level Defenses* *Idealization / Devaluation* *Narcissism 8*		**Does it happen to you that you idealize extraordinary people, you know, putting them up on a pedestal or expecting a lot from them, only to realize or feel, after a while, very disappointed or let down, finding fault with or criticizing them?** **<u>If yes,</u>** With whom does this happen? Can you provide an example? **Do you struggle with disappointments like this in your romantic relationships, where you feel very excited initially, only to eventually feel that you could do better, wondering what it would be like to be with someone else?** **In relationships *other than* your romantic relationships, do you tend to look up to people, to put them on a pedestal?** Are there people whom you would say that you idealize, whom you hold in an unrealistically high regard? And does the same pattern apply, where you eventually become quite disappointed in, or critical of them? **<u>If yes to either item stem,</u>** Does this pattern occur across many or most of your relationships?	
		0=	*No evidence of idealization / devaluation in relationships as described*
		1=	*Some tendency towards idealization / devaluation as described may be limited to some relationships or to times of stress*
		2=	*Unstable view of relationships; unpredictable shifts in view of others based on idealization / devaluation; shifts may be extreme and/or frequent; may occur across many relationships, regardless of level of respondent's life-stress*

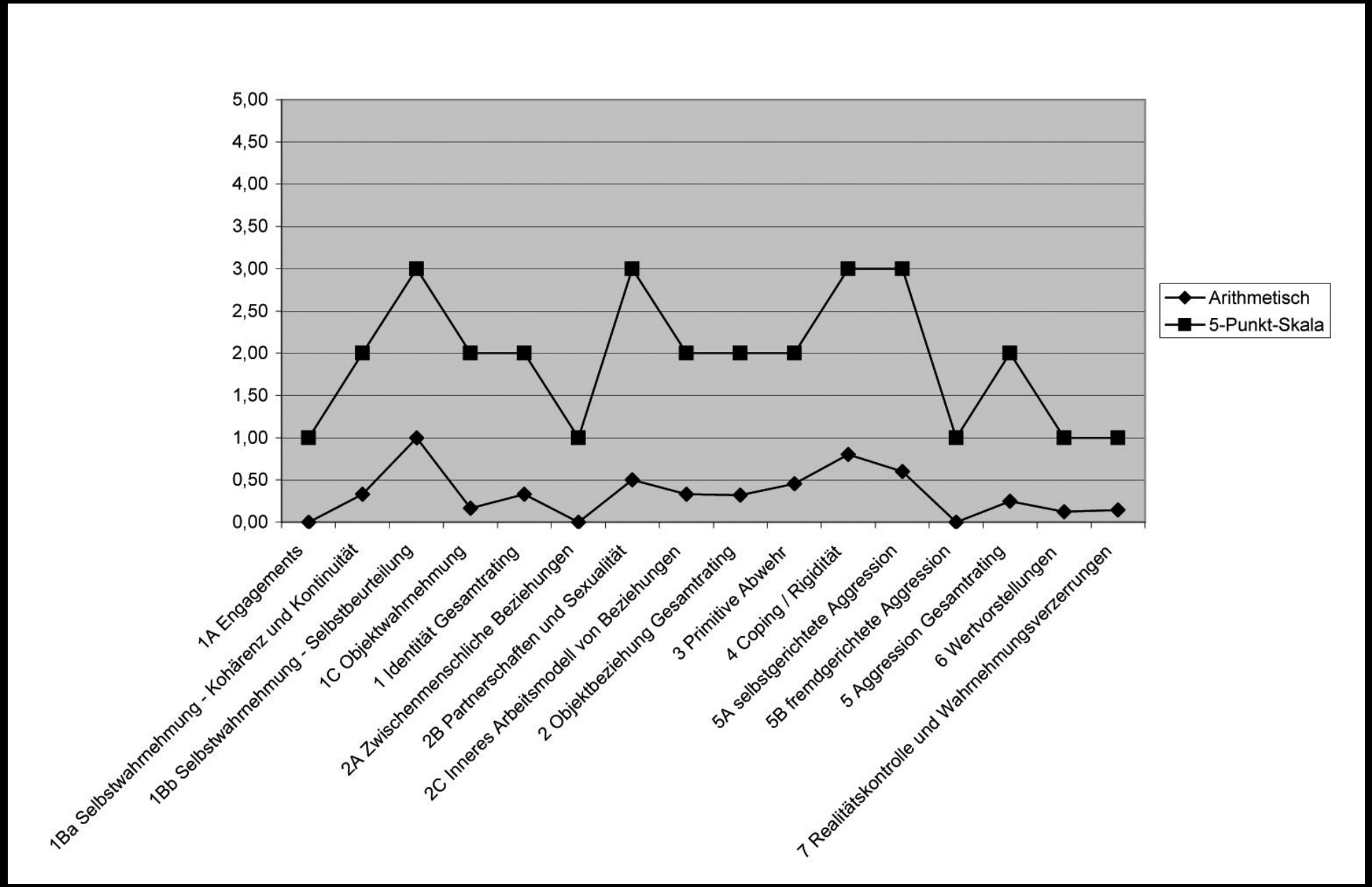
STIPO-R – Profile of Personality Organization

Subdimension/ Dimension		arith-metic	5-point scale
	1. A. Capacity to invest		
	1. B. Sense of self		
	1. C. Representation of others		
1. Overall rating of identity			
	2. A. Interpersonal relationships		
	2. B. Intimate relationships and sexuality		
	2. C. Internal investments in others		
2. Overall rating of quality of object relations			
3. Lower-level (primitive) defenses			
4. Higher-level defenses (coping and rigidity)			
	5. A. Self-directed aggression		
	5. B. Other-directed aggression and hostility		
5. Overall rating of aggression			
6. Moral values			
Narcissism items			

STRUKTURNIVEAU

normal	
neurotic 1	
neurotic 2	
borderline 1	
borderline 2	
borderline 3	

(please tick as appropriate)


5,00
4,50
4,00
3,50
3,00
2,50
2,00
1,50
1,00
0,50
0,00
Arithmetisch
5-Punkt-Skala
1A Engagements
1Ba Selbstwahrnehmung - Kohärenz und Kontinuität
1Bb Selbstwahrnehmung - Selbstbeurteilung
1C Objektwahrnehmung
1 Identität Gesamtrating
2A Zwischenmenschliche Beziehungen
2B Partnerschaften und Sexualität
2C Inneres Arbeitsmodell von Beziehungen
2 Objektbeziehung Gesamtrating
3 Primitive Abwehr
4 Coping / Rigidität
5A selbstgerichtete Aggression
5B fremdgerichtete Aggression
5 Aggression Gesamtrating
6 Wertvorstellungen
7 Realitätskontrolle und Wahrnehmungsverzerrungen


I would like to ask you some
questions about your personality.

Sense of Self

Sense of self – coherence and continuity

12. *Self-Description*

I want to shift gears a little bit here and ask you some questions about you as a person….about your personality. Let's say that you wanted me to get to know you as quickly as possible, in just a few minutes – how would you describe yourself to me so that I get as live and full of picture of the kind of person you are?

Probe: Wait for the respondent's full reply, and then ask: Is there anything else you can tell me about what makes you unique and special, about your qualities as a person, that describe for me your personality?

Probe: List of Adjectives -- : "you just described yourself to me using a list of adjectives; I was wondering if you could fill your description of yourself in for me a bit, perhaps giving me more of a live picture of who you are or of what kind of person you are."

Probe: Superficial description -- if the person cannot elaborate on the adjectives or describes self in highly superficial terms, inquire about one or more of the adjectives or qualities offered, and ask if the respondent can describe those qualities in greater detail.

Probe: Highly idealizes or devalued representation – "your description of "___" seems so entirely glowing, positive / angry, negative that it almost sounds to extreme to be real, like a caricature of a person; are there any negative / positive things you might also say about "_____"?

(Probe: Severe difficulty describing self – "it seems very difficult to describe yourself; do you have any sense of what that is?")

0= Describes self with subtlety, depth and self-awareness; easy for respondent to elaborate multiple, diverse qualities, and to see both positive and negative aspects of the self; narrative quality; reflection on sense of his or her personality and inner mental life

1= Somewhat superficial description of self; contains some self-awareness, some sense of reflection related to inner mental life; difficulty seeing self as whole object; some poverty in descriptors of self; tends towards list of adjectives with little elaboration, narration;

2= Superficial description of self, little subtlety or depth; no ability to see self as whole object; poverty in descriptors of self; list of adjectives with no elaboration; little to no narrative quality; little to no reflection on inner mental life

Journal of Personality Assessment, 92(1), 35–44, 2010

ISSN: 0022-3891 print / 1532-7752 online
DOI: 10.1080/00223890903379308

Routledge
Taylor & Francis Group

Structured Interview of Personality Organization (STIPO): Preliminary Psychometrics in a Clinical Sample

BARRY L. STERN,[1] EVE CALIGOR,[1] JOHN F. CLARKIN,[2] KENNETH L. CRITCHFIELD,[3] SUSANNE HORZ,[4] VERNA MACCORNACK,[1] MARK F. LENZENWEGER,[2,5] AND OTTO F. KERNBERG[2]

[1]*Columbia University College of Physicians and Surgeons and the Columbia Center for Psychoanalytic Training and Research*
[2]*Personality Disorders Institute, Weill Medical College of Cornell University*
[3]*Department of Psychology, University of Utah*
[4]*Department of Psychology, Ludwig-Maximilians-Universitaet Muenchen, Germany*
[5]*Department of Psychology, State University of New York at Binghamton*

In this article, we describe the development and preliminary psychometric properties of the Structured Interview of Personality Organization (STIPO), a semistructured interview designed for the dimensional assessment of identity, primitive defenses, and reality testing, the three primary content domains in the model of personality health and disorder elaborated by Kernberg (1984; Kernberg & Caligor, 2005). Results of this investigation, conducted in a clinical sample representing a broad range of personality pathology, indicate that identity and primitive defenses as operationalized in the STIPO are internally consistent and that interrater reliability for all 3 content domains is adequate. Validity findings suggest that the assessment of one's sense of self and significant others (Identity) is predictive of measures of positive and negative affect, whereas the maladaptive ways in which the subject uses his or her objects for purposes of regulating one's self experience (Primitive Defenses) is predictive of measures of aggression and personality disorder traits associated with cluster B personality disorders. We discuss implications of these findings in terms of the theory-driven and trait-based assessment of personality pathology.

Alongside the empirical elaboration of Axis II of the *Diagnostic and Statistical Manual for Mental Disorders* (4th ed., text revision [*DSM–IV–TR*]; American Psychiatric Association, 2000) and the host of standardized assessment tools keyed to the *DSM* criteria sets (e.g., Loranger, 1999; First, Spitzer, Gibbon, Williams, & Benjamin, 1997), other theory-driven approaches to the study of personality disorder have emerged in recent years with accompanying assessment technologies (e.g., Benjamin, 2005; Westen & Shedler, 1999a, 199b). In this report, we present preliminary data on the psychometric development of the Structured Interview of Personality Organization (STIPO), a semi-structured interview developed to assess dimensions of personality pathology within Kernberg's (1984) particular psychodynamic frame of reference. Informed by contemporary object relations theory, Kernberg (1984; Kernberg & Caligor, 2005) has described what is essentially a dimensional model of personality centered on the assessment of three key domains: identity disturbance, primitive psychological defenses, and reality testing (1984; Kernberg & Caligor, 2005). In his clinical writing and teaching, Kernberg characterized the clinical psychopathology of personality disorder according to the individual's standing on these three dimensions as falling into two primary regions: the borderline (BPO) and neurotic (NPO) levels of "personality organization." The purpose of this study was not to validate these putative typological classifications; rather, we sought to establish preliminary reliability and validity of the underlying clinical dimensions, that is, identity, primitive defenses, and reality testing.

Identity in Kernberg's (1984) model is comprised of the various ways in which individuals experience themselves in relation to others. Normal identity is based on the individual's ability to shift flexibly across various self-representations, resulting in an appraisal of the self that is realistic and integrated, with an ability to tolerate both the positively and negatively imbued qualities of the self and a correspondingly realistic and stable experience of others. In contrast, identity pathology is characterized by inflexible and unstable, poorly integrated, black and white (i.e., "all good" or "all bad") experiences of self and other, with a resulting incoherence in the experience of self and others and a predominance of negative affects as well as instability and conflict in the interpersonal sphere (Kernberg & Caligor, 2005).

