THE UNIVERSITY OF ARIZONA
COLLEGE OF MEDICINE TUCSON
Psychiatry

SOUTHWEST PSYCHOANALYTIC SOCIETY

# How does Transference Focused Psychotherapy Work?

**Richard Hersh, MD**

# How Does Transference-Focused (TFP) Psychotherapy Work?

Southwest Summit on Transference-Focused Psychotherapy

Saturday, October 5, 2024

9:10 a.m. to 9:40 a.m.

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Columbia Vagelos College of Physicians and Surgeons

Columbia Center for Psychoanalytic Training and Research

# Goals

- TFP's place in the continuum of treatments that include psychoanalysis and psychoanalytic psychotherapy, and the evidence-based treatments (EBTs) for borderline personality disorder (BPD)
- Key principles of TFP

# Overview

**TFP-A**
for use with
Adolescent Patients

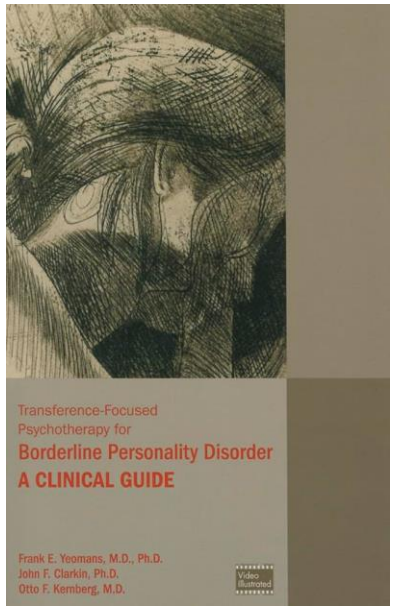
**TFP-N**
for use with patients with
Pathological Narcissism

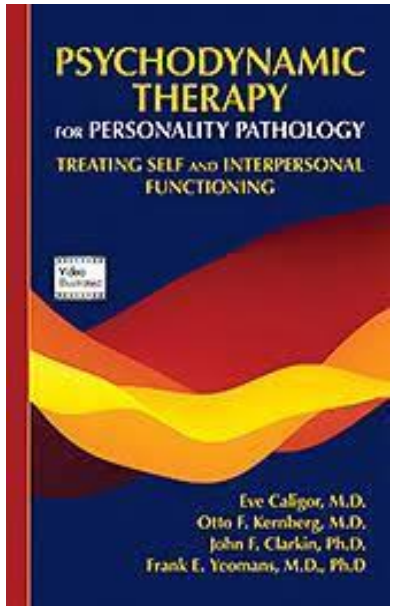
**TFP-E**
for Personality Disorder
Pathology Across the
Continuum

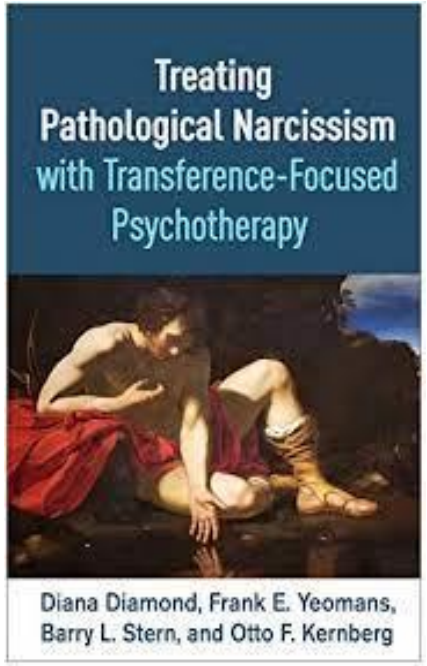
**Applied TFP**
use in General Settings

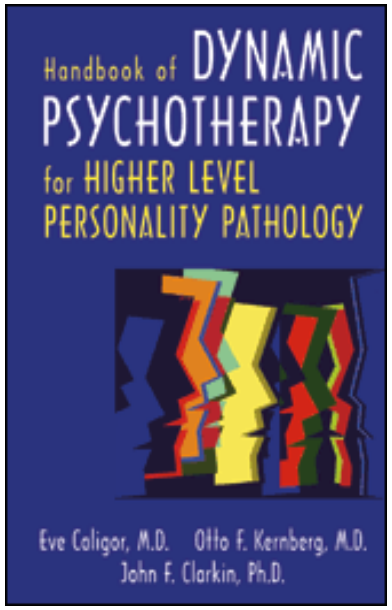
**TFP**
for Borderline Personality Disorder

