Eric A. Fertuck, Ph.D.
The City College and Graduate Center of the City University of New York

Training Curriculum Transference-Focused Psychotherapy (TFP)

Personality Disorders Institute-Weill Cornell Medical College
www.borderlinedisorders.com

Columbia Center for Psychoanalysis Borderline Personality Disorder Resource Center
www.BPDResourceCenter.org

International Society of Transference-Focused Psychotherapy (ISTFP)
www.istfp.org

Frank Yeomans, M.D., Ph.D., Otto Kernberg, M.D.
John Clarkin, Ph.D., Eve Caligor, M.D.
Diana Diamond, Ph.D, Ken Levy, PhD, Stephan Doering M.D.
Educational Objectives

• Achieve a better understanding of personality and personality disorders:
  – Personality structure and identity
  – Phenomenology and functioning

• Understand how appreciation of personality structure and the crucial role of identity help us provide better patient care... help us move beyond the symptom
How do we consider personality?
Two Dominant Approaches to Personality

- **Trait theory approach**: goal is to characterize people in terms of a comprehensive but small set of stable behavioral dispositions.

- **Processing approach**: personality as a system of mediating units (expectancies, goals, motives) and psychological processes (cognitive-affective units) that interact with the situation.

Mischel & Shoda, 1999
Personality

- It is a permanent organization of how one perceives and reacts to stimuli – it involves how one perceive self and other
- Assessment of and adaptation to the environment

General Descriptive Features of Personality Disorders

PD’s in general are distortions of normal personality characterized by:

- Rigidity or loss of flexibility of behavior patterns, resulting in poor adaptation
- Inhibition of normal behaviors
- Exaggeration of certain behaviors
- Chaotic alternation between inhibitory and impulsive behavior patterns
- Vicious circles develop: abnormal behaviors elicit abnormal responses
Consequences of Personality Disorders:

- A reduction in the capacity to adapt to the psychosocial environment and to satisfy internal psychological needs (e.g., self-affirmation, sexuality, and dependency).

- In turn, personality disorders tend to be re-enforced by the pathological responses that patients elicit in their environment.
We Use the Structural Features of Personality to Develop a Diagnostic System for Personality Disorders

• The focus is on key psychological processes ("structures") that process information and affects, thus influencing behavior

• This focus leads to the concepts of "Structural diagnosis" and "level of personality organization"
The Structural Features/Variables at the Center of the Diagnostic System

- **Identity - Sense of self and sense of others**
- **Defensive Operations - Customary ways of coping with external stress and internal conflict**
- **Reality Testing - Appreciation of conventional notions of reality**
- **Quality of Object Relations - Understanding of the nature of interpersonal relations**
- **Moral Functioning - ideals and values, expressed in ethical, or unethical behavior**
Structural Diagnosis and Levels of Personality Organization

- These structural features of personality determine the severity of the personality pathology and the level of functioning; more specifically they determine the ability to deal with life tasks and with related instinctual impulses (aggression, love, sexuality, and interdependence).

- Treatments that effect change at the level of psychological structures result in change at the symptom level and quality of life.
The Structural Classification of Personality Disorders by Levels of Severity

Normal personality: Consolidated identity, adaptive defenses, stable RT, flexible moral functioning, full object relations including capacity for intimacy and healthy dependency

Neurotic level of personality organization: Rigidity of defenses, inflexible morality, +/- problems with intimacy

Borderline level of personality organization: More fully described below
  - High level borderline: dependent, needy, depressive
  - Low level borderline: hostile, aggressive

Psychotic level of functioning (loss of reality testing)
Relationship Between DSM-5 Personality Disorders and Structural Diagnosis

Borderline Personality Disorder
Developmental Psychology and Object Relations Theory
Theoretical Underpinnings of TFP: Object Relations Theory
Understanding Split Psychological Structure as the basis for Identity Diffusion

The Object Relations Dyad

Self <-> Other
Affects
Early repeated experiences in relationships as basic modules of experience of self and objects (Clarkin, 2003, according to Kernberg)
S1 = abused victim
O1 = sadistic aggressor
a1 = fear

S2 = powerful, controlling father
O2 = weak, submissive child
a2 = rage

S3 = dependent child
O3 = ideal caring mother
a3 = love

Split Personality Organization
Paranoid-Schizoid Position
Normal Personality Organization
Achieved by working through the Depressive Position
Neurobiology and Object Relations Theory

• The primitive mental mechanism of splitting and its derivatives are based on biological developments of separate positive and negative affective systems.