Working hand in glove with the construct of identity is the construct of primitive defensive operations, conceived as psychological strategies for the regulation of emotion carried on outside of conscious awareness, which involve the separation of positive and negative sectors of experience (commonly referred to as "splitting"). This separation comes at the expense of the individual's maintaining a distorted, fragmentary, caricatured, and brittle sense of self and others. In addition to the assessment of identity and primitive defenses, the assessment of reality testing, specifically, attunement to social and interpersonal norms and the demonstration of expected tact and empathy (as opposed to the ability to separate self from nonself and internal from external stimuli) is central to the classification of personality organization. In sum, greater identity pathology and the more extensive use of primitive defenses, in the context of grossly intact reality testing, are pathognomonic of severe personality

Received February 21, 2009; Revised July 17, 2009.
Address correspondence to Barry L. Stern, Columbia University College of Physicians and Surgeons, 286 Madison Avenue, Suite 1602, New York, NY 10017; Email: bs2137@columbia.edu

Doering *et al. BMC Psychiatry* 2013, **13**:210
http://www.biomedcentral.com/1471-244X/13/210

BMC Psychiatry

RESEARCH ARTICLE Open Access

Reliability and validity of the German version of the Structured Interview of Personality Organization (STIPO)

Stephan Doering[1*], Markus Burgmer[2], Gereon Heuft[2], Dina Menke[3], Brigitta Bäumer[4], Margit Lübking[5], Marcus Feldmann[6], Susanne Hörz[7] and Gudrun Schneider[2]

Abstract

Background: The assessment of personality organization and its observable behavioral manifestations, i.e. personality functioning, has a long tradition in psychodynamic psychiatry. Recently, the DSM-5 Levels of Personality Functioning Scale has moved it into the focus of psychiatric diagnostics. Based on Kernberg's concept of personality organization the Structured Interview of Personality Organization (STIPO) was developed for diagnosing personality functioning. The STIPO covers seven dimensions: (1) identity, (2) object relations, (3) primitive defenses, (4) coping/rigidity, (5) aggression, (6) moral values, and (7) reality testing and perceptual distortions. The English version of the STIPO has previously revealed satisfying psychometric properties.

Methods: Validity and reliability of the German version of the 100-item instrument have been evaluated in 122 psychiatric patients. All patients were diagnosed according to the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) and were assessed by means of the STIPO. Moreover, all patients completed eight questionnaires that served as criteria for external validity of the STIPO.

Results: Interrater reliability varied between intraclass correlations of .89 and 1.0, Crohnbach's α for the seven dimensions was .69 to .93. All a priori selected questionnaire scales correlated significantly with the corresponding STIPO dimensions. Patients with personality disorder (PD) revealed significantly higher STIPO scores (i.e. worse personality functioning) than patients without PD; patients cluster B PD showed significantly higher STIPO scores than patients with cluster C PD.

Conclusions: Interrater reliability, Crohnbach's α, concurrent validity, and differential validity of the STIPO are satisfying. The STIPO represents an appropriate instrument for the assessment of personality functioning in clinical and research settings.

Keywords: Personality functioning, Personality disorder, Diagnosis, Reliability, Validity

Background

The concept of personality organization or, in other terms, personality structure stands for intrapsychic formations that represent a basis of the personality and determine a person's functioning in dealing with his or her own self and interpersonal relationships. Thus, personality functioning can be regarded as the observable manifestation of the underlying personality organization. The assessment of personality functioning goes back to Freud's first structural model [1], that distinguished conscious, pre-conscious, and unconscious aspects of the mind. Based on Anna Freud's work about the defense mechanisms [2] Hartmann [3,4] described ego functions as result of a healthy development and a basic condition for a mental equilibrium and psychosocial functioning. Kernberg [5,6] coined the term personality organization and initially distinguished three levels: Neurotic, borderline, and psychotic level of personality organization. While neurotic patients are characterized by an integrated identity, mature defense mechanisms (e.g., repression, rationalization, intellectualization), and good reality testing, borderline patients show impaired identity integration ("identity diffusion") and primitive

* Correspondence: stephan.doering@meduniwien.ac.at
[1]Department of Psychoanalysis and Psychotherapy, Medical University of Vienna, Währinger Gürtel 18-20, A-1090 Wien, Austria
Full list of author information is available at the end of the article

Inventory of Personality Organization (IPO)

Inventory of Personality Organization (IPO)

Item		Scale
1.	I feel like a fake or imposter, that others see me as quite different from the way I really am.	PD/ID
3.	When I'm nervous or confused, it seems like things in the outside world don't make sense either.	PD/ID
4.	I feel I'am a different person at home as compared to how I am at work or at school.	PD/ID
5.	I feel I don't get what I want.	PD/ID
7.	I find that I do things which get other people upset and I don't know why such things upset them.	PD/ID
8.	Some of my friends would be surprised if they knew how differently I behave in different situations.	PD/ID
9.	I feel that my tastes and opinions are not really my own, but have been borrowed from other people.	PD/ID
11.	I feel that my wishes or thoughts will come true as if by magic.	RT
12.	People tell me I provoke or mislead them so as to get my way.	PD/ID
13.	I am not sure whether a voice I have heard, or something that I have seen is my imagination or not.	RT
15.	I think I see things which, when I take a closer look, turn out to be something else.	RT
17.	I can't explain the changes in my behavior.	PD/ID
20.	I can see things or hear things that nobody else can see or hear.	RT
22.	I find myself doing things which at other times 1 think are not too wise like having promiscuous sex, lying, drinking, having temper tantrums or breaking the law in minor ways.	PD/ID
23.	People tell me I behave in contradictory ways	PD/ID
24.	I can't tell whether certain physical sensations I'm having are real, or whether I am imagining them.	RT
25.	I hear things that other people claim are not really there.	RT
28.	I act in ways that appear to others as unpredictable and erratic.	PD/ID
29.	People tend to use me unless I watch out for it.	PD/ID
30.	I understand and know things that nobody else is able to understand or know.	RT
31.	My life, if it were a book, seems to me more like a series of short stories written by different authors than like a long novel.	PD/ID
32.	I have favorite people whom I not only admire, but almost idealize.	PD/ID
33.	I pick up hobbies and interests and then drop them.	PD/ID
34.	I have seen things which do not exist in reality.	RT
35.	I find myself doing things which feel okay while I am doing them but which I later find hard to believe I did.	PD/ID
36.	Even people who know me well cannot guess how I'm going to behave.	PD/ID
38.	I have heard or seen things when there is no apparent reason for it.	RT
39.	It is hard for me to be sure about what others think of me, even people who have known me very well.	PD/ID
40.	People tend to respond to me by either overwhelming me with love or abandoning me.	PD/ID
41.	I tend to feel things in a somewhat extreme way, experiencing either great joy or intense despair.	PD/ID
42.	I see myself in totally different ways at different times.	PD/ID
44.	In the course of an intimate relationship, I'm afraid of losing a sense of myself.	PD/ID
45.	My life goals change frequently from year to year.	PD/ID
46.	I am a "hero worshiper" even if I am later found wrong in my judgment.	PD/ID
48.	I fluctuate between being warm and giving at some times, and being cold and indifferent at other times.	PD/ID
49.	I do things on impulse that I think are socially unacceptable.	PD/ID
50.	My goals keep changing.	PD/ID
51.	When everything around me is unsettled and confused, I feel that way inside.	PD/ID
54.	People see me as being rude or inconsiderate, and I don't know why.	PD/ID
55.	I feel as if I have been somewhere or done something before when I really haven't.	RT
56.	I believe that things will happen simply by thinking about them.	RT

The numbers before the items correspond to the numbers used in Table 1.

John Clarkin

Based on Kernberg´s model.

56-item self-rating instrument.

Three scales:

1. Reality testing
2. Primitive defenses
3. Identity diffusion

Psychological Assessment
2001, Vol. 13, No. 4, 577–591

1040-3590/01/$5.00 DOI: 10.1037//1040-3590.13.4.577

The Inventory of Personality Organization: Psychometric Properties, Factorial Composition, and Criterion Relations With Affect, Aggressive Dyscontrol, Psychosis Proneness, and Self-Domains in a Nonclinical Sample

Mark F. Lenzenweger
Harvard University

John F. Clarkin, Otto F. Kernberg, and Pamela A. Foelsch
Weill Medical College of Cornell University

This report describes 2 studies of the psychometric characteristics of the primary clinical scales of the Inventory of Personality Organization (IPO; O. F. Kernberg & J. F. Clarkin, 1995), which assess reality testing, primitive psychological defenses, and identity diffusion, in a nonclinical sample. The 3 IPO scales display adequate internal consistency and good test–retest reliability. Item-level confirmatory factor analysis supported a two-factor structure of the IPO consistent with O. F. Kernberg's (1984, 1996) model of borderline personality organization. Each of the 3 IPO scales was associated with increased negative affect, aggressive dyscontrol, and dysphoria as well as lower levels of positive affect consistent with Kernberg's model of borderline personality organization. The IPO Reality Testing scale is closely related to various measures of psychotic-like phenomena.

The diagnosis of personality pathology has increased dramatically in recent years, largely due to the introduction of the Axis II nomenclature within the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM* e.g., American Psychiatric Association, 1994) system (Loranger, 1990). There has been a concomitant increase in the number of assessment tools designed to aid in the detection and characterization of personality disorders (PDs), most of which are guided by the *DSM* definitions of personality disorder. The available *DSM*-related assessment tools include structured interviews—for example, International Personality Disorders Examination (IPDE; Loranger, 1999); and Structured Clinical Interview for *DSM–IV* Axis II Personality Disorders (First, Gibbon, Spitzer, Williams, & Benjamin, 1997)—self-report instruments—for example, Millon Clinical Multiaxial Inventory—III; (Millon, Millon, & Davis, 1994) and Schedule for Nonadaptive and Adaptive Personality (Clark, 1993)—and Q-sort methods (Westen & Shedler, 1999). Although the primary approach to classifying the PDs remains the *DSM* nomenclature, the system is descriptive and atheoretical in nature.

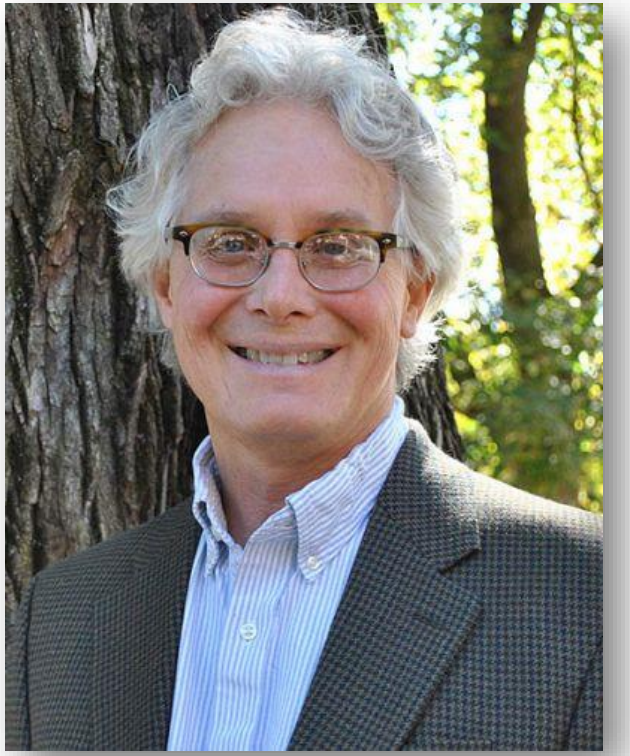
Alternative approaches to the classification and diagnosis of personality pathology have been theory guided, and several of these have developed a related assessment methodology. The interpersonal approach advocated by Benjamin (1996), Millon's (1996) evolutionary model, and Beck, Freeman, et al.'s (1990) cognitive–behavioral model of the PDs serve as examples outside of the *DSM* approach. Another theoretical approach to PD classification and diagnosis is embodied in the psychodynamic model of Kernberg (1984, 1996). The diagnostic and theoretical framework of Kernberg (1984, 1996) defines general PD as developing from a confluence of factors, which include both neurobiologically mediated (e.g., temperament, aggression) and subsequent environmentally moderated (e.g., trauma, neglect) factors. The specific PD formation visible at the phenotypic–clinical level is reflective of an admixture of these factors as well as a level of severity dimension (Kernberg, 1996). Kernberg (1984, 1996) has theorized that personality "organization" falls into three broad classes, namely the neurotic, borderline, and psychotic levels of organization. Specific PDs and their related behavioral and psychological referents, even those delineated within the *DSM* nomenclature, emanate from within the borderline level of personality organization. This level of organization is characterized by (a) broadly intact reality testing, (b) predominance of primitive psychological defenses, and (c) marked identity diffusion, and it defines the underlying developmental matrix from within which all forms of PD arise. The borderline level of organization, however, should not be confused with *DSM*-defined borderline personality disorder, which is but one disorder that can derive from borderline personality organization (BPO).

Mark F. Lenzenweger, Department of Psychology, Harvard University; John F. Clarkin, Otto F. Kernberg, and Pamela A. Foelsch, Department of Psychiatry and Personality Disorders Institute, Weill Medical College of Cornell University.