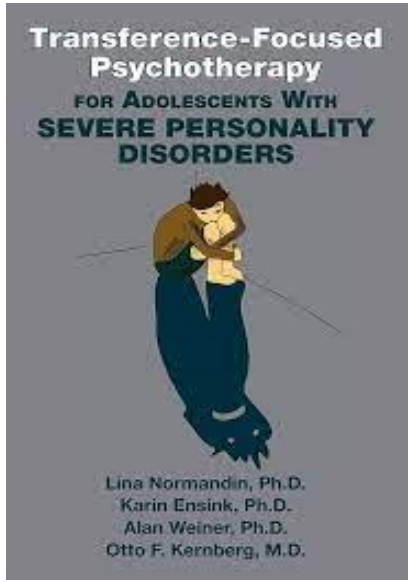
# Key TFP Texts

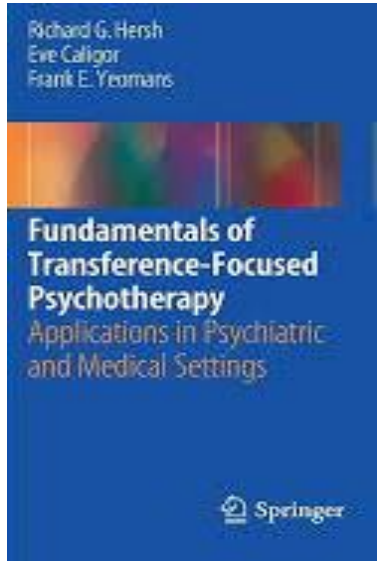


# Overview of Transference-Focused Psychotherapy (TFP)

- Psychoanalytic psychotherapy informed by Object Relations theory
- Reworking of standard psychoanalytic psychotherapy to treat more impaired patients
- Evidence-based for the treatment of patients with borderline personality disorder (BPD)
- Manualized
- Twice-weekly, one to three years
- Anchored by the **structural interview** and the negotiation and maintenance of a **treatment contract**

# Four Critical Elements of Psychoanalysis and Psychoanalytic Psychotherapy (Kernberg, 2016)

- Transference analysis

***More immediate and intense with patients with BPD***

- Interpretation (or offering a hypothesis about unconscious motivation)

