A Comparative Evaluation of Two Therapy Theories, Specifically the Transference Focused Psychotherapy (TFP) Theory and the Dialectical Behaviour Therapy (DBT) Theory, Focused On the Treatment of Borderline Personality Disorder

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ABSTRACT

This paper is a comparative evaluation of two different treatment theories, specifically the Transference Focused Psychotherapy (TFP) theory and **the Dialectical Behavioural Therapy (DBT) theory focused on the treatment of Borderline Personality Disorder (BPD).** The first theory, Transference Focused Psychotherapy, is developed to focus on the treatment of Borderline Personality Disorder using a diagnosis from the Psychodynamic approach. This theory diagnosis BPD as a result of a permanent division between the idealized and negative representations of ones self and others (Clarkin, Yeomans, Kernberg, 2005). Transference Focus Psychotherapy uses the method of transference in therapy to help re-connect these internalized object relations which have been separated during childhood in order to treat BPD patients (Clarkin, et al., 2005). Dialectical Behaviour Therapy uses the biosocial model of diagnosis for BPD. This theory proposed that BPD is a result of an emotionally vulnerable individual being brought up in an invalidating environment and as a result, effective functioning and coping mechanisms are not learnt by individuals (Linehan, Dimeff, 2001). The strengths and weaknesses of each of these theories are discussed and evaluated and comparisons and differences between the two theories are discussed. It is concluded that as a result of the lack of empirical evidence supporting the long term effectiveness of either treatment (Giesen-Bloo, et al. 2005; Binks, et al. 2006), as well as the differences in the diagnosis theories that each stem from, neither Transference Focused Psychotherapy, nor Dialectical Behavioural Therapy can be determined to be more effective than the other in treating sufferers of BPD. However, each does seem to provide an effective treatment for BPD.

A Comparative Evaluation of Two Therapy Theories, Specifically the Transference Focused Psychotherapy (TFP) Theory and the Dialectical Behaviour Therapy (DBT) Theory, Focused On the Treatment of Borderline Personality Disorder

Borderline Personality Disorder (BPD) is characterized by persuasive instability in moods, interpersonal relationships, self-image, and behaviour (National Institute of Mental Health). Originally thought to be on the borderline between neurosis and psychosis, BPD has developed its own unique classification which distinguishes it from each of these by its individual characteristics, consisting of a mixture of both psychotic and neurotic features (Swartz, Blazer, George, Winfield, 1990). Individuals suffering BPD display signs of erratic and unpredictable behaviour, often shifting abruptly between emotional states, most commonly to anger. Indications of BPD are complex and consist of a diverse range of symptoms, including; argumentativeness, irritability, sarcasm, impulsiveness, self doubt, fears of abandonment, chronic feelings of depression and emptiness as well as other similar psychological abnormalities (Gunderson, 1984). BPD is a quite common and affects 2% of adults, with prevalence in young women (Swartz, Blazer, George, Winfield, 1990).

Numerous theories have been postulated regarding the diagnosis and etiology of BPD, from a range of psychological perspectives, including the neurobehavioral, biological, cognitive, psychodynamic and psychosocial perspectives. However, many of these perspectives have been unable to produce treatment formulations specific to BPD patients due to the difficulties presented in defining the cause of this complex disorder. BPD patients are also very difficult to treat because of their erratic changes in behaviour which as a result makes it hard to keep them in therapy and causes a frequent failure in response to many therapeutic efforts made by the therapist (Paris, 1994). For these

reasons, many theories of therapy such as those of the biological perspective and the neurobehavioral perspective, which only provide diagnosis and treatment theories for BPD as a development on their other theories, fail in effectively treating patients with Borderline Personality Disorder.

However there are two prominent treatment theories, which have been developed specifically to focus on the treatment ofBPD patients, each of which stems from alternate perspectives. These are the Transference Focused Psychotherapy (TFP) Theory which provides treatment for BDP by focusing on the deep psychological make up of patients, and the Dialectical Behaviour Therapy (DBT) Theory which uses both individual and group therapy sessions to help build skills not fully developed within BDP patients.

The aim of this essay is to comparatively evaluate these two treatments, in their ability to provided reliable treatments for individuals suffering Borderline Personality Disorder.

Transference Focused Psychotherapy

Originating from the psychoanalytic object relations theory proposed by Kernberg and supported by findings from developmental and neurobiological research (Clarkin and Posner 2005; Depue and Lenzenwegar 2001), the Transference Focused Psychotherapy Theory (TFP) is fundamentally a part of the psychodynamic perspective. This theory is built on providing treatment to BPD patients through a focus on the deep psychological make-up. The treatment involves gaining an understanding for the underlying causes of BPD in patients, and building newer and behaviours (Clarkin, Yeomans, Kernberg, 2005).