• There is the potential of integrating these at a cortical level of processing.

• Intrapsychic structures reflect a second level of organization, based upon the primary neurobiological one.

• The integration of self and of object representations depends on the predominance of positive relationships, and is threatened by the predominance of ones charged with negative affects.
“I’m neither a good cop nor a bad cop, Jerome. Like yourself, I’m a complex amalgam of positive and negative personality traits that emerge or not, depending on circumstances.”
Diagnosis in TFP
A complete diagnosis covers

- Syndromal diagnosis according to DSM-5
- Structural diagnosis
- Diagnosis of transference patterns (including experiences in previous treatments)
- Biography
Clinical Assessment of Personality Organization

Evaluate:

- Identity
- Object Relations
- Defenses-Coping and Rigidity
- Ethical Functioning
- Aggression
- Reality Testing
The Structural Interview

- Reference: Kernberg: *Severe Personality Disorders*, 1984 – chapters 1 and 2
- “Structural” interview – to assess psychological structure (vs. a structured interview)
- The “Symfora Tapes”
- A more structured version: the STIPO
What is TFP?
What is TFP?

An evidence-based manualized individual outpatient therapy for serious personality disorders that can be adapted to all psychiatric settings.

It combines structure and limit-setting with an exploratory psychodynamic approach to target the split, intrapsychic structure that results in the borderline phenomenology.

It brings about change in psychological structure as well as improvement in symptoms.
How broadly can TFP principles be applied?

Transference-Focused Psychotherapy in the General Psychiatry Residency: A Useful and Applicable Model for Residents in Acute Clinical Settings

Erin Zerbo, Shelly Cohen, Wiktoria Bielska, and Eve Caligor

Abstract: Transference-focused psychotherapy (TFP) is a manualized, psychodynamic treatment for severe personality disorders. Training in TFP during residency can provide a readily applicable model for understanding and treating personality pathology in a variety of settings, even for residents who do not obtain additional training in psychodynamic treatments or go on to practice psychotherapy. Although TFP was developed as a long-term outpatient treatment, the authors have found the diagnostic and theoretical framework and the clinical techniques described in the TFP treatment manual to be useful in acute settings, even when the clinician does not have a clearly established relationship with the patient. In the authors’ experience, residents find this model of understanding and working with patients with personality disorders enjoyable to learn and easy to apply.

Hersh et al book

Draijer and Van Zon article
Two Central Aspects of TFP

- With the focus on the interaction between Patient and Therapist, it fosters activation of basic neurobiological systems, involving CNS, intrapsychic, and interpersonal systems.

- The concept that “an affect is, to some degree, the manifestation of an underlying object relation” includes an object relations dimension to the view of BPD as primarily a disorder of emotional dysregulation.
Goals and objectives of TFP

• Phase I: The containment of acting out behaviors and transformation of emotional experience to cognition in the hours

• Phase II: Core of the treatment - the resolution of identity diffusion and the development of a coherent sense of self and others
Who is TFP for and why learn it?

- TFP is for the full range of personality disorders
- The goal of TFP is to go beyond symptom change and effect change in the personality that makes it possible to find satisfaction in work and love.
- Research shows changes in reflective function, attachment status, and coherence of the patient’s narrative as well as symptom change that are unique to TFP
Basic Principles of TFP
Transference and how working with it effects structural change
What is Transference?

- The activation of internal object relations in the relationship with another person.

- These internalized relations with significant others are not literal representations of past relations, but are modified by fantasies and defenses.
Transference in Therapy

Unlike most other people in the patient’s life, the therapist *invites* the transference to unfold... and stays around to explore it and work with it.