This research was supported in part by a grant from the Borderline Personality Disorder Research Foundation as well as, in part, by National Institute of Mental Health Grant MH-45448 to Mark F. Lenzenweger.

We thank Richard A. Depue and Lauren Korfine for helpful consultations and comments. We are grateful to Auke Tellegen and Scott O. Lilienfeld for a comprehensive and helpful review of an earlier version of this article. We are grateful to Jack D. Barchas, for his support of both this work and the Personality Disorders Research Institute at the Weill Medical College of Cornell University.

Correspondence concerning this article should be addressed to Mark F. Lenzenweger, who is now at the Department of Psychology, Binghamton University, Science IV, Binghamton, New York 13902-6000. Electronic mail may be sent to mlenzen@binghamton.edu.



Mark Lenzenweger

2001

Part II: Outcome Research

Psychological therapies for people with borderline personality disorder (Review)

Stoffers JM, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K

THE COCHRANE COLLABORATION®

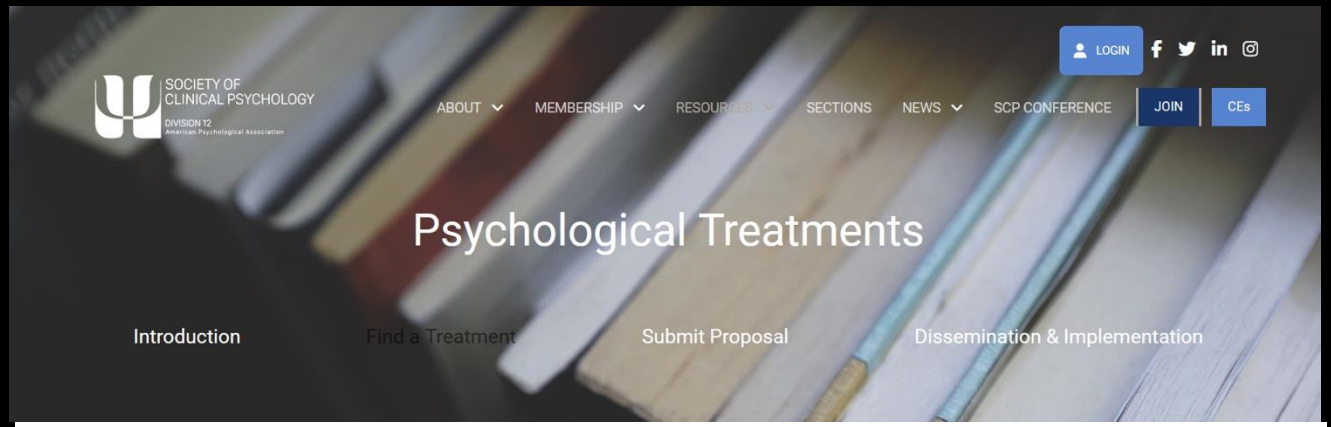
Jutta Stoffers Klaus Lieb

This is a reprint of a Cochrane r
2012, Issue 8

Authors' conclusions

There are indications of beneficial effects for both comprehensive psychotherapies as well as non-comprehensive psychotherapeutic interventions for BPD core pathology and associated general psychopathology. DBT has been studied most intensely, followed by MBT, TFP, SFT and STEPPS. However, none of the treatments has a very robust evidence base, and there are some concerns regarding the quality of individual studies. Overall, the findings support a substantial role for psychotherapy in the treatment of people with BPD but clearly indicate a need for replicatory studies.

https://div12.org/treatments/?_sfm_related_diagnosis=8152



Below is a list of psychological treatments that have been evaluated using either the Chambless & Hollon (1998) criteria or the current Tolin (2015) criteria. Note that the absence of a treatment does not necessarily suggest the treatment has insufficient evidence; rather, it may simply reflect that the treatment has yet to undergo evaluation. Use the search field to filter by symptoms and/or disorders to find a treatment. Select a treatment to view a description, research support, and relevant resources.

SYMPTOMS: All Symptoms

DISORDER: Borderline Personality Disorder (4)

Found 4 Results

Mentalization-Based Treatment For Borderline Personality Disorder

Schema-Focused Therapy For Borderline Personality Disorder

Transference-Focused Therapy For Borderline Personality Disorder

Dialectical Behavior Therapy For Borderline Personality Disorder

BRIEF SUMMARY

TRANSFERENCE-FOCUSED THERAPY FOR BORDERLINE PERSONALITY DISORDER

STATUS: STRONG/CONTROVERSIAL RESEARCH SUPPORT

What does this mean?

DESCRIPTION

Transference-Focused Therapy (TFP) focuses on revealing the underlying causes of a patient's borderline condition and working to build new, healthier ways for the patient to think and behave. From the perspective of TFP, the borderline patient's perceptions of self and of others are split into unrealistic extremes of bad and good. These conflicting dyads are thought to be expressed through the specific self-destructive symptoms of BPD. The term “transference” refers to the patent’s experience of his or her moment-to-moment relationship with the therapist. The treatment focuses on transference, because it is believed that patients will display their unhealthy dyadic perceptions not only in day-to-day life, but also in the interactions they have with their therapist. TFP focuses on using patient-therapist communications to help the patient integrate these different representations of self and, in the process, develop better methods of self-control.

October 3, 2024

3 Uncontrolled Studies (2000-2004)

Journal of Personality Disorders, 15(6), 487-495, 2001

THE DEVELOPMENT OF A PSYCHODYNAMIC TREATMENT FOR PATIENTS WITH BORDERLINE PERSONALITY DISORDER: A PRELIMINARY STUDY OF BEHAVIORAL CHANGE

John F. Clarkin, PhD, Pamela A. Foelsch, PhD, Kenneth N. Levy, PhD, James W. Hull, PhD, Jill C. Delaney, MSW, and Otto F. Kernberg, MD

This study examines the effectiveness of a modified ps
treatment called Transference Focused Psychotherapy (
specifically for patients with borderline personality di
Twenty-three female patients diagnosed with DSM-IV
twice-weekly TFP. Patients were assessed at baseline and a
months of treatment with diagnostic instruments,
suicidality, self-injurious behavior, and measures of medic
atric service utilization. Compared to the year prior to t
number of patients who made suicide attempts significan
as did the medical risk and severity of medical condition fol
jurious behavior. Compared to the year prior, study patie
treatment year had significantly fewer hospitalizations as w
and days of psychiatric hospitalization. The dropout rat
This uncontrolled study is highly suggestive that this st
manualized psychodynamic treatment modified for borde
shows promise for the ambulatory treatment of these pati
rants further study.

2001

John Clarkin

- uncontrolled study
- n=23
- 12 months of treatment
- significant reduction of
  - # of suicide attempters
  - medical risk of suicide attempts
  - severity of self-injurious behavior
  - # and days of psychiatric hospitalizations

Cambios en la psicopatología del trastorno limítrofe de la personalidad, en los pacientes tratados con psicoterapia psicodinámica

Pablo Cuevas*
José Camacho*
Rodolfo Mejía*
Ivonne Rosario*
Ramón Parres*
Josefina Mendoza*
David López*

Summary

There are very few studies on the changes in patients with borderline personality disorder (BPD) treated with psychodynamic psychotherapy, around the world, and as far as we know, this is the first report in Mexico on this subject. The main features of this disorder appear at 18 years of age (75% females; 25% males) and are frequent crises characterized by impulsivity (physical figths, substance abuse, suicide or self-mutilating behavior), affective instability (episodes of depression, anxiety and anger) and alterations in identity (sudden changes in values, vocational or laboral goals) that consume a lot of health resources and contribute to many failures in academic and work performance. Its treatment always needs some form of individual or group psychotherapy, with medication at times. In most of the clinical settings this disorder is considered as untractable or to take years to produce beneficial modifications. According to the epidemiological studies of several countries, this disorder appears in 1.1 to 4.6% in the general population, in 10% of the patients in ambulatory mental health centers, in 20% of the hospitalized psychiatric patients and in 30 to 60% of the patients with personality disorders. In a clinical psychiatric population in the Central Military Hospital (Mexico City) the prevalence was 35.7%. This paper reports changes observed in the psychopathology of borderline personality disorder treated by therapists trained in the Kernberg's manualized psychodynamic psychotherapy, delivered in two weekly 45 minutes sessions, videorecorded and supervised once a week by experts. As for the therapists that participated in the study, four were psychoanalysts with a mean experience of 12 years (D.E. = 1.15) and 10 psychotherapists with a mean experience of 4.67 years (D.E. = 4.23). The experience of both groups of therapists was significately different (U = 7.5, p, .002). Nineteen patients were treated: four males and 15 females who met the DSM IV borderline personality disorder criteria. Measurements of the psychopathology and global functioning were made at the beginning of the treatment, and every 24 sessions during a two years period, using the Clarkin's Dimensional Scale of the DSM IV Borderline Personality Disorder, and the DSM IV Global Assessment of Functioning. The results were: a) Eleven patients no longer met the DSM IV borderline personality disorder criteria at the 72nd session measurement, b) there was a positive change in the severity of the psychopathology in all criteria along time, c) the impulsivity criteria disappeared at the 24th session evaluation; affective instability criteria almost disappeared at the 48th session evaluation, while identity alterations criteria had only minimal changes even in those patients that remained in treatment for almost two years, d) the gaining in the Global Assessment of Functioning from the beginning to the 72nd session measurement was 70% and, f) there were no significative differences between the type of therapist and the improvement of the patient in the measurements. These results should be replicated and contrasted with randomized and comparative studies between this type of therapy and supportive psychotherapy, cognitive-behavioral therapy, interpersonal therapy, group therapy and medication in patients of other social classes treated by residents in psychiatry and clinical psychologists before making available this therapy to a wider patients population.

Key words: Borderline personality disorder, psychodynamic psychotherapy, psychotherapy-methods.

Resumen

Los estudios sobre los cambios en los pacientes con psicopatología del trastorno limítrofe de la personalidad (TLP) tratados con psicoterapia psicodinámica son muy escasos en el resto del mundo, y en México este es el primer trabajo del que tenemos noticia. El trastorno limítrofe de la personalidad aparece alrededor de los 18 años, con un patrón de relaciones interpersonales intensas e inestables en las que ocurren crisis frecuentes de gran impulsividad (conducta suicida, abuso de sustancias, pleitos verbales y violencia física), inestabilidad afectiva (episodios de depresión, ira y ansiedad) y alteraciones de identidad (cambios súbitos de metas, valores y orientación vocacional), que consumen gran cantidad de recursos de salud y frecuentemente impiden el desarrollo académico y el inicio de la vida laboral. Su tratamiento requiere de alguna forma de psicoterapia individual o grupal y, con frecuencia, del uso de medicamentos; en general, el tratamiento es difícil y la impresión es que estos trastornos son intratables o que

* *Asociación Psicoanalítica Mexicana, A.C. Bosque de Caobas 67, Bosques de las Lomas, Miguel Hidalgo, 11700, México, D. F.*
Primera versión: 7 de abril de 1999.
Segunda versión: 16 de octubre de 2000.
Aceptado: 6 de noviembre de 2000.

2000

- uncontrolled study
- n=19
- 72 treatment sessions
- significant reduction of
  - DSM-IV borderline criteria
  - GAF score

PSICOTERAPIA FOCALIZADA EN LA TRANSFERENCIA PARA EL TRASTORNO LÍMITE DE LA PERSONALIDAD. UN ESTUDIO CON PACIENTES FEMENINAS

David López*, Pablo Cuevas*, Araceli Gómez**, Josefina Mendoza*

SUMMARY

The objective of the study was to observe the changes in the psychopathology of women with Borderline Personality Disorder (BPD) after 48 sessions of Transference-Focused Psychotherapy (TFP) conducted by novel therapists, videotaped and supervised by experts. TFP is a specific treatment based on a manual, with two weekly individual sessions for BPD and also for the narcissistic and histrionic personality disorders. The treatment was developed in the last 20 years by Kernberg and colleagues at the Institute of Personality Disorders, Cornell Medical Center, according to the USA National Institute of Mental Health requirements.

Transference-Focused Psychotherapy is important because it provides a systematic guide for the containment and analysis of the victim-victimizer and rescued-rescuer transference-countertransference paradigms that arise along the treatment sessions which, if not properly handled, are responsible for the failure of most treatments of BPD patients. Before starting TFP, a therapy contract is set with detailed prescriptions for the management of suicidal behavior (the patient must accept to self- contain suicidal urges in order to receive the treatment), other forms of impulsivity, affective instability and alterations of identity related to destructive decisions regarding leaving home, school or work, use of illegal and prescribed drugs and taking proper care of mental and physical comorbidities.

Most BPD patients receive "treatment as usual" (TU) with supportive therapy, short and erratic courses of medication and brief hospitalizations. This is done despite the existence of specific therapies for them as psychodynamic therapy, supportive therapy, group therapy, family therapy and reliable and well- studied prolonged regimes of medications with fluvoxamine, olanzapine, valproate and omega fatty acid. Drop out rate of TU is almost 60% and the remaining patients exhibit little improvement even with several years of therapy conducted by experienced therapists.