Transference Focused Psychotherapy uses a psychodynamic approach for the diagnosis of Borderline Personality Disorder. It is the belief that BPD is a result of pathological features of underlying psychological structures[1] and the lack of integrations between them (Clarkin, Yeomans, Kernberg, 2005). As a result of this, the personality organization of the patient is offset, and unlike an individual with a normal personality organization, BDP patients do not have an integrated concept of themselves and significant others. The objects relations theory (Jacobson 1964; Kernberg 1980; Mahler 1971), which TFP therapy is based on, suggests that the ego-self only exists in relation to other internal or external objects. Internal object relations dyads[2] are formed from early interactions with caregivers and are the internalized versions of external objects and relationships (Kernberg, 1980). It is believed that in infancy, due to negative experiences and a lack of care given by caregivers, sufferers of BPD were unable to undergo the processes of integration between extreme good and bad representations of the self and others. This results in a defence mechanism made by the child in which a more permanent division between the idealized and negative representations of ones self and others is developed resulting in an inability for those suffering with BPD to find a suitable median between positive and negative moods, emotions and situations (Trull, 2001). This theory also suggests that BPD patients are essentially driven by intensive, uncontrollable, primitive emotions that do not allow for successful integration into external reality (Clarkin, et al., 2005). These emotions activate along with corresponding cognitive systems so that not only do sufferers of BPD show signs of extreme and

[1] A psychological structure is a stable and enduring pattern of mental functions that organize the individual's behaviour, perceptions, and subjective experience (Clarkin, Yeomans, Kernberg, 2005).
[2] Internal object relations dyads are templates of specific types of relationships the individual has encountered. They are what make up psychological structures, and are responsible for the organisation of an individual's personality and motivation (Kernberg, 1980).

completely unwarranted anger towards themselves and others, but they also develop justification and reasons for these extreme behaviours (Clarkin, et al., 2005).

The Transference Focused Psychotherapy method of treatment focuses on activating the distorted internal representations of the self and others of BPD patients in the present relationship between patient and therapist through the process of transference. The patient is able to relive the internal object relations of past experiences by treating the therapist as an externalized version of these internalized objects. This results in the activation of primitive object relations dyads that unfold during therapy sessions, allowing the therapist to understand and analyse what the patient perceives at their most profound level of cognition in order to identify the internal object relations dyads which distort the patients perception of the world (Koenigsberg, Kernberg, Stone, et al., 2000).

However, before this process can occur it is fundamental that a treatment contract and frame are established between the patient and the therapist. This contract and frame outlines the boundaries of the treatment and sets out the conditions for allowing exploratory therapy. The contract concerns everything from the time arrangements to the role of both the patient and the therapist and also treatment elements, which addresses any of the patient's behaviours that may jeopardise the therapy. The contract also addresses specific forms of acting out which require limit setting, including attacks on self or others or on the boundaries of treatment (Gray, 1994).

Once the treatment contract is established and both parties have agreed with the terms of the treatment, therapy can begin. Therapy occurs in two weekly sessions, the general guidelines for the course of treatment follows: the patient is free to act out their

internal object relations in their sessions, whilst the therapist, who remains technically neutral during sessions whilst still treating the patient with civility and courtesy, observes these object relations and tries to identify and trace them back to their origins. Once these underlying, unintegrated representations of self and others are identified the therapist then helps the patient to understand the fears and anxieties responsible for the separation between these internalized object relations dyads (Materson, Tolpin, Sifneos, 1991). The patient also experiences strong affects[3] within the therapeutic relationship, and when paired with the understanding of the underlying cause of the unintegrated and contradicting representations of themself and others, the patient can begin to re-establish connections between these separate internal object relations, resulting in a more integrated sense of self and others (Clarkin, et al., 2005) This results in a decrease in the erratic behaviour traits of the BPD patient, allowing them to return to a healthier and more integrated life.

The duration of TFP therapy can differ from patient to patient and whilst no exact timeframe can be confirmed many cases have been reported "in which the patient's acting out comes under control within the first 6 months of treatment and in which the use of primitive defence mechanisms is significantly decreased in the second year of treatment." (Clarkin, et al., 2005, p.44). After this stage, therapy can begin to focus more specifically on resolving the patient's identity diffusion and can start to help rebuild a healthy identity for the patient as well as healthy relations with others.