Working with object relations that are activated in the immediate moment creates a therapy that is “experience-near” – makes it possible to work with affect and reflection simultaneously.
Change of psychological structure during treatment
(Yeomans et al, 2015)
The Evolution of Treatment

From Splitting to Integration;
From the **projection** of negative motivations to the capacity to **take responsibility** for one’s thoughts, feelings, actions and **integrate** them.
(In older psychoanalytic terminology, to move from the Paranoid-schizoid position to the Depressive position)

How does focusing on the transference facilitate this change?
Consider the Patient’s Dissociated Internal World

S = Self-Representation  
O = Object - Representation  
a = Affect

Examples
S1 = Victim  
O1 = Abuser  
a1 = Fear

S2 = Childish-dependent figure  
O2 = Ideal, giving figure  
a2 = Love

S3 = Powerful figure  
O3 = Weak, Slave-like figure  
a3 = Wrath
In the Transference, this world gets played out between 2 parties

Experience of self ...

...and of therapist

S1, S2, S3, O1, O2, O3

a1, a2, a3
Working with Transference

• Since transference is the activation of internal object relations leads to the activation of affects and conflicts, the basic strategy is to:
  – to tease out these internal relationships,
  – to help the patient
  • Gain and tolerate awareness of these internal relationship representations,
  • Integrate them into a coherent whole, and
  • Generalize the experience in therapy to other relations
Therapist position: To empathically watch with the patient, as if through his /her eyes, to be able to perceive and contain the dyad being experienced.
Victim Persecutor

(Oscillation is usually in behavior, not in consciousness)

Object Relationship Interactions: Oscillation

Self-Rep

Victim

Fear, Suspicion, Hate

Persecutor

Fear, Suspicion, Hate

Victim

Persecutor

Object Rep
Object Relationship Interactions:

**DEFENSE**

Victim

Fear, Suspicion, Hate

Persecutor

Opposites

Cared-for Child

Longing, Love

Perfect Provider
How to apply this theory in practice?

This workshop allows for only a brief introduction to the practice of TFP
The Relationship of Strategies, Tactics and Techniques

STRATEGIES:
Long-Term Objectives

TACTICS:
Tasks for each Session that set the conditions for Techniques

TECHNIQUE:
Consistent interventions that address what happens from Moment-to-Moment
Strategies
The Specific Strategies - I

Strategy 1: Defining the dominant object relation

Step 1: The therapist experiences and tolerates the confusion of the patient’s inner world as it unfolds in the transference

Step 2: The therapist identifies and formulates in his/her mind the object relation that is dominant in the moment

Step 3: The therapist describes and explores this object relation – the actors and/or the action - with the patient
The Specific Strategies - II

**Strategy 2:** Observing and interpreting patient role reversals in the transference

**Strategy 3:** Interpreting the defensive function of the split between idealized and persecutory segments of the patient’s mind. This brings together broad elements of the patient’s contradictory affective experiences and leads to integration of the concept of self and others.
Tactics
Tactics – assuring the conditions for the analytic work and helping the therapist maintain a sense of security
Treatment Tactics - function

• Tactics form the bridge between the strategies of the treatment and the moment-to-moment therapist interventions

• Tactics guide the therapist as s/he strives to implement the techniques in the service of meeting its central objectives:
  – They guide decision-making with regard to where, when, and how to intervene
The Tactics

- **Set the Treatment Contract**
  - Setting the frame of treatment serves multiple functions
- **Maintain the frame and boundaries of treatment to control acting out**
- **Select the focus of attention and intervention**
  - Attend to what is affectively dominant
  - Attend to what is in the transference
  - Attend to the general priorities of treatment
- ** Maintain common perceptions of reality**
- **Analyze both positive and negative transferences**
- **Regulate the intensity of affective involvement**
BEGINNING TREATMENT

Pre-Therapy

Assessment Sessions → Discussion of Dx and Contracting Sessions → Family Session → Therapy

Therapy Begins (or not)