***Used more judiciously in TFP and usually following extensive clarification and confrontation***

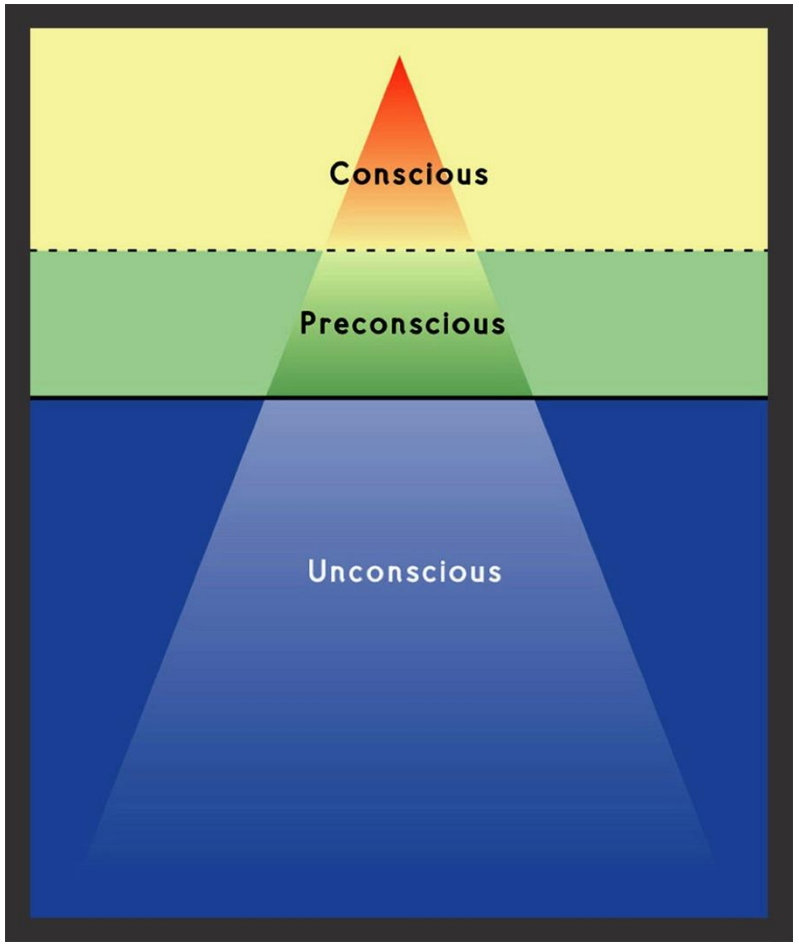
- Monitoring of countertransference

***Likely to be more intense and unambiguous with patients with BPD***

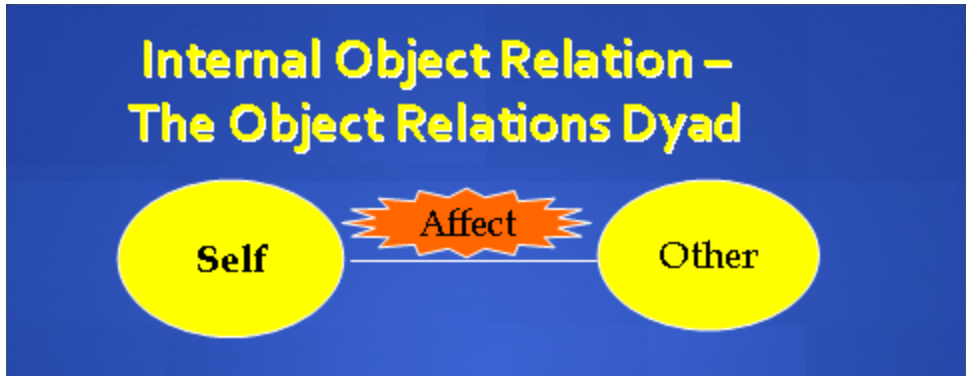
- Technical neutrality

***While maintaining an overarching goal of not endorsing one particular side of a patient's conflict, deviating from technical neutrality may be more often required with patients with impulsivity and prominent denial***