Specific therapies for BPD, besides TFP, are Linehan's Dialectical Behavioral Therapy (DBT) and Bateman and Fonagy's Partial Hospitalization (PH) treatment (these two treatments use a combination of individual and group therapies) and Stevenson and Meares's Self Psychotherapy (SP) (two individual sessions a week closely supervised in a weekly meeting with all therapists). These four therapies are effective for reducing the more destructive BPD manifestations within 12 to 18 months of treatment. Drop out rates are: PFT, 19.1%; DBT, 16.7%; PH, 12% and SP, 16%. In all these therapies, impulsivity and affective instability begin to remit after four to six months of treatment and the alterations of identity and the BPD diagnosis do not disappear at the end of the treatment.

In a previous study carried out by some of us with experienced (mean experience, 12 years; S.D.=1.15) and novel therapists (mean experience, 4.67 years; S.D.=4.23), where the experience of each group was significatively different ($U=7.5$, $p< .002$), impulsivity remitted after 24 sessions and affective instability remitted almost completely after 48 sessions in 11 out of 19 patients of both sexes who were offered a two-year treatment with videorecorded supervised TFP. There were no differences in results between both groups of therapists.

With that background, we planned the present study which, as far as we know, is the first TFP study with 48 sessions delivered only by novel therapists. The research project was approved by the Anahuac University research and ethical committees. Patients were recruited from respondents to an offer of treatment for BPD at the university psychotherapy clinic. Selection of patients was made with clinical and semi-structured interviews using the SCID I and the SCID II. At least one of the supervisors interviewed all patients and their families and offered to be available in the case of emergencies for patients, families and therapists. Inclusion criteria were: being 18 to 40 years old; meeting the first three criteria and two other of the remaining six BPD criteria; having graduated at least from junior high school, and not suffering from schizophrenia, bipolar disorder, delusional disorder, severe substance abuse, severe mental organic disorder or antisocial disorder.

Therapists were selected among recent graduates from the Anahuac University psychotherapy post-graduate program after attending two semesters on BPD psychopathology and therapy and a 20-hours course on the treatment manual given by the

*Grupo de investigación sobre pacientes limítrofes. Asociación Psicoanalítica Mexicana. Bosque de Caobas 67. Bosques de las Lomas. 11700, México DF.
**Coordinadora de la Maestría en Psicología Clínica y Psicoterapia de la Universidad Anáhuac.
Recibido primera versión: 6 de mayo de 2003. Segunda versión: 9 de enero de 2004. Tercera versión: 29 de marzo de 2004. Aceptado: 9 de abril de 2004

2004

- uncontrolled study
- n=10
- 48 treatment sessions
- significant reduction of
  - GAF score
  - SCL-90

3 RCTs (2006-2010)

ORIGINAL ARTICLE

Outpatient Psychotherapy for Borderline Personality Disorder

Randomized Trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy

Josephine Giesen-Bloo, MSc; Richard van Dyck, MD, PhD; Philip Spinhoven, PhD; Willem van Tilburg, MD, PhD; Carmen Dirksen, PhD; Thea van Asselt, MSc; Ismay Kremers, PhD; Marjon Nadort, MSc; Arnoud Arntz, PhD

Context: Borderline personality disorder is a severe and chronic psychiatric condition, prevalent throughout health care settings. Only limited effects of current treatments have been documented.

Objective: To compare the effectiveness of schema-focused therapy (SFT) and psychodynamically based transference-focused psychotherapy (TFP) in patients with borderline personality disorder.

Design: A multicenter, randomized, 2-group design.

Setting: Four general community mental health centers.

Participants: Eighty-eight patients with a Borderline Personality Disorder Severity Index, fourth version, score greater than a predetermined cutoff score.

Intervention: Three years of either SFT or TFP with sessions twice a week.

Main Outcome Measures: Borderline Personality Disorder Severity Index, fourth version, score; quality of life; general psychopathologic dysfunction; and measures of SFT/TFP personality concepts. Patient assessments were made before randomization and then every 3 months for 3 years.

Results: Data on 44 SFT patients and 42 TFP patie were available. The sociodemographic and clinical ch acteristics of the groups were similar at baseline. S vival analyses revealed a higher dropout risk for T patients than for SFT patients ($P=.01$). Using an intenti to-treat approach, statistically and clinically signific improvements were found for both treatments on all m sures after 1-, 2-, and 3-year treatment periods. Afte years of treatment, survival analyses demonstrated t significantly more SFT patients recovered (relati risk=2.18; $P=.04$) or showed reliable clinical impro ment (relative risk=2.33; $P=.009$) on the Borderline P sonality Disorder Severity Index, fourth version. Rob analysis of covariance (ANCOVA) showed that they a improved more in general psychopathologic dysfu tion and measures of SFT/TFP personality conce ($P<.001$). Finally, SFT patients showed greater creases in quality of life than TFP patients (rob ANCOVAs, $P=.03$ and $P<.001$).

Conclusions: Three years of SFT or TFP proved to be fective in reducing borderline personality disorde specific and general psychopathologic dysfunction a measures of SFT/TFP concepts and in improving qual of life; SFT is more effective than TFP for all measure

Arch Gen Psychiatry. 2006;63:649-658

Arnoud Arntz

2006

- RCT of TFP vs. Schema-Focused Therapy (SFT)
- n=88
- 3 years, sessions twice a week
- significant reduction of all outcome measures in both groups
- significant superiority of SFT in
  - BPDSI-IV
  - drop-out risk
  - QoL
  - SCL-90
  - „psycho- and personality pathology“

Questions Concerning the Randomized Trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy

I'm writing as a consultant to the study in the June 2006 issue of the ARCHIVES, "Outpatient Psychotherapy for Borderline Personality Disorder: Randomized Trial of Schema-Focused Therapy vs Transfer-

Frank Yeomans

ence-Focused Psychotherapy."[1] The topic is important, but I regretfully have to object to aspects of this study and question its conclusions. Besides the facts that (1) the patient group treated by psychodynamic therapists was more symptomatic and (2) a completers analysis, which I know was done, was not published, there is an issue concerning what therapy was delivered. The question of adherence is essential to any psychotherapy research and in this study, we must consider both observation of the therapists' work and the authors' "integrity check."

Giesen-Bloo et al[1] state "all the therapists had previous therapy experience in their orientation with patients with BPD [borderline personality disorder]" and the transference-focused psychotherapy (TFP) therapists had an average of 11.73 years' experience in the model. This represents a misunderstanding of TFP in relation to general psychodynamic psychotherapy. Transference-focused psychotherapy is a form of psychodynamic psychotherapy, modified to address patients with borderline personality disorder, that was being developed at the time this study was beginning.[2] The Dutch therapists had prior experience in psychodynamic psychotherapy but not in TFP. Most commented on how different TFP was from their customary approach as they attempted to learn TFP.

Another issue is the use of the term *supervisor* in defining my role. While the term was used, the more accurate term is *consultant*. Visiting the Netherlands 8 times in 7 years, I could not provide regular supervision. I tried

wouldn't do what was required."

Even in my last consultation I expressed the concern that a number of the therapists had not grasped the specific concepts of TFP and were using a more traditional and generic psychodynamic mode without the modifications that TFP brings to that approach. In summary, I question the idea that this is a study of SFT and TFP. It is actually a study of SFT and psychodynamic treatment as usual, where some of the psychodynamic therapists grasped the model of TFP and others did not.

Frank Yeomans, MD, PhD

Correspondence: Dr Yeomans, Weill Medical College of Cornell University, Banker Villa, 21 Bloomingdale Rd, White Plains, NY 10605 (fyeomans@nyc.rr.com).
Financial Disclosure: None reported.

1. Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T, Kremers I, Nadort M, Arntz A. Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Arch Gen Psychiatry*. 2006;63:649-658.
2. Clarkin JF, Yeomans FE, Kernberg OF. *Psychotherapy for Borderline Personality*. New York, NY: John Wiley & Sons; 1999.

In reply

With this response we want to clarify and, for the most, refute the issues raised by Dr Yeomans.

The role of Dr Yeomans as a consultant was described in the article.[1(pp650-651)] *If Dr Yeomans means that he was not responsible for the individual treatments, he is correct; he was not a supervisor in that sense.*

"Recent suicidality" and "parasuicidality," both based on several items within 1 Borderline Personality Disorder Severity Index, fourth version (BPDSI-IV), subscale, did not significantly influence dropout (P>.20). If anything, suicidality was related to completing treatment (odds ratio=1.7).

The gold standard nowadays is intention-to-treat analysis because, among other reasons, completers analysis might be biased in 2 respects. First, general outcome may be inflated when dropouts are not taken into account, if dropouts are dominated by patients who did not profit from treat-
usually the case, at least in our trial. Second,
nalysis of treatments with differential dropout
ted with poorer response, leads to a biased con-
e comparison between treatments.
for our trial is whether the relative recovery
nt between completers and dropouts. In the sur-
, the condition × dropout status interaction failed
nificance (relative risk [RR]=0.68; Wald sta-
P=.66). Thus, the difference between treat-
overy was very similar in the completers and
.
ess, we report herein some completer analyses
ive analyses will be reported in a submitted pa-
with follow-up results [J.G., R. van Dyck, MD,
noven, PhD, W. van Tilburg, MD, PhD, C. Dirk-
van Asselt, MSc, I. Kremers, PhD, M. Nadort,
npublished data, December 2006]). First, a sur-
s of the completers only on the recovery status
the difference between schema-focused therapy
ansference-focused therapy (TFP) remained in
the same range as in the whole sample (RR=1.77 vs 2.18). The difference between treatments was no longer significant, but it is clear that this is more of a power than an effect size problem because RRs remained similar. Controlling for medication use (which was negatively associated with recovery), the difference became significant (RR=4.01 [95% confidence interval, 1.35-11.99]; Wald statistic=6.24; P=.01). Adding recent self-mutilation and suicidal behavior at pretest as additional covariates yielded essentially the same results, with SFT having more and quicker recovery (RR=4.44 [95% confidence interval, 1.50-13.12]; Wald statistic=7.28; P=.007). Lastly, Wilcox robust analysis of co-

Criticism

- patients in the TFP group were more symptomatic
- lack of training and treatment integrity in TFP therapists

John Clarkin

2007

Article

Evaluating Three Treatments for Borderline Personality Disorder: A Multiwave Study

John F. Clarkin, Ph.D.

Kenneth N. Levy, Ph.D.

Mark F. Lenzenweger, Ph.D.

Otto F. Kernberg, M.D.

Objective: The authors examined three year-long outpatient treatments for borderline personality disorder: dialectical behavior therapy, transference-focused psychotherapy, and a dynamic supportive treatment.

Method: Ninety patients who were diagnosed with borderline personality disor-

behavior therapy were significantly associated with improvement in suicidality. Only transference-focused psychotherapy and supportive treatment were associated with improvement in anger. Transference-focused psychotherapy and supportive treatment were each associated with improvement in facets of impulsiv-

- RCT of TFP vs. DBT vs. supportive treatment
- n=90
- 1 year of treatment
- Significant positive change in all groups:
  - depression, anxiety
  - global functioning, social adjustment

- Significant improvement:
  - TFP and DBT: suicidality
  - TFP and supportive: anger, facets of impulsivity
  - TFP: irritability, verbal and direct assault

BJPsych | The British Journal of Psychiatry (2010)
196, 1–7. doi: 10.1192/bjp.bp.109.070177

Transference-focused psychotherapy *v.* treatment by community psychotherapists for borderline personality disorder: randomised controlled trial

Stephan Doering, Susanne Hörz, Michael Rentrop, Melitta Fischer-Kern, Peter Schuster, Cord Benecke, Anna Buchheim, Philipp Martius and Peter Buchheim

Background
Transference-focused psychotherapy is a manualised treatment for borderline personality disorder.

Aims
To compare transference-focused psychotherapy with treatment by experienced community psychotherapists.

Method
In a randomised controlled trial (NCT00714311) 104 female out-patients were treated for 1 year with either transference-focused psychotherapy or by an experienced community psychotherapist.

Results
Significantly fewer participants dropped out of the transference-focused psychotherapy group (38.5% *v.* 67.3%) and also significantly fewer attempted suicide ($d = 0.8$, $P = 0.009$). Transference-focused psychotherapy was significantly superior in the domains of borderline symptomatology ($d = 1.6$, $P = 0.001$), ($d = 1.0$, $P = 0.002$), personality orga and psychiatric in-patient admissio groups improved significantly in th and anxiety and the transference-f group in general psychopathology, group differences ($d = 0.3$–0.5). Self- not change in either group.