N.B.:
Often a Sense of Urgency

Goal: To move from Acting Out to Transference

A necessary tenet: the patient has at least a modicum of control most of the time

International Society of Transference-Focused Psychotherapy - ISTFP
Functions of the Contract - 1

1. Protect the patient, the therapist, and the therapy
2. Establish mutual understanding of problem and define the reality of the relation - Define patient and therapist responsibilities
3. This sets the stage for interpreting the meaning of deviations from the contract
4. Minimize Secondary Gain
5. Protect the therapist’s ability to think clearly
Functions of the Contract - 2

6. Provide a safe place for the patient’s dynamics to unfold = contain the patient’s affects

7. Provide an organizing therapeutic frame that permits therapy to become an anchor in the patient’s life

8. Begin to define patient’s choices = begin to clarify elements of identity
Standard Content of the Contract: Patient Responsibilities

− Attendance
− Participation in the therapy process:
  • the therapist emphasizes the role of the free association as the essential means of gaining access to the core levels of personality structure.
  • The “pure” free association of psychoanalysis is slightly modified to “Without censoring, to report all thoughts and feelings related to the problems that brought you to therapy.”
− Paying the fee
Standard Content of the Contract: Therapist Responsibilities

– To offer and attend to a regular schedule
– To contain the intense affects that arise
– Participation in the therapy process: “To listen and, when you get to the limit of your awareness, to help you get beyond it. It is different from an ordinary dialogue. I may not always have something to say, or I may talk a lot.”
– To clarify the limits of the therapist’s involvement (if needed)
Treatment Contracting Process

- It is a verbal, not written, agreement
- Therapist presents a part of the contract
- Patient responds to those conditions of treatment
- Therapist pursues elaboration of patient’s response
- Consensus -- or not
Examples of Resistances/
Threats to the Treatment that would Require Parameters

- Suicidal and self-destructive behaviors
- Homicidal impulses or actions, including threatening the therapist
- Lying or withholding of information
- Substance dependence
- Eating disorder
- Poor attendance
- Excessive phone calls or other intrusions into the therapist’s life
- Not paying the fee or arranging not to be able to pay
- Problems created external to the sessions that interfere with therapy
- A chronically passive lifestyle, favoring secondary gain of illness
Combining Therapy with Life Activity

• Therapy needs to be combined with a consistent level of engagement in the world. This:
  – Provides material for the therapy (examples of what provokes anxiety in the patient)
  – Counters secondary gains of illness
  – Helps further delineate dyads as the patient’s internal world encounters external reality

• The specific activity must be geared to the patient’s current capacities
We are not rigid in our approach: we assume that the patient’s character pathology will lead to breaches of the contract agreement.

We explore the meaning of the breaches

If this does not lead to change over time, we would question the appropriateness of the therapy.
Once the Contract has been agreed upon...

- There is typically a decrease in acting out after the first few months of therapy: life settles down while dynamics get focused in the therapy.
- There is an increasing awareness of the importance of the therapist for the patient, and defenses against this (attachment themes); increase in **affect intensity** in sessions.
The Tactics beyond the Contract

• **Set Contract**
  – To protect the survival of patient, therapist and treatment
  – To eliminate secondary gain of illness
• **Maintain the frame and boundaries of treatment to control acting out and elicit transference**
• **Select the focus of attention and intervention**
  – Attend to what is affectively dominant
  – Attend to what is in the transference
  – Attend to the general priorities of treatment
• **Address “incompatible realities”**
• **Analyze both positive and negative transferences**
• **Regulate the intensity of affective involvement**
Tactics after the contract

Select the focus of attention and intervention: when, why, and how to intervene

- First – follow what is affectively dominant
- Then – follow the hierarchy of priority themes
Techniques
Techniques

The techniques of TFP are the 4 basic techniques of psychoanalysis, modified according to the needs of the patient population.