# Premise of Psychoanalytic Exploration

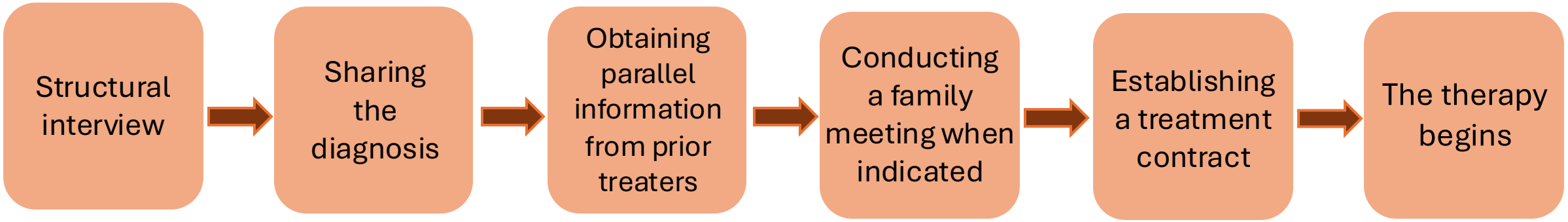


# Object Relations Dyad



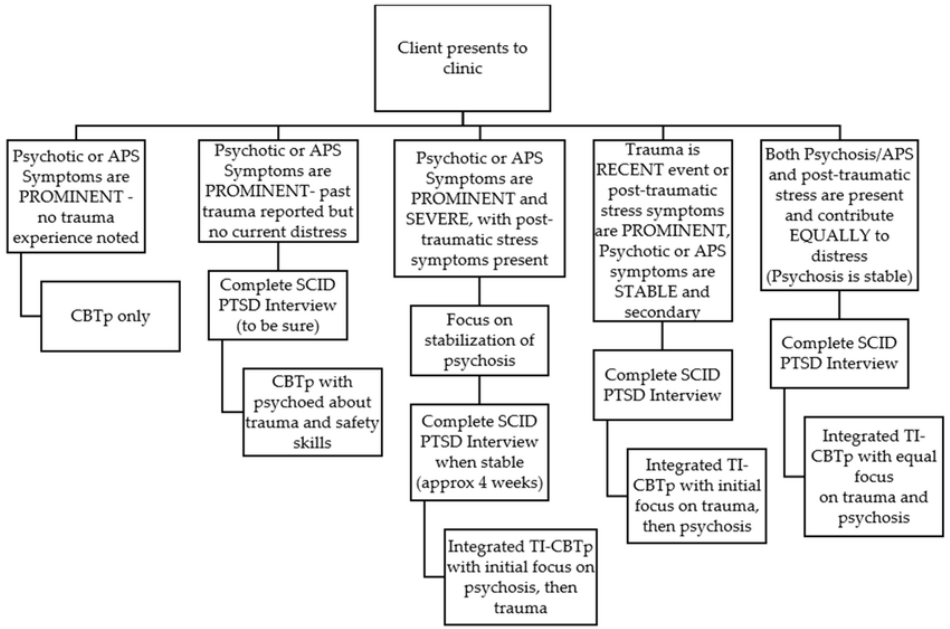
# How I First Thought About TFP

# How TFP Unfolds

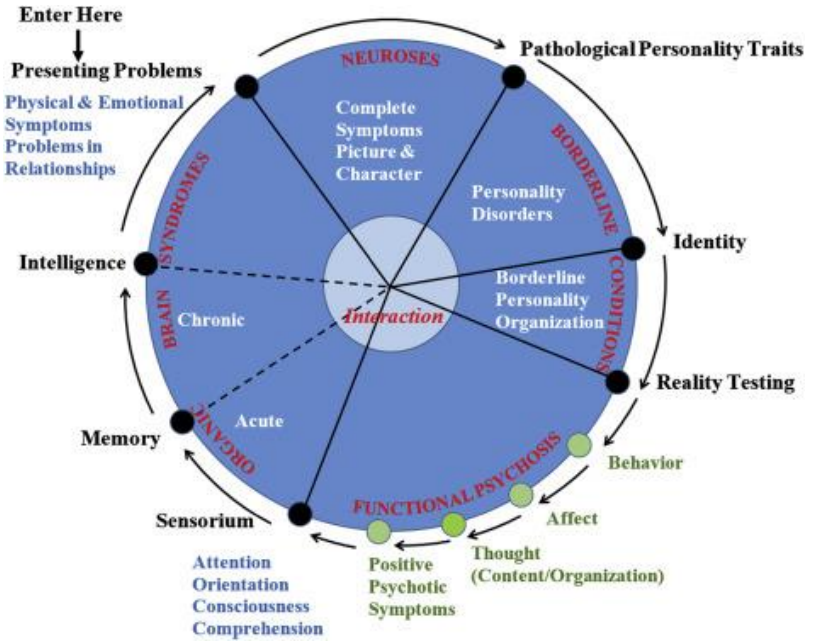


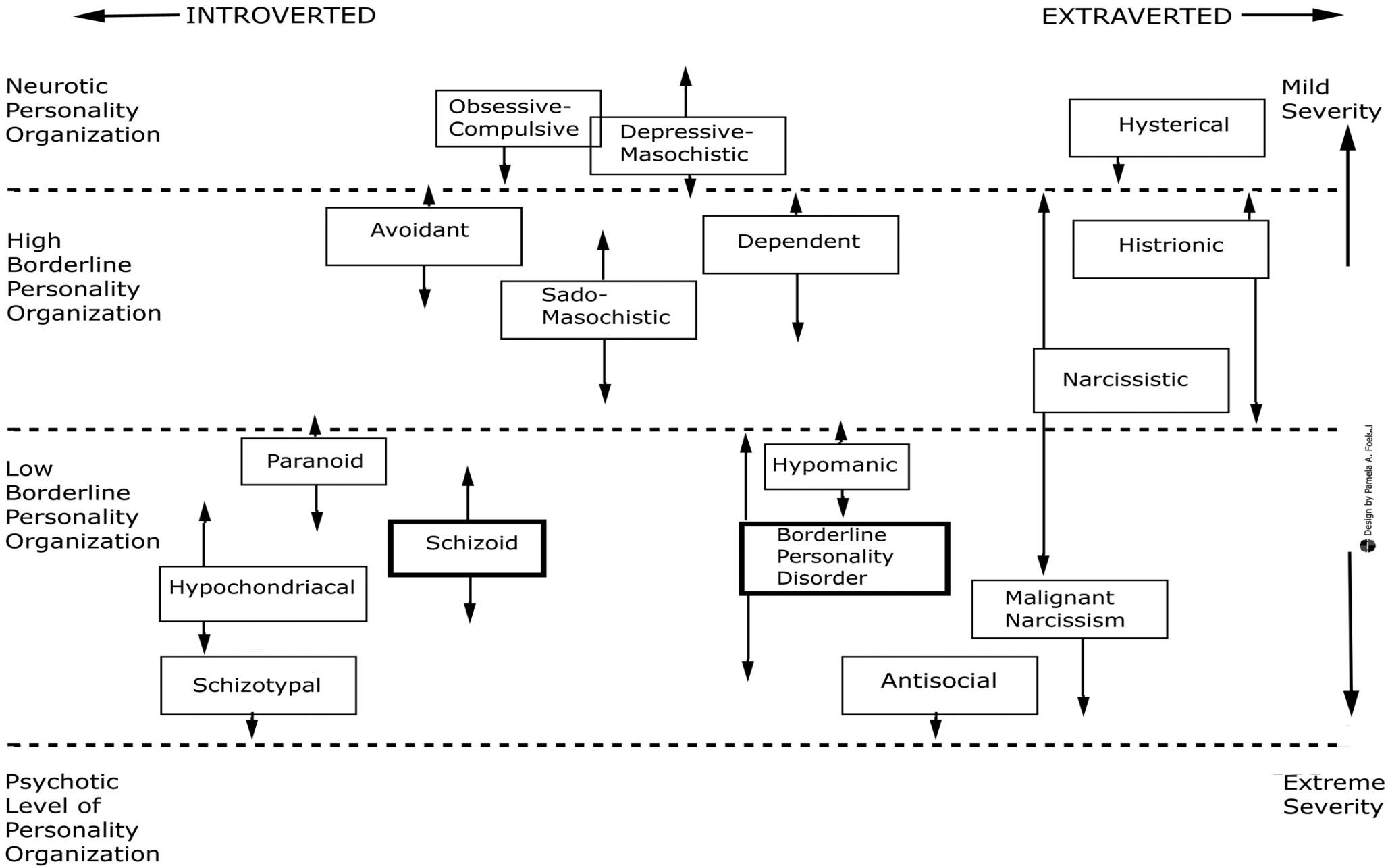
# Structural Interview

## Decision Tree Format




## Structural Interview Format




INTROVERTED
EXTRAVERTED
Neurotic Personality Organization
Mild Severity
Obsessive-Compulsive
Depressive-Masochistic
Hysterical
Avoidant
Dependent
Histrionic
High Borderline Personality Organization
Sado-Masochistic
Narcissistic
Paranoid
Hypomanic
Low Borderline Personality Organization
Schizoid
Borderline Personality Disorder
Hypochondriacal
Malignant Narcissism
Schizotypal
Antisocial
Psychotic Level of Personality Organization
Extreme Severity
Design by Pamela A. Foels, J

# Sharing the Diagnosis

- Expected in all evidence-based treatments for BPD
- Allows for genuine informed consent process
- Helps guide families and patients to evidence-based treatments
- Addresses in advance unrealistic expectations for pharmacotherapy
- Allows clinicians to document honestly and therefore protect themselves

# Familiar Challenges in Making and Sharing a Personality Disorder Diagnosis

- Clinicians may not “believe” in making a diagnosis
- Clinicians may conflate the patient’s chief complaint (what the patient believe she/he may have) and the diagnosis (what the clinician believes the patient has)
- Clinicians may feel that personality disorder diagnoses are stigmatizing
- Clinicians may feel that a personality disorder conveys that the patient is untreatable
- Real life challenges in accessing treatment specific for patients with a personality disorder diagnosis

# Obtaining Parallel Information from Prior Treaters

- Considered standard of care in psychiatry
- Guides the TFP therapist in including specific details in the treatment contract
- May be an early activation of expectable splitting (“That therapist was not helpful; you understand me”)
- May be an early activation of paranoia in the transference (“Why do you need to speak to her; don’t you trust my account?”)