The strengths of Transference Focused Psychotherapy as a method of treating patients with Borderline Personality Disorder is that it focuses specifically on the

[3] An affect is an evaluative dimension of attitude (Clarkin, et al. 2005)

underlying cognitive causes behind a patients diagnosis with BPD proposed by the psychodynamic approach, and uses specific techniques and strategies to address these causes and help remedy them. Through the method of transference the therapist is able to identify the reasons behind the separations of the patients internal object relations and then constructively work with the patient to become aware of these causes, and through the process of therapy work to re-establish connections between these object relations allowing the patient to live a more fulfilled and integrated life (Levy, Clarkin, In Press). Limitations of TFP however, question the reliability of the treatment as a method of treating patients with Borderline Personality Disorder. These limitations are generally associated with the method of transference, because the reactivation of past events through internal object relations can never be assumed to show a correct representation of the past due to the effects of the patient's views changing as a result of retrospective modification of the trauma.[4] "This means that the treatment does not reproduce a specific experience in time but rather an internal construction, the ultimate origin of which cannot be precisely identified." (Clarkin, et al., 2005, p.41). This therefore poses a difficulty for therapists because they may incorrectly interpret the patients internalized object relations therefore making treatment difficult because the therapy is then not focusing specifically on the cause of the BPD in the patient in order to then treat it. However, those in favour of TFP disregard the relevance of validity in the recount of past events, since it is essentially an internal representation of the patient's current physical reality and therefore

[4] Retrospective modification of the trauma is where the events of a past trauma are modified in the process of recounting the events in retrospect to how the individual perceives them as a result of transformational processes, progression, regression and fixation, affecting the individual's memory of the event. (Clarkin, et al., 2005)

still represents a psychic structure which is the main focus of modification in treatment (Clarkin, et al. 2005).

Dialectical Behaviour Therapy

Originating as a result of the dissatisfaction with Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), developed by Marsha Linehan, Ph.D. (1993), is essentially a skill-based therapy which focuses on teaching patients effective and practical techniques to cope with their disorder. With cognitive and behavioural underpinnings, DBT uses both the change strategies used in CBT along with acceptance strategies and dialectical strategies, to help patients to find a healthy median between what they can change and what they must accept about themselves (Linehan, Schmidt Dimeff, et al., 1999).

Dialectical Behaviour Therapy builds from the biosocial theory of diagnoses of Borderline Personality Disorder. This theory postulates that BPD is a consequence of early childhood experiences, and is the result of an emotionally vulnerable individual being brought up in an invalidating environment. An emotional vulnerable individual is classified as someone who encompasses a low threshold for emotional stimulation, whose automatic nervous system overreacts abnormally to relatively low levels of stress resulting in high arousal, and whose emotional experiences last for long periods of time with the individual taking longer than normal to return to baseline after the stress is removed. An invalidating environment is often in relation to significant others within the individual's life during childhood, most commonly parents, who fail to treat the

individual in a manner that conveys attention, respect and understanding, instead often disqualifying the individual's experiences and emotional responses. This is often a result of mismatched relationships between the child and caregiver. (Linehan, Dimeff, 2001). As a result of the individual being in this environment, they are often unable to understand and deal with their feelings and find it difficult to trust their own responses to situations since no acknowledgment is made to them by their surrounding environment. Their behaviour may switch between periods of emotional introversion, in order to appear 'normal' and be accepted by their environment, and periods of extreme emotional outbursts, in order to seek attention and have their feelings acknowledged. The response of others towards these erratic behaviour patterns can result in reinforcement causing the behaviours to become persistent. As a consequence of this, individuals suffering BPD do not learn to control their emotions correctly and instead often resort to high-risk methods of coping which can result in both mental and physical harm (Swales, Heard, Williams, 2000).

Dialectic Behaviour Therapy encompasses both "behavioural change oriented strategies with concepts and techniques associated with acceptance and tolerance." (Lynch, Ph.D., Robins, Ph.D., 1997, Vol 8/Iss 1). The structure of the therapy includes three main modes of treatment, group sessions, individual therapy, and phone coaching. The focus of each of these modes of treatment varies, however each shares a common goal of helping the patient to find a balance between changing their unwanted behaviours and accepting the things about themselves that the are unable to change (Linehan, Dimeff, 2001).