Conclusions
Transference-focused psychotherap treatment by experienced communi domains of borderline symptomato functioning, and personality organis preliminary evidence for a superior suicidality and need for psychiatric

Declaration of interest
None.

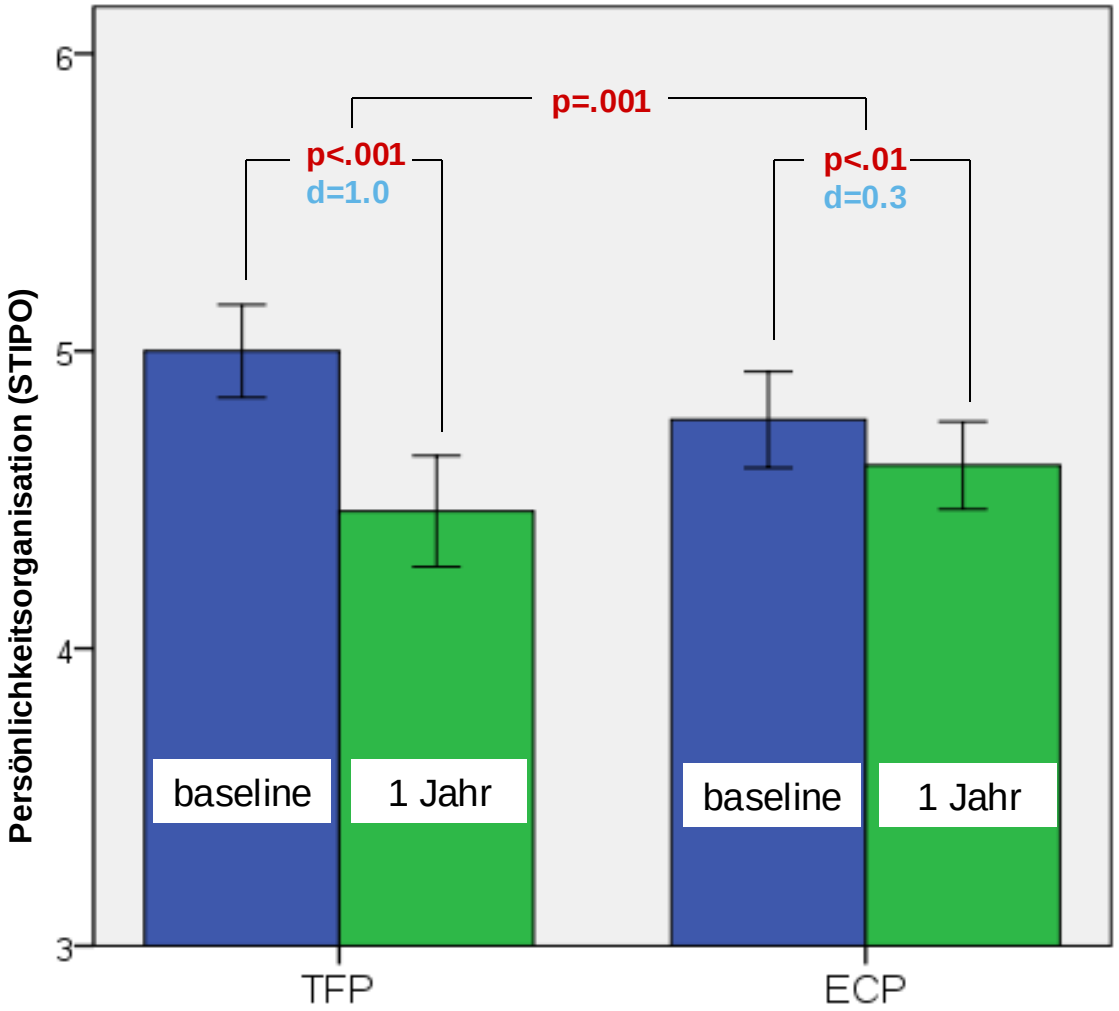
2010

Stephan Doering

- RCT of TFP vs. treatment by experienced community psychotherapists (ECP)
- n=104
- Multi-center: Munich, Vienna
- 1 year
- Significant superiority of TFP
  - Reduction of suicide attempts
  - Drop-out rate (38,5% vs. 67,3%)
  - Reduction of DSM-IV criteria (BPD) and “remission“ (42,3% vs. 15,4%)
  - GAF-Score
  - Inpatient psychiatric treatment
- Significant improvements:
  - Anxiety, depression, general psychopathology
- No change in self-harming behavior

Personality functioning

STIPO



ANCOVA
F=12.136
df=1, 101
p=0.001

Significantly higher improvement of personality functioning

Mentalization

RF-Scale

Journal of Consulting and Clinical Psychology
2006, Vol. 74, No. 6, 1027–1040

0022-006X/06/$12.00 DOI: 10.1037/0022-006X.74.6.1027

Change in Attachment Patterns and Reflective Function in a Randomized Control Trial of Transference-Focused Psychotherapy for Borderline Personality Disorder

Kenneth N. Levy, Kevin B. Meehan, Kristen M. Kelly, Joseph S. Reynoso, and Michal Weber
City University of New York

John F. Clarkin and Otto F. Kernberg
Joan and Sanford I. Weil Medical College of Cornell University

Changes in attachment organization and reflective function (RF) were assessed as putative mechanisms of change in 1 of 3 year-long psychotherapy treatments for patients with borderline personality disorder (BPD). Ninety patients reliably diagnosed with BPD were randomized to transference-focused psychotherapy (TFP), dialectical behavior therapy, or a modified psychodynamic supportive psychotherapy. Attachment organization was assessed with the Adult Attachment Interview and the RF coding scale. After 12 months of treatment, participants showed a significant increase in the number classified secure with respect to attachment state of mind for TFP but not for the other 2 treatments. Significant changes in narrative coherence constructs during t Findings suggest th research should es identify treatment outcome of these c

Keywords: attachn

2006

Ken Levy

Table 5
Change in RF, Coherence, and Lack of Resolution of Loss and Trauma From Time 1 to Time 2

	TFP (N = 22)				DBT (N = 15)				SPT (N = 23)			
	Time 1		Time 2		Time 1		Time 2		Time 1		Time 2	
Measure	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
RF	2.86	1.16	4.11	1.38	3.31	0.95	3.38	1.15	2.80	0.80	2.86	1.28
Coherence	2.93	1.34	4.02	1.69	3.00	1.64	3.25	1.41	3.25	1.33	3.16	1.20
Resolution of Loss	2.39	2.62	1.80	2.11	2.63	2.80	2.78	3.02	1.52	1.98	1.68	2.08
Resolution of Trauma	2.09	2.22	1.41	1.48	2.44	2.54	2.06	1.96	1.61	2.29	1.23	2.10

Note. TFP = transference-focused psychotherapy; DBT = dialectical behavior therapy; SPT = supportive psychotherapy; RF = reflective function.

BJPsych The British Journal of Psychiatry
1–2. doi: 10.1192/bjp.bp.113.143842

Short report

Transference-focused psychotherapy for borderline personality disorder: change in reflective function

Melitta Fischer-Kern, Stephan Doering, Svenja Taubner, Susanne Hörz, Johannes Zimmermann, Michael Rentrop, Peter Schuster, Peter Buchheim and Anna Buchheim

Summary
Borderline personality disorder is associated with deficits in personality functioning and mentalisation. In a randomised controlled trial 104 people with borderline personality disorder received either transference-focused psychotherapy (TFP) or treatment by experienced community therapists. Among other outcome variables, mentalisation was assessed by means of the Reflective Functioning Scale (RF Scale). Findings revealed only significant imp
function in the TFP group within 1 ye
between-group effect was of medium
Improvements in reflective function were sig
correlated with improvements in personality

Declaration of interest
M.R. has received fees from Janssen-Cilag, E
AstraZeneca, Essex Pharma and Roche, unlr
present work

Melitta Fischer-Kern

Table DS2 Paired *t*-tests and analyses of covariance of reflective function usi

Measure	*n*	Transference-focused psychoth: Baseline 1 year, mean (s.d.)	Paired *t*-tes: *t* (d.f.)	Within-group effect size, *d*
Last observation carried forward	47			0.37
Reflective function score			−2.998 (46)	
Baseline		2.74 (1.28)		
1 year		3.15 (1.08)		
Observed cases	38			0.51
Reflective function score			−3.062 (37)	
Baseline		2.82 (1.29)		
1 year		3.32 (0.99)		
Multiple imputation	52			0.54
Reflective function score			−4.047 (51)	
Baseline		2.75 (1.26)		
1 year		3.31 (1.03)		

a. We used estimated marginal means (i.e. means controlled for baseline differences) and the pooled standa
on multiple imputation can be expected to be the most accurate because they take into account that missin

deal with missing values[a]
ent by experienced community psych

Measure	Baseline 1 year, mean (s.d.)	Paired *t*-test: *t* (d.f.)	*P*	A: *P*	Between-group effect size, *d*
Last observation carried forward					0.34
Reflective function score		−1.000 (44)	0.323	0.012	0.34
Baseline	2.69 (0.95)				
1 year	2.76 (0.98)				
Observed cases					0.39
Reflective function score		−1.000 (24)	0.327	0.043	0.39
Baseline	2.80 (0.96)				
1 year	2.92 (1.00)				
Multiple imputation					0.45
Reflective function score		−1.235 (51)	0.317	0.024	0.45
Baseline	2.68 (0.98)				
1 year	2.82 (1.00)				

Cohen's *d*. Since individuals who drop-out ar
demographical and clinical characteristics at b
andom, estimates based

Between-group effect size, *d*

Attachment representation

AAI

Journal of Consulting and Clinical Psychology
2006, Vol. 74, No. 6, 1027–1040

0022-006X/06/$12.00 DOI: 10.1037/0022-006X.74.6.1027

Change in Attachment Patterns and Reflective Function in a Randomized Control Trial of Transference-Focused Psychotherapy for Borderline Personality Disorder

Kenneth N. Levy, Kevin B. Meehan, Kristen M. Kelly, Joseph S. Reynoso, and Michal Weber
City University of New York

John F. Clarkin and Otto F. Kernberg
Joan and Sanford I. Weil Medical College of Cornell University

Changes in attachment organization and reflective function (RF) were assessed as putative mechanisms of change in 1 of 3 year-long psychotherapy treatments for patients with borderline personality disorder (BPD). Ninety patients reliably diagnosed with BPD were randomized to transference-focused psychotherapy (TFP), dialectical behavior therapy, or a modified psychodynamic supportive psychotherapy. Attachment organization was assessed with the Adult Attachment Interview and the RF coding scale. After 12 months of treatment, participants show with respect to attachment state of mind for TFP in narrative coherence and RF were found as a fu constructs during treatment. No changes in resol Findings suggest that 1 year of intensive TFP ca research should establish the relationship betw identify treatment components responsible for outcome of these changes.

Keywords: attachment, reflective function, bord

Ken Levy

Table 3
Association Between Attachment Security Time 1 and Time 2 as a Function of Treatment Group

	Time 1 attachment							
	TFP		DBT		SPT			
Time 2 attachment	Secure	Insecure	Secure	Insecure	Secure	Insecure	Total	χ^2
Secure	1 (100%)	6 (28.6%)	1 (100%)	0 (0%)	1 (100%)	0 (0%)	9	8.25**
Insecure	0 (0%)	15 (71.4%)	0 (0%)	14 (100%)	0 (0%)	22 (100%)	51	
Total	1	21	1	15	1	21	60	

Note. TFP = transference-focused psychotherapy; DBT = dialectical behavior therapy; SPT = supportive psychotherapy. Percentages are for the columns.
** $p < .02$.