# Conducting a Family Meeting When Indicated

- In TFP we arrange for a family meeting at the outset of treatment in any situation where the patient is fundamentally (financially, emotionally) dependent
- This obviously captures many, maybe even most, patients with these diagnoses

# Goals of the Family Meeting

- Obtain parallel information
- Provide psychoeducation about the disorder
- Explain the treatment including counterintuitive elements (limits on intersession contact; deferring to emergency department and inpatient psychiatry staff about certain clinical decisions)
- Address in advance expectable splitting
- Describe the range of family interventions (psychoeducation, coaching, family therapy)

# Clarifying the Patient's Personal Goals

- The patient's goals will organize the treatment
- Discussion of goals will add a dimension to the assessment and contracting parts of the treatment
- A focus on goals will help to avoid aimless, "intellectualized" treatments
- A focus on goals will help to measure progress in the treatment

# TFP's Focus on Concrete, Measurable Goals

**NOT TFP Goals**

- "I want to be happy"
- "I want to know myself better"
- "I want to have better self-esteem"
- "I want to accept my impaired functioning"

**TFP Goals**

- Work or studies
- Dating/romance/sexual intimacy
- Friendships
- Hobbies and avocations

# Establishing a Treatment Contract

- The treatment contract will be personalized and detailed
- The treatment contract goes beyond standard “office policies”
- Obtaining parallel information from other clinicians should add a dimension to the treatment contracting process
- The treatment contract should facilitate the emergence of negative, or paranoid, transference elements
- The aim in TFP is “grudging acceptance” rather than unambivalent agreement

# Details of the Treatment Contract

- **Meaningful activity requirement (paid work, volunteer work, studies)**
- Scheduling process
- Starting and stopping sessions on time
- Patient hygiene
- Fee and payment schedule
- Cancelation policy
- Intersession contact
- Permission to contact family members
- Permission to contact other treaters.
- Adherence with medical care
- Adherence with laboratory testing
- Adherence with medication
- A requirement for abstinence from substance abuse, if indicated
- A plan for managing eating disorder symptoms, if indicated
- Participation in adjunctive treatments
- The patient's obligation to be honest
- Management of suicidal behavior
- Involvement of psychiatric emergency services
- Involvement of psychiatric inpatient services

# Once the Treatment Begins

- Patients are instructed to speak freely, with particular focus on material that relates to their goals
- The TFP therapist will not organize the session, as is often the case in supportive psychotherapy or cognitive-behavioral therapy.
- This change in format may present a challenge for some patients requiring the therapist to acknowledge the difficulty in “free association” and to explore with the patient the specific barriers that emerge

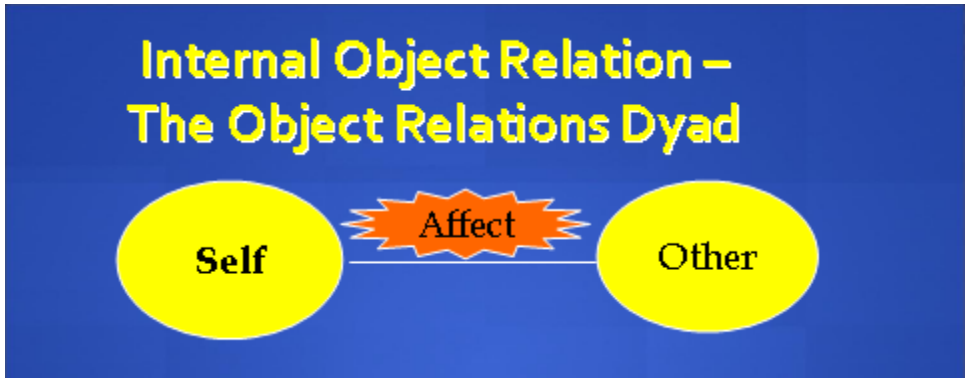
# Monitoring the Three Channels of Communication

- What the patient says
- How the patient behaves (non-verbal communication)
- How the therapist feels (counter-transference)

# Tolerating the Confusion

- Personality disorder patients will not likely present material in an orderly and coherent way
- The therapist may be moved to organize the material for the patient
- In TFP, tolerating the confusion allows the therapist to listen for emerging dominant object relations dyads to emerge

# Identifying Dominant Object Relations Dyads



# Identifying the Dominant Object Relations Dyad (“Naming the Actors”)

- The goal is to put into words the patient’s experience of him/herself, the experience of an important other (including the therapist), and an associated affect
- Ideally this process will contribute to the patient feeling understood
- The goal is not for the therapist to name the dyad with precision, but rather to offer a conjecture that leads to a dialogue