Group sessions occur once a week and are focused around teaching individuals suffering with BPD, behavioural skills to improve their quality of life. The skills learned in group sessions are categorised under four modules. The first module consists of Core Mindfulness Skills. These skills teach individuals to become aware of events, emotions and behaviours and how to deal with them in a focused and non-judgemental manner. The second set of skills learned are Interpersonal Effectiveness Skills which teach the patient how to effectively communicate their needs and deal with interpersonal conflict. Emotional Regulation Skills are the third set of skills and are focused around learning to understand ones emotions and how to reduce emotional vulnerability in order to decrease emotional suffering. The final module is Distress Tolerance Skills which are intended to help individuals tolerate and endure crisis, and to accept life for what it is (Lynch, Ph.D., Robins, Ph.D., 1997).

Individual Therapy is the second mode of treatment and it occurs once a week with a one-on-one session between the patient and the therapist. In these sessions the patient is able to convey issues and difficulties that came up for them during the week that they are concerned about which they record on treatment diary cards. In order to deal with these issues and difficulties a treatment target hierarchy is followed which focuses on the most important issues, such as self-injurious and suicidal behaviours, followed by therapy interfering behaviours, then quality of life issues, and finally, once each of these issues is addressed the therapist works with the patient to apply the skills that the patient learns in group sessions to help improve the overall quality of life for the patient (Lynch, Ph.D., Robins, Ph.D., 1997).

The final mode of treatment, phone coaching, is not as consistent and structured as the other two modes; however it is still an essential part in a patient's treatment. The idea behind phone coaching is that before an individual performs physical harm on themselves, they ring their personal therapist who then coaches them through the situation using safer alternative dealing strategies (Linehan, Schmidt Dimeff, et al., 1999)

DBT therapists also get together in consultation groups to receive DBT from each other. This is in order for them to remain in the frame of mind that is needed to perform DBT correctly due to the strain that it puts on therapists as a result of the nature of dealing with BPD patients. These regular therapist consultation groups are another essential part in maintaining that DBT remains as an effective treatment for BPD patients (Linehan, Dimeff, 2001).

The strengths of DBT as a method of treatment for BPD patients is its strong emphasize on helping the patient find a balance between change and acceptance, addressing some of the problems with alternate treatments such as Cognitive Behavioural Therapy. Each of the three modes of therapy allows the patient to work through the key targets for each stage of treatment, and with the main focus on skills learning DBT addresses the direct cause of BPD as defined by the biosocial theory, that patients were unable to develop essential development and coping skills during childhood (Swales, Heard, Williams, 2000).

However, DBT also faces limitations with its methodology. Firstly, problems are faced with effective training of therapists in the techniques of DBT because of the

intensive training needed to effectively master the methods (Sharma et al., 2007). Secondly, questions have arisen about the how long the gains of one year of DBT actually last, after the outcomes of patients who underwent DBT and those in a control group were similar a year after the treatment had ceased (Linehan et al, 1993). The contribution of individual elements of DBT to the overall treatment outcome is also still unclear, with the addition of a skill training group to a non-dialectic individual therapy showing no obvious benefit (Linehan, 1993*a*). The limited focus of DBT on the acting-in of BPD patients (suicidal and self harming behaviours) whilst neglecting acting-out component of BPD patients seems to also limit its ability to effectively treat all BPD patients who suffer from different severities of the disorder and different symptoms. However regardless of these limitations Dialectical Behaviour Therapy proves to be a clear alternative for traditional treatments, which, if as effective in its outcomes as it proposes to be, should be strongly considered by patients and their families when looking for an effective means of treatment.

Evaluation

Transference Focused Psychotherapy and Dialectical Behaviour Therapy, whilst different in their methods, provide adequate alternatives to traditional treatments of the Borderline Personality Disorder, such as medication and cognitive behavioural therapy. Due to each of these theories of therapy being developed specifically to focus on treating sufferers of BPD, the methods developed in each have been far superior in dealing with the erratic and unpredictable nature of those suffering with Borderline Personality Disorder than other theories which have merely been applied to BPD from other focuses.

Both TFP and DBT establish their methods around treating patients in a way that addresses the causes behind the patient getting BPD in the first place, which are outlined in the diagnosis theories that each treatment accepts and both are similar, in that they maintain that BPD is a result of individuals not fully developing certain skills during childhood due to ineffective relationships with their caregivers. However, this seems to be one of the limited similarities between the two diagnoses', with the causes behind the patients development of BPD varying between methods. Each of these theories has a strong argument to support its views on the causes of BPD and both have a strong following by psychologists in the field that the theory comes from. The methods of each therapy obviously differ from each other in their focus due to the diagnosis theories that they stem from and therefore the symptoms that they are focused on treating. Therefore it can make it difficult to asses the effectiveness of one form of treatment over another, although each both have their strengths and weaknesses.