2017

Psychotherapy and Psychosomatics

Letter to the Editor

Received: July 25, 2016
Accepted after revision: February 6, 2017
Published online: September 14, 2017

Psychother Psychosom 2017;86:314–316
DOI: 10.1159/000460257

Change of Unresolved Attachment in Borderline Personality Disorder: RCT Study of Transference-Focused Psychotherapy

Anna Buchheim[a], *Susanne Hörz-Sagstetter*[c], *Stephan Doering*[b], *Michael Rentrop*[d], *Peter Schuster*[b], *Peter Buchheim*[d], *Dan Pokorny*[e], *Melitta Fischer-Kern*[b]

[a]Institute of Psychology, University of Innsbruck, Innsbruck, and [b]Medical University Vienna, Vienna, Austria; [c]Psychologische Hochschule Berlin (PHB), Berlin, [d]Technical University Munich, Munich, and [e]Ulm University, Ulm, Germany

Anna Buchheim

Table 1. Changes between insecure and secure respective unresolved and organized attachment represe
outcome (intent-to-treat LOCF and OC analyses)

	ECP						TFP					
	exact McNemar test OC = LOCF						exact McNemar test OC = LOCF					
(a) Security			T2 Ins	Sec	all				T2 Ins	Sec	all	
	T1	Ins	21	0[a]	21		T1	Ins	24	12[a]	36	
		Sec	1[b]	3	4			Sec	0[b]	2	2	
		all	22	3	25			all	24	14	38	
	McNemar – 0:1 $p = 1.000$						McNemar – 12:0 $p < 0.001$					
(b) Unresolved trauma			T2 U	Org	all				T2 U	Org	all	
	T1	U	10	3[a]	13		T1	U	4	17[a]	21	
		Org	0[b]	12	12			Org	0[b]	17	17	
		all	10	15	25			all	4	34	38	
	McNemar – 3:0 $p = 0.250$						McNemar – 17:0 $p < 0.001$					

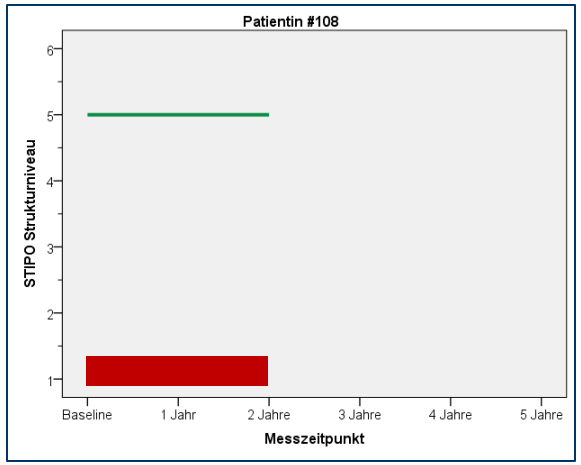
(c) Coherence scale	Baseline 1 year	*t* test pre-post			Effect size	Baseline 1 year	*t* test pre-post			Effe size			
	mean ± SD	*t*	df	*p*	d	mean ± SD	*t*	df	*p*	d			
OC		(*n* = 25)					(*n* = 38)				(*N* = 63)		
T1 T2	2.88±1.24 3.24±0.97	2.377	24	0.026	0.32	2.71±1.06 4.11±1.13	9.381	37	<0.001	1.27	21.964	1, 61	0.048
LOCF		(*n* = 45)					(*n* = 47)				(*N* = 92)		
T1 T2	2.80±1.14 3.00±1.02	2.283	44	0.027	0.18	2.64±1.03 3.77±1.29	7.796	46	<0.001	0.97	29.462	1, 90	<0.001

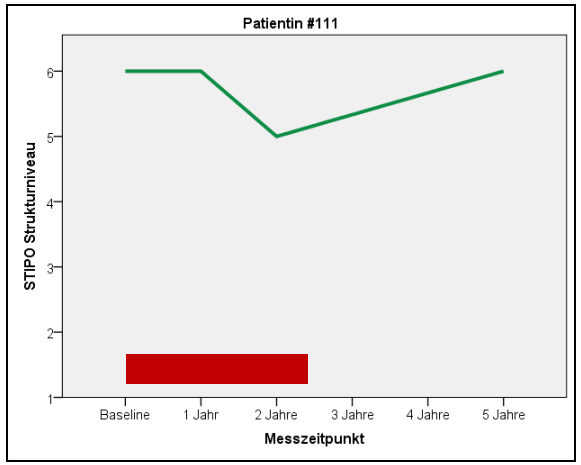
Group comparison was done with the exact Mann-Whitney *U* test. T1, baseline; T2, after 1 year of treatment; ECP, experienced community psychotherapy; TFP, transference-focused psychotherapy; Ins = insecure, Sec = secure, U = Unresolved, Org = organized (non-U); OC, observed cases, LOCF, last observation carried forward; *p*, significance (2-sided); *t*, *t*-statistic for the paired *t* test; df, degrees of freedom; d, Cohen's effect size. [a] worsened, [b] improved.

Group comparison		
N	*z*	*p*
OC 63	3.260	0.001
LOCF 92	3.719	<0.001
OC 63	2.709	0.012
LOCF 92	3.411	<0.001

Long-term effects

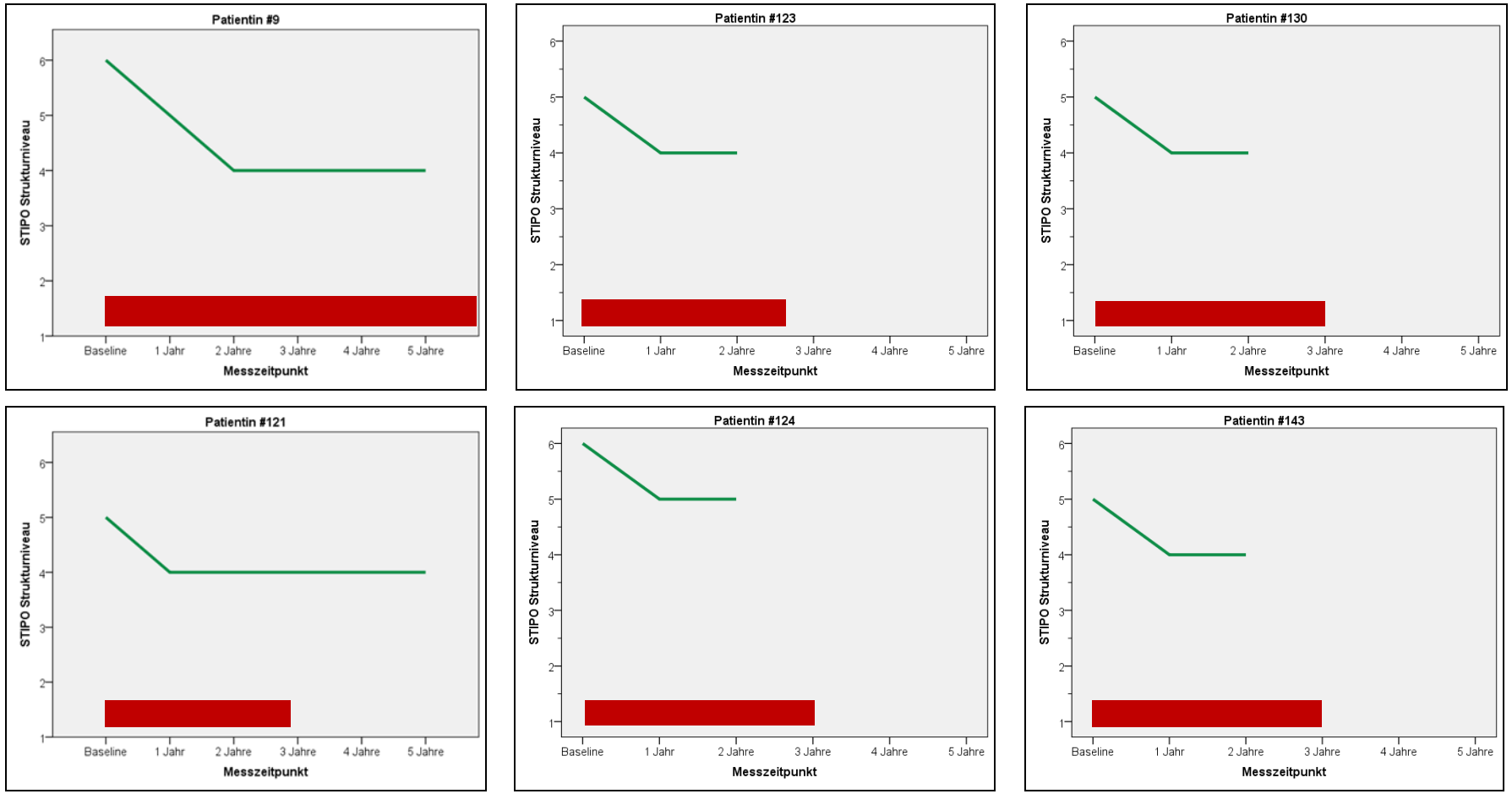
STIPO





Transference-Focused Psychotherapy (TFP)

11,1% no improvement

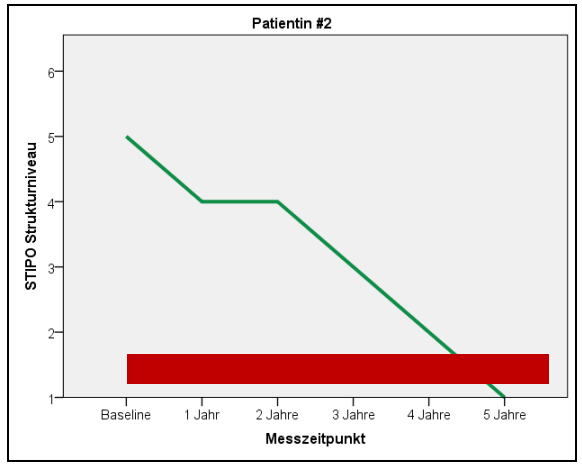


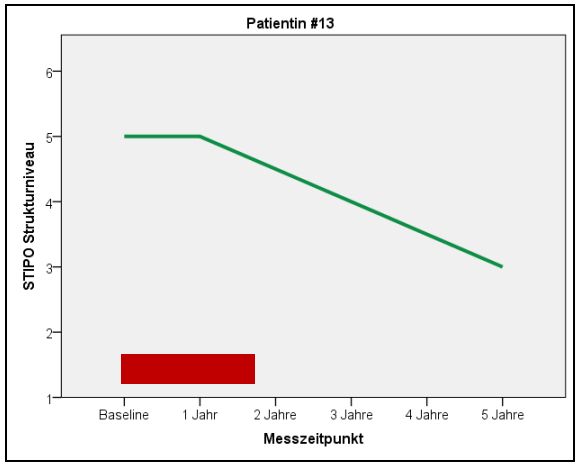
Transference-Focused Psychotherapy (TFP)

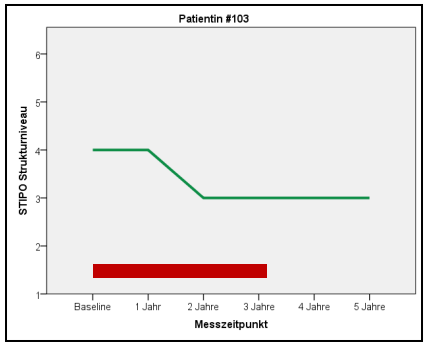
33,3% improvement, still borderline functioning

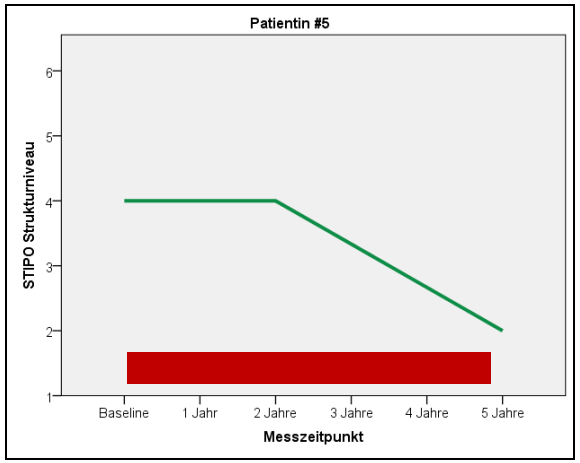
Transference-Focused Psychotherapy (TFP)