These 4 techniques are found, with varying emphasis, in psychoanalysis and all forms of psychoanalytic therapy
The Techniques

• Conducting transference analysis (systematic analysis of distortions in the relationship)

• Managing technical neutrality (attitude of concerned objectivity; not drawn into patient’s problems)

• Utilizing countertransference awareness

• The interpretive process:
  – Consists of clarifying, confronting, and interpreting
  – Is a means of enhancing mentalization
The Techniques must be applied with attention to the 3 Channels of Communication

1 – the patient’s verbal communication
2 – the patient’s non-verbal communication
3 – the therapist’s countertransference

Channels 2 and 3 are often the most important channels in the early phase of therapy with borderline patients
Techniques: Consistent Transference Analysis

- On-going analysis of distortions of a “normal” relationship in the treatment setting (“How would a ‘normal’ person react in this situation?”)
- The **reality** of the therapeutic relation is defined in the contract
- Link distortions explored in therapy to similar distortions in the patient’s relations outside of the therapy
Technical Neutrality

- Neutrality means maintaining the position of an observer in relation to the patient and his difficulties/conflicts.
- When working from a position of technical neutrality the therapist is aligned with the patient’s “observing ego”.
Aggressive impulse

Harsh Superego
Precursors

The position of the therapist and patient’s observing ego

External reality

Libidinal impulse
Technical Neutrality

- Technical neutrality refers to the manner in which the therapist frames his interventions.
- The therapist is not neutral in his attitude towards the patient—neutrality does not imply indifference.
- The therapist is not neutral in his internal reactions to the patient—neutrality does not imply emotional distance.
Technical Neutrality
Clinical Example

• Support observing ego
• Point out the division within the patient
• Describe the two sides of the division without siding with one or the other
Techniques: Countertransference in TFP

When evaluating countertransference, consider the therapist’s total emotional reaction to the patient.
Use of Countertransference in TFP

- The therapist uses his/her countertransference as a source of information about the patient’s internal world but does not generally communicate it to the patient (examples)
- The therapist is honest if the patient notices a reaction in him/her
- The therapist is alert to possible enactments and acting out
Complementary Identifications in the Countertransference

- A complementary countertransference involves experiencing a part of the patient that is dissociated from his/her awareness.
- These predominate in the treatment of patients with borderline personality disorder.
- They reflect the impact of projective identification on the clinical process.
The Interplay of Countertransference and Technical Neutrality

- Countertransference is most common cause of unnecessary deviations from neutrality
- It is only from a position of neutrality that therapist can reflect upon and metabolize countertransferences to deepen her understanding of patient
Transference Interpretation Process

• Conceptualized as a series of interventions that build on one another
  – Clarification
  – Confrontation (bid for reflection)
  – Interpretation per se
Interpretation per se

• A hypothesis about unconscious determinants of present experience
• Interpretations address and attempt to resolve psychological conflicts
• Interpretations attempt to increase awareness of the impact of unconscious material on the patient’s thoughts, affects, and behaviors
Interpretation first spells out the nature of the dominant object relation and the patient’s difficulty identifying with both poles of that dyad.

Interpretation then addresses the defensive split between persecutory dyads and idealized dyads. The dyad “on the surface” can change rapidly from one moment to another.
Typical evolution of therapy I

- The patient tests/challenges the contract
- Early emphasis on nonverbal and counter-transference channels of communication
- Decrease in acting out: life settles down while dynamics get focused in the therapy
- Increasing awareness of the importance of the therapist for the patient, and defenses against this (attachment themes); increase in affect intensity in sessions
- Alternation between persecutory and idealized transference – the ideal may be erotic
Typical evolution of therapy II

As therapy advances to the midphase:

• Interpretation of defenses against integration
• A cycle ("looping") where the problematic dynamics reappear, but in a more contained and limited way
• There is evidence of integration, initially tentative and subject to frequent regressions to splitting
• Practical problems arise stemming from earlier life choices that no longer "fit" well
Preview of TFP for Narcissistic Personality Disorder (NPD)

Slides by Eve Caligor, M.D.
Diana Diamond, Ph.D.
Otto Kernberg, M.D.
Barry Stern, Ph.D.
Frank Yeomans, M.D., Ph.D.
NPD Structural Organization: the Pathological Grandiose Self