Similarities between the two methods of treatment are limited, however some do exist. One of these similarities which can also be considered a strength of each method is the structured and precise style of therapy. Whilst both allow for variation and spontaneity in their sessions, the basic structure and outline of the targets of therapy are clear. With transference focused psychotherapy this is seen in the form of the treatment contract which outlines the boundaries of the treatment (Gray, 1994). In dialectical behavioural therapy this is seen in the entire layout of therapy, including the four stages of therapy and the treatment target hierarchy (Linehan, Dimeff, 2001).

Another similarity between the two methods which is also another strength of both is the role of the therapist as more than just the typical, stone cold type of traditional

therapy treatments. In both therapies the role of the therapist is key to the success of the therapy. In TFP this is seen in the nature of the therapist's role as an externalized version of the patients internalized object relations which in itself requires a lot of personal strength and control whilst remaining professional in the analysis of the patient (Koenigsberg, Kernberg, Stone, et al., 2000). In DBT the role of the therapist is also very involved with them not only working one-on-one with the patient in personal therapy sessions but also co-ordinating all those involved in the patients therapy, as well as phone coaching patients at any time that they ring in distress to avert them from hurting themselves (Linehan, Dimeff, 2001). It is clear that both therapies require the therapist to be highly trained and dedicated to their roles as therapist, especially considering the difficult nature of dealing with BPD patients.

One of the main differences in the two therapies is the focus on the methods of treatment. Whilst TFP focuses more on first understanding the individual causes and underlying object relations of each individual before then helping the patient to acknowledge the separation between these and therefore work to re-connect them and improve the patient's health (Clarkin, Yeomans, Kernberg, 2005). On the other hand, DBT focuses more on a generalised diagnosis for patients, which they then work to fix through the progression through stages, each with separate targets, and the development of skills not learn during childhood (Linehan, Schmidt, Dimeff, et al., 1999).

One of the main limitations of both of these treatments is the lack of empirical evidence to support their effectiveness of treating BPD. Although some researchers conducted studies and trials for each, since they are still quite newly developed the long

term effectiveness of either has been determined (Giesen-Bloo, et al. 2005; Binks, et al. 2006).

It is clear that both of these methods each face strengths and limitations. Whilst they are each very different in their focus and methods of treatment they also share many similarities. However, as a result of the complete different diagnosis theory that each is based on and therefore the different methods and goals for treatment and with the lack of empirical evidence to show the long term effectiveness of both, it is almost impossible to compare them and come up with a clear winner in its effectiveness of treating BPD.

Conclusion

Both the Transference Focused Psychotherapy and Dialectical Behaviour Therapy methods of treatment for Borderline Personality Disorder provide efficient and adequate alternatives for traditional methods of treatment. With TFP's psychodynamic roots, it specifically focuses on helping the individual re-connect separated idealized and negative representations of ones self and others through the process of transference in therapy sessions to help the patient to learn to function properly (Clarkin, Yeomans, Kernberg, 2005). DBT on the other hand extends its treatment from the biosocial diagnosis theory, and it focuses on the teaching of important skills in four different areas, to help the patient to learn proper skill functioning that they did not pick up during childhood (Linehan, Schmidt, Dimeff, et al., 1999).

Both methods have proven to have limitations in their methodologies which have questioned their reliability as effective methods of treatment for BPD patients, and due to a lack of empirical evidence existing to support the long term effectiveness of either

method, it makes it hard to know the outcomes of long term breaks after therapy (Giesen-Bloo, et al. 2005; Binks, et al. 2006)

Interestingly amongst the differences between the two methods, there are some striking similarities which are also seen as some of the main strengths of each therapy suggesting that they are essential components in any effective treatment of BPD. These similarities include the origins of BPD, the structure of both methods and the important role of the therapist in the effectiveness of both therapies. However, these similarities are not enough to make the comparison of the two methods easy. Since the diagnosis theories that each method of therapy builds on are from two different psychological approaches, the focus of each therapy is so different because it is centred on specifically treating the symptoms of BPD by addressing the causes outlined by the diagnosis theory it is built upon. Therefore it seems that these two alternative theories cannot be compared in their effectiveness of treating BPD because each focuses on doing so in a different way. However, it is clear, that both Transference Focused Psychotherapy and Dialectical Behaviour Therapy, whilst different in their methods, each effectively addresses their same focus, which is the effective treatment of Borderline Personality Disorder.

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