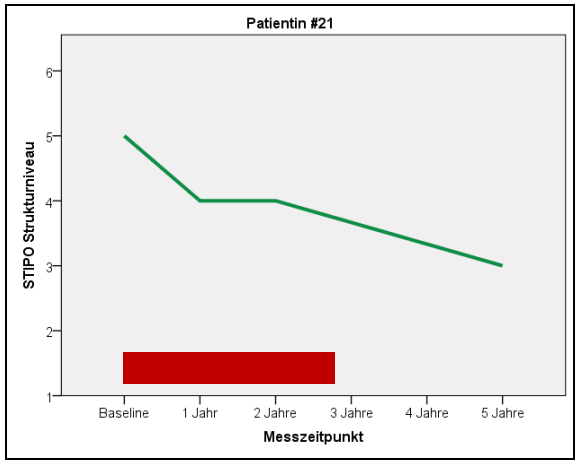
55,6% improvement, neurotic functioning

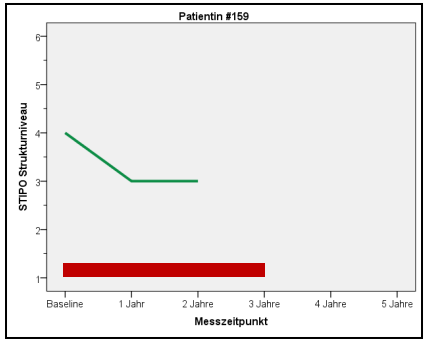


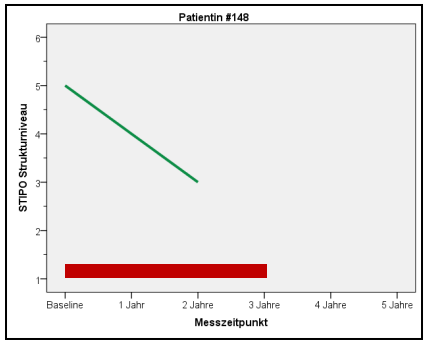


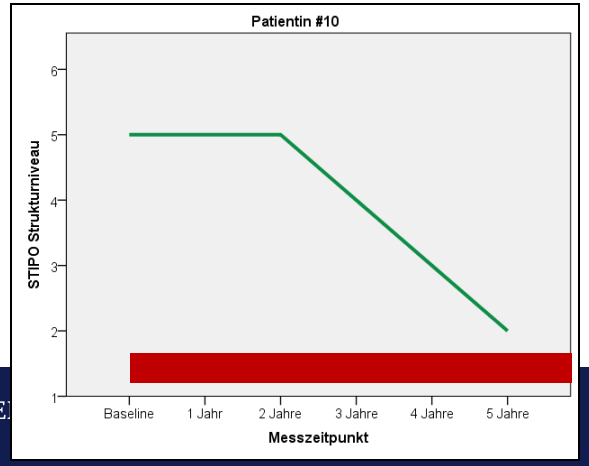


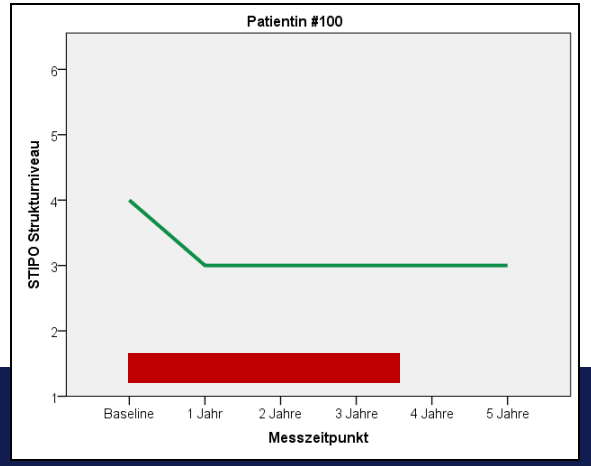


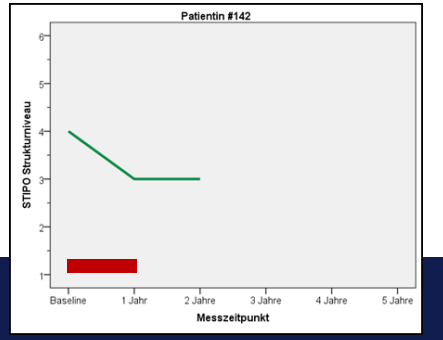


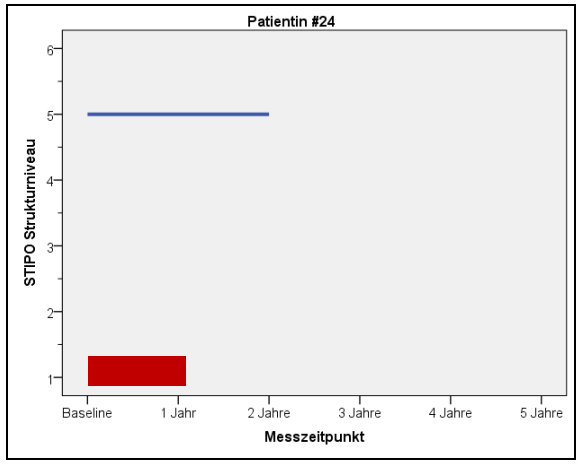


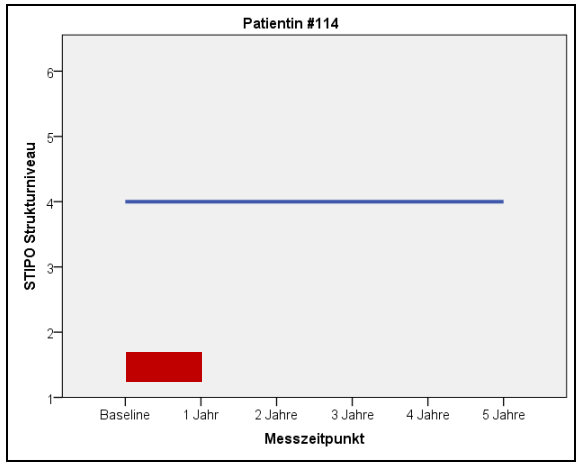


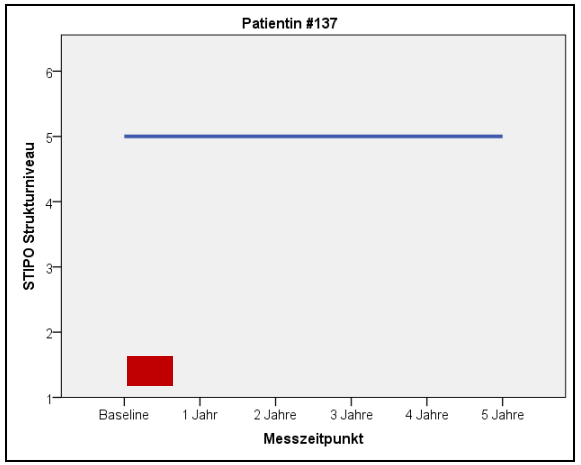


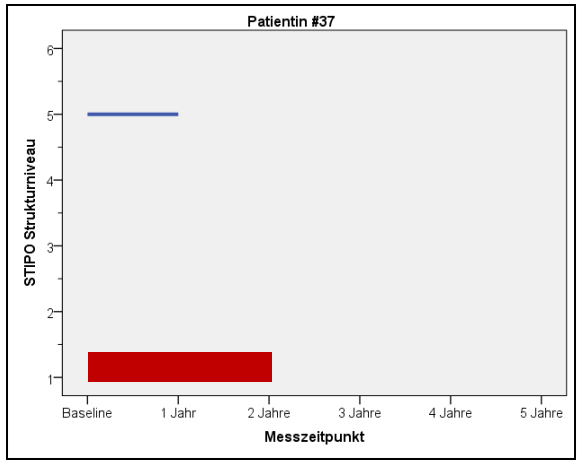


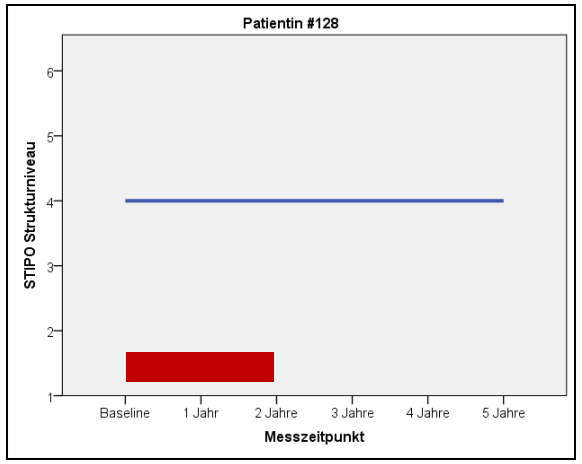


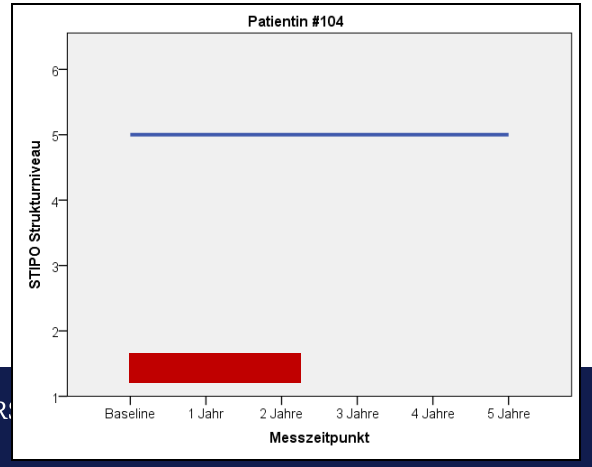


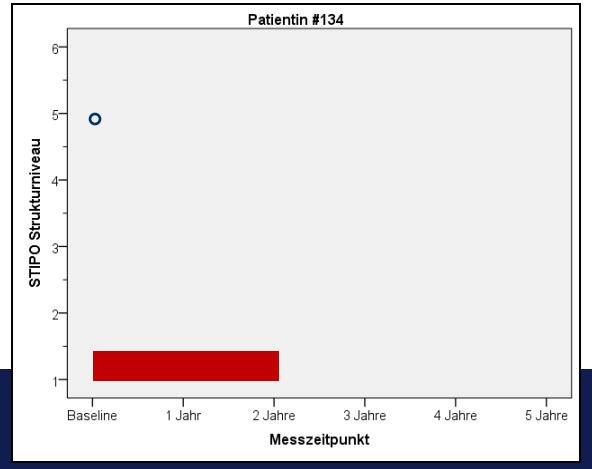






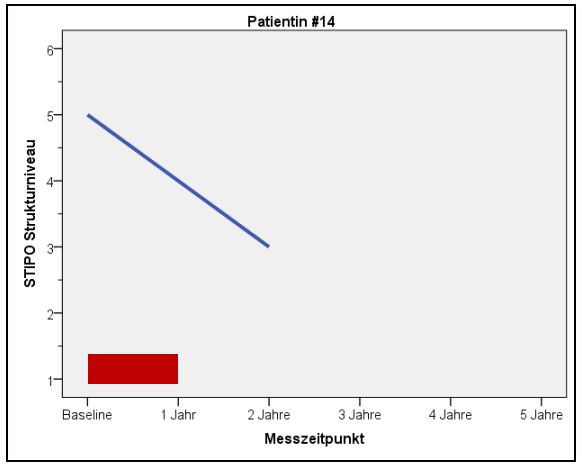


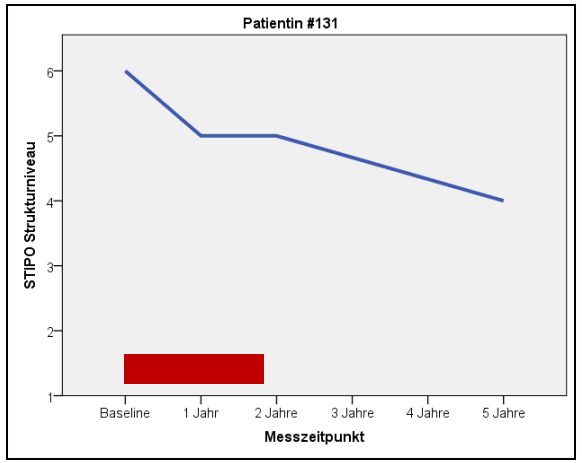


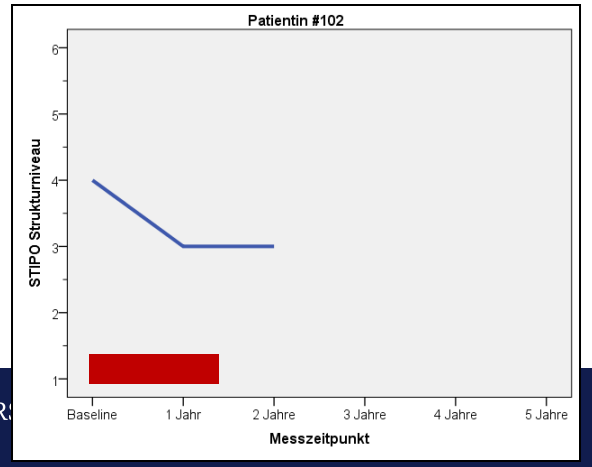


Treatment by experienced community psychotherapists

70% no improvement







Treatment by experienced community psychotherapists

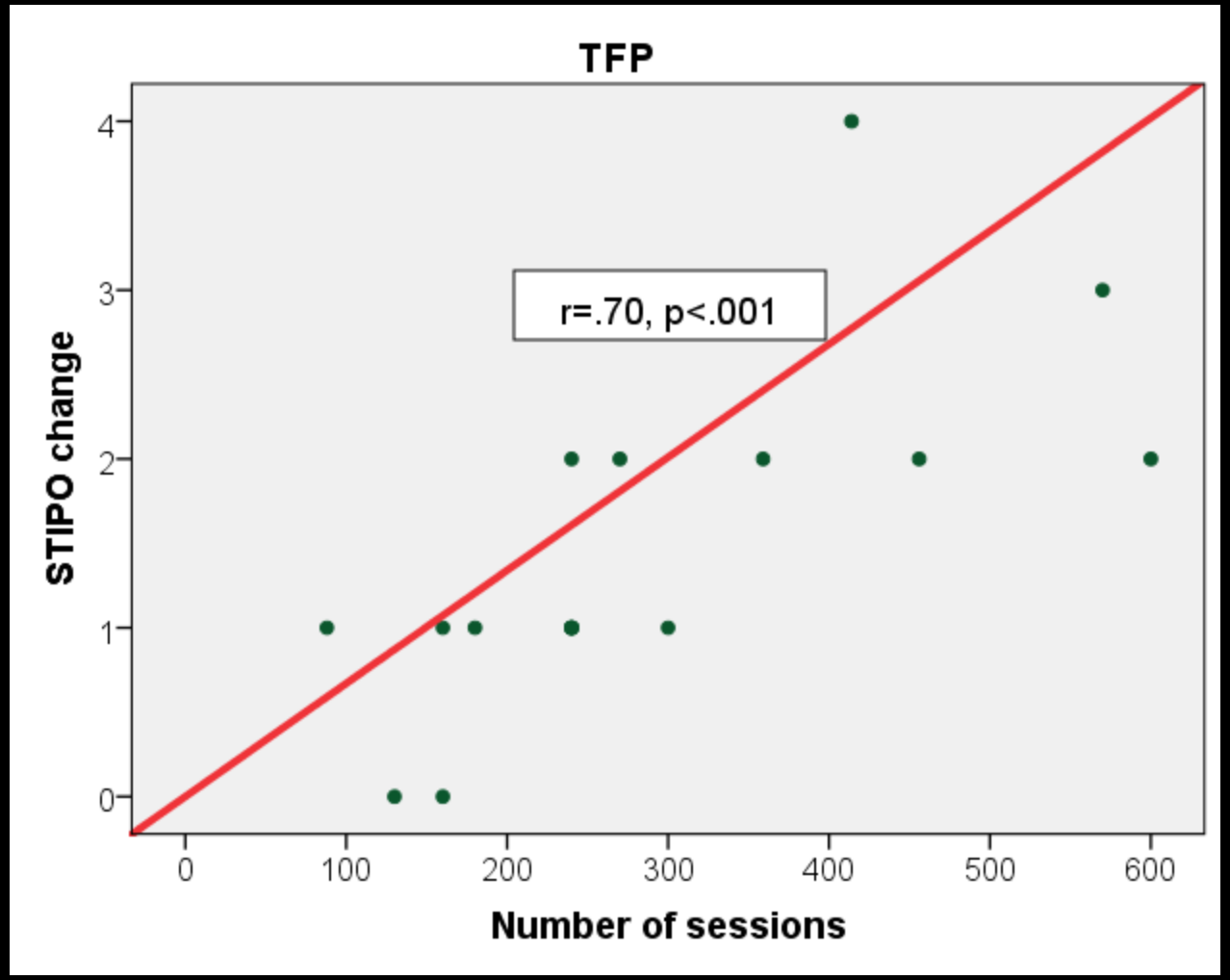
20% improvement, neurotic functioning

10% improvement, still borderline functioning

TFP: 55.5% achieve a neurotic level of personality organization

TAU: 20.0% achieve a neurotic level of personality organization

Dose effect


TFP
r=.70, p<.001
STIPO change
Number of sessions
0
1
2
3
4
0
100
200
300
400
500
600

Compared to the other borderline treatments, the strength of TFP might be its potential to change personality functioning and attachment status. TFP might be particularly indicated in patients with problems in the domains of **interpersonal relationships** and **social adaptation**.

Inpatient TFP

Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. (2014)
Published online in Wiley Online Library (wileyonlinelibrary.com). **DOI:** 10.1002/cpp.1915

Change in Identity Diffusion and Psychopathology in a Specialized Inpatient Treatment for Borderline Personality Disorder

Daniel Sollberger,[1*] Daniela Gremaud-Heitz,[1,2] Anke Riemenschneider,[1] Puspa Agarwalla,[3] Cord Benecke,[4] Oliver Schwald,[5] Joachim Küchenhoff,[1,3] Marc Walter[1] and Gerhard Dammann[1,2]

[1] *Psychiatric University Hospital, Basel, Switzerland*
[2] *Psychiatric Clinic, Münsterlingen, Switzerland*
[3] *Psychiatric Clinic, Liestal, Switzerland*
[4] *Institute of Psychology, University of Kassel, Kassel, Germany*
[5] *Outpatient Clinic for Victims of Torture and War, Swiss Red C*

Objectives: Patients with borderline personality disord symptoms and suffer especially from disturbance in the investigate changes—particularly in affective BPD sy structured, disorder-specific inpatient treatment (DST) th focused psychotherapy approach with modules of dialect
Method: In a prospective, two-group comparison trial, 44 tionnaires addressing identity diffusion and state, as w and after 12 weeks of inpatient treatment. Thirty-two pati given inpatient treatment-as-usual (TAU). The patients w two groups, in order of admission and availability of trea
Results: In the pre-post-comparison, the DST group show ($p < 0.001$) and improvements in instability of the image o ological (trait and state) symptoms. However, there was n
Conclusions: After a 12-week inpatient treatment, the find DST group in typical affective borderline symptomatolo identity diffusion. This highlights the significance of a sh

Daniel Sollberger

Gerhard Dammann

Table 2. Between-group comparisons at pre-treatment

	DST ($n = 32$)	TAU ($n = 12$)	p
IPO (theoretical construct), mean (SD)			
Identity diffusion	62.71 (12.81)	47.75 (13.74)	$t = 3.70$, $p = 0.001$
Primitive defences	43.42 (8.94)	37.41 (9.08)	$t = 2.19$, $p = 0.034$
Reality testing	41.19 (12.67)	38.83 (16.66)	ns
Aggression	34.11 (8.21)	32.27 (7.12)	ns
Moral values	25.59 (7.80)	21.83 (5.94)	ns
IPO (empirically evaluated four-factor structure)*, mean (SD)			
Instability in self and others	94.41 (17.95)	75.33 (19.90)	$t = 3.31$ $p = 0.002$
Instability in goals	5.61 (2.38)	4.75 (2.65)	ns
Psychosis	21.42 (8.65)	20.67 (9.70)	ns
Instability in behaviour	19.10 (5.56)	16.40 (6.81)	ns
STAXI, mean (SD)			
State anger	18.56 (8.07)	15.00 (6.83)	Z = -2.12, p = 0.034
Trait anger	22.10 (7.30)	18.67 (6.27)	ns
STAI, mean (SD)			
State anxiety	56.25 (11.0)	50.70 (14.86)	ns
Trait anxiety	58.33 (8.65)	53.58 (14.22)	ns
BDI, mean (SD)			
Depression score	27.16 (9.16)	23.64 (12.92)	ns

*Ellison & Levy, 2012
DST = disorder-specific treatment. TAU = treatment as usual. IPO = Inventory of Personality Organisation. STAXI = State-Trait Anger Expression Inventory. STAI = State-Trait Anxiety Inventory. SD = standard deviation. ns = non-significant.

TFP-A

Reduktion selbstverletzenden Verhaltens bei Jugendlichen mit Borderline-Persönlichkeitsorganisation mittels der übertragungsfokussierten Psychotherapie

Cecily Jahn, Esma Wieacker, Stephan Bender und Maya Krischer

Cecily Jahn Maya Krischer

Summary

Reduction of Non-Suicidal Self-Injury (NSSI) in Adolescents with Borderline Personality Organization Treated with TFP-A

This study examines whether transference-focused psychotherapy for adolescents (TFP-A) in a dayclinic setting increases the capability to regulate affects and decreases self-destructive behavior in adolescents with borderline personality organization in comparison to treatment as usual (TAU). A total of 120 adolescents consecutively presenting to the dayclinic were allocated to either TFP-A or TAU. They were assessed for aggression, irritability, depression, self-harm, internalizing behavior and pathological personality traits at baseline and after twelve weeks. TFP-A was more effective than TAU in reducing self-harm. Aggression and irritability was improved within the treatment group. These results can be explained by an improvement in affect regulation through a treatment with TFP-A in a dayclinic setting. Further research is necessary in order to assess whether TFP-A reduces self-harm, aggressive behavior and irritability from a long-term perspective and whether these exploratory results can be replicated in independent samples.