- In contrast to BPD, NPD has a facsimile of identity integration
- This “Grandiose self” distinguishes NPD from other Personality Disorders
- It is a compensatory self structure overlaying a split self
- It provides some stability of self functioning – but at a cost
In contrast to normal identity, the grandiose self is a defensive structure. It is superficial and distorted, rigid and brittle. It requires constant external support and is vulnerable to abrupt discontinuity in response to environmental stressors. Yet, because of grandiose self, NPD can have more stable sense of self and more stable functioning than other PDs of comparable severity. This has treatment implications.
The Grandiose Self, Reality and Interpersonal Functioning

• The need to maintain the illusion that the self has subsumed all that is ideal, and contains no negative elements, leads to a defensive withdrawal from genuine relationships and, to varying degrees, from reality
• Contact with the real world threatens the person’s psychological equilibrium (defensive structure)
  • FOR THE NARCISSIST, REALITY IS AN AGGRESSION
The Grandiose Self, Reality and Interpersonal Functioning - 2

• It is not just self-esteem but the entire sense of self that is at stake
  The grandiose self defends against anxieties regarding dependency – against having genuine needs and having to rely on others
  It defends against
  ▪ fears of humiliation, inferiority, exploitation,
  ▪ shame and guilt in relation to aggression

• Relationships with others are used to support the grandiose self
The Grandiose Self as a Defensive Structure – the Price to Pay

- The grandiose self provides these protections but at the cost of sacrificing genuine connections with others and to some degree with reality
Principle Subtypes of Narcissism

Grandiose/”Thick-skinned” vs Vulnerable/”Thin-skinned”
Why are Patients with NPD so difficult to treat?

- Tendency to provoke, control, devalue and disengage therapist which alternates with fragile idealization
- Tendency to demand special treatment and privileges
- Grandiose self organizes experience and shapes the transference
- Difficulty in acknowledging and/or verbalizing subjective experience; Patient in a retreat from contact with others—to an illusory world
- Enormous fear of exposure related to feelings of inadequacy, dependency, loss of status and control
Adjustment of TFP Techniques for NPD

• Be more flexible in setting up the contract—and yet more structured if the patient has antisocial traits.

• Address the manifestations of the grandiose self as they emerge in the moment to moment interaction with the therapist particularly, especially the structure of language and obstacles to free association

• Expect a long phase of containing the warded off affects in the countertransference (importance of projective identification)
  – Do not retaliate or dissociate

• Use therapist-centered interpretations in the initial phase of treatment.
Working with the Pathological Grandiose Self

• Initially the grandiose self obscures specific OR dyads; manifestation of patients’ inability to invest in object relation

• The absence of transference is the transference

• Interpretations experienced as impingement, criticism or even attacks
Evolution of NPD Structure as Therapy Advances

- As Grandiose self is analyzed and dismantled, more specific self and object representations appear

- Transferences become more chaotic and complex and patient more lively and related:
  - patient presents as more related with clinging dependency, longing for loving relationship, guilt about consequences of aggression and grandiosity; depression emerges

Exploration of anxieties motivating splitting-based defenses helps promote normal identity integration.
Later Phases of Treatment

- Dissolution of grandiose self leads to distress and apparent chaos that can make the patient look worse before they get better.

- Alternation between investment in object relation and retreat to grandiose self structure.

- As patients confront the consequences of grandiose self; inability to live in reality; loneliness, broken relationships; lack of consistent investment in work.

- Depressive transferences emerge with the awareness of negative aspects of the self; mourning for damage done to self and others; Depressive transferences are painful and agonizing.
As Therapy Progresses...

- The patient gradually experiences a conflict between his refuge in the grandiose self and some awareness of how seeking the ideal has eclipsed the needs of the real self.

- The relationship with the therapist often becomes the representative of the latter; a bridge to a real alternative to the “exquisite” grandiose isolation.

- The therapist must address the pain and sense of humiliation involved in this process with empathy and tact.