Prax. Kinderpsychol. Kinderpsychiat. 70/2021, 728-747

Keywords

personality disorders – adolescence – dayclinic treatment – affect regulation – self-harm

Zusammenfassung

Die Studi
rence foc
Vergleich
me selbst
sation fül
te tageskl
eine allge
Die Jugendlichen wurden zu Beginn und nach zwölf Wochen auf Aggressivität, Reizbarkeit, Depressivität, Selbstverletzung, internalisierendes Verhalten und pathologische Persönlichkeitsmerkmale untersucht. TFP-A erwies sich als wirksamer als TAU in der Reduktion von

TFP-A was more effective than TAU in reducing self-harm. Aggression and irritability was improved within the treatment group. These results can be explained by an improvement in affect regulation through a treatment with TFP-A in a dayclinic setting.

Prax. Kinderpsychol. Kinderpsychiat. 70: 728 – 747 (2021), ISSN: 0032-7034 (print), 2196-8225 (online)

TFP for Groups

Clinical Article

Developments in Group Transference-Focused Psychotherapy

María Jesús Rufat, M.Sc., Jonathan Radcliffe, M.Sc., Tennyson Lee, M.D., Philipp Martius, M.D., Eric Fertuck, Ph.D., Iván Arango, M.D., Heimhild Lappe, M.D., Eulàlia Ripoll, M.D., and Frank E. Yeomans, Ph.D.

Abstract

Several evidence-based psychotherapies for personality disorders have been developed in recent decades, including transference-focused psychotherapy (TFP), a contemporary model of psychodynamic psychotherapy developed by Otto Kernberg. Kernberg established Group TFP (TFP-G) as an alternative or adjunct treatment to individual TFP. Although not yet manualized, TFP-G is used in publicly and privately funded mental health services, including outpatient clinics, subacute hospitals, therapeutic inpatient units, partial hospitalization services, and rehabilitation services serving people with borderline personality. Kernberg's model of TFP-G psychotherapy, its application in clinical settings, and what differentiates it from other group psychotherapy models is described as well as illustrated with some examples useful to practitioners.

Keywords: borderline personality organization, borderline personality disorder, mental health services, group psychotherapy, TFP, TFP-G

Psychotherapies for patients with personality disorders have evolved significantly in recent decades. People with personality disorders were at one time widely seen as untreatable. However, recent decades have seen the development of specialized, evidence-based psychotherapies to serve this population. Five specialized psychotherapies with an established evidence base are dialectical behavior therapy (DBT; Linehan, 1993), mentalization-based treatment (MBT; Bateman & Fonagy, 2006), transference-focused psychotherapy (TFP; Yeomans et al., 2015), schema therapy (ST; Young et al., 2006), and systems training for emotional predictability and problem solving (STEPPS; Blum et al., 2002). DBT, ST, and STEPPS are specialized cognitive-behavioral approaches.

Corresponding author: María Jesús Rufat, Centre Psicoteràpia Barcelona—Seveis Salut Mental (CPB-SSM). Calle Mare de Deu del Coll, núm. 20 (planta baja), Barcelona, Spain, 08023. Email: mjrufat@cpbssm.org

Psychodynamic Psychiatry, 51(3), 311–329, 2023

https://doi.org/10.1521/pdps.2023.51.3.311

Jonathan Radcliffe

Maria Jesus Rufat

TFP for Couples

Vol. XX / No. X

Barry L. Stern

The "Fact of the Matter": A Model for Working with Activated Internal Object Relations in Psychodynamic Couple Therapy

Extensive clinical scholarship has described the application of object-relational principles, particularly the operation of projective identification, to psychodynamic psychotherapy with couples. The author explores the way in which a more complete depiction of projective processes, one that incorporates each partner's intrapersonal management of multiple internal object relations, interacting interpersonally in the couple therapy process, can explain the escalating cycles of conflict between couples that are elaborated in the family-systems literature, and be helpful in understanding the object-relational substrate of chronic conflict in couples more generally. A description of how to map each partner's internal object world through the identification of these cycles in the early couple therapy process is elaborated in a theoretical model and illustrated with case material.

Keywords: couples, psychodynamic psychotherapy, object relations, projective identification, family systems

OBJECT RELATIONS IN COUPLE THERAPY: INTRODUCTION

For the modern Kleinian analyst, it is the manifestation of the patient's internal object relations as they become enacted between patient and therapist that defines a "clinical fact," and which becomes the primary object of interest in the clinical situation (Caper 1994; Joseph 1988; Riesenberg-Malcolm 1994). Similarly, as an object-relations-oriented

Clinical Associate Professor of Medical Psychology (in Psychiatry), Columbia University College of Physicians and Surgeons; Associate Director and Chair of Psychology, Columbia University Center for Psychoanalytic Training and Research. Submitted for publication April 11, 2021; revised August 12, 2021; revised December 13, 2023; accepted April 11, 2024.

DOI: 10.1177/00030651241257525

Barry Stern

Thank you very much for your attention!