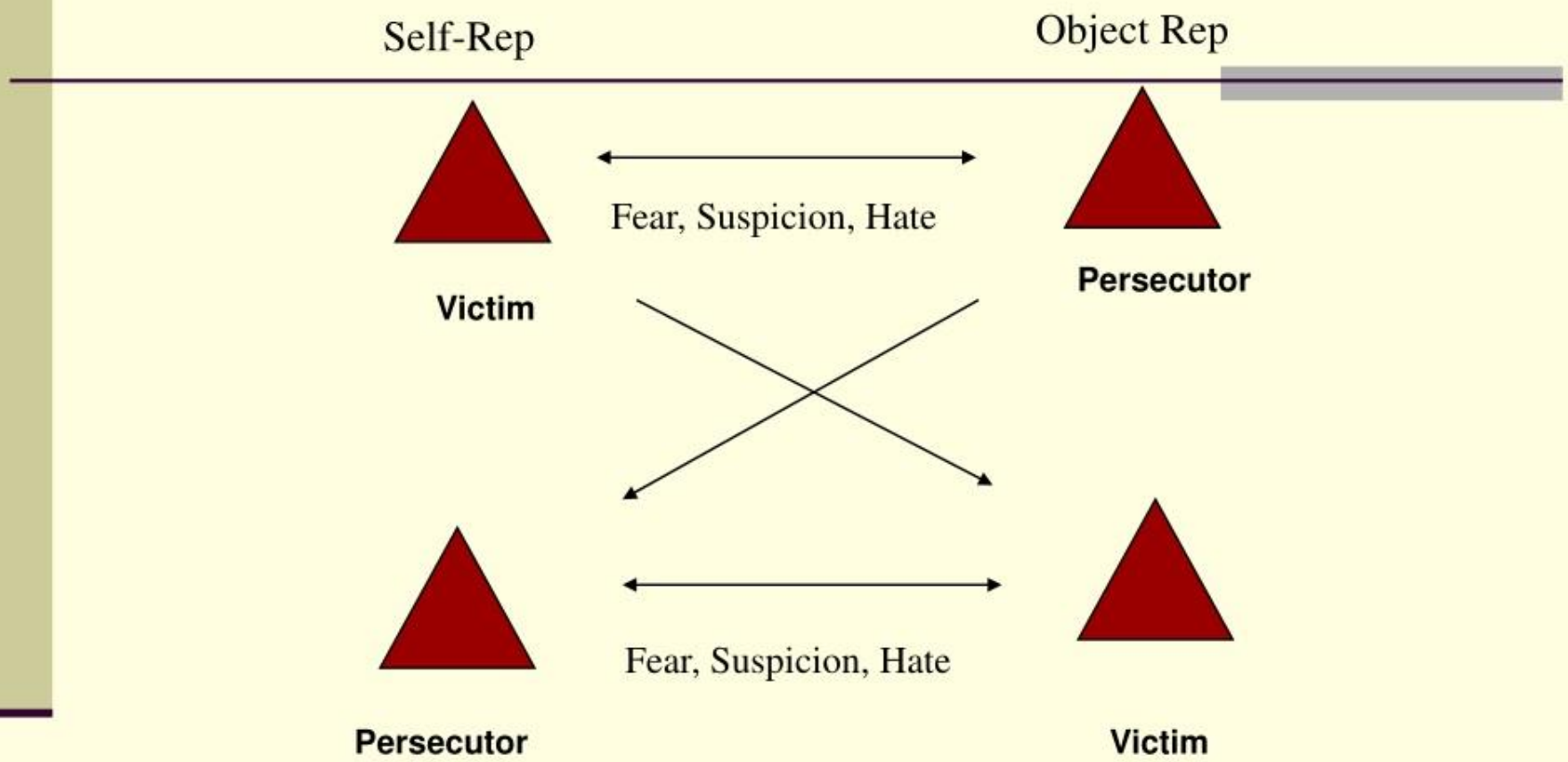
# Using Clarification, Confrontation, and Interpretation

- Clarification: Asking for additional information about anything that is vague, confusing or contradictory
- Confrontation: Bringing to the patient's attention material that is somehow discrepant, including contradictions between spoken and non-verbal communication
- Interpretation: Offering a hypothesis about motivation than may not be entirely in the patient's awareness. In TFP, use of interpretation is judicious, and often delayed.

# Identifying Role Reversals

- Central in the effort to bring into the patient's awareness aspects of aggression that are denied or disavowed
- The aggression can be self- or other-directed
- Requires tact and timing
- Will usually work best when the therapist has established some kind of working alliance with the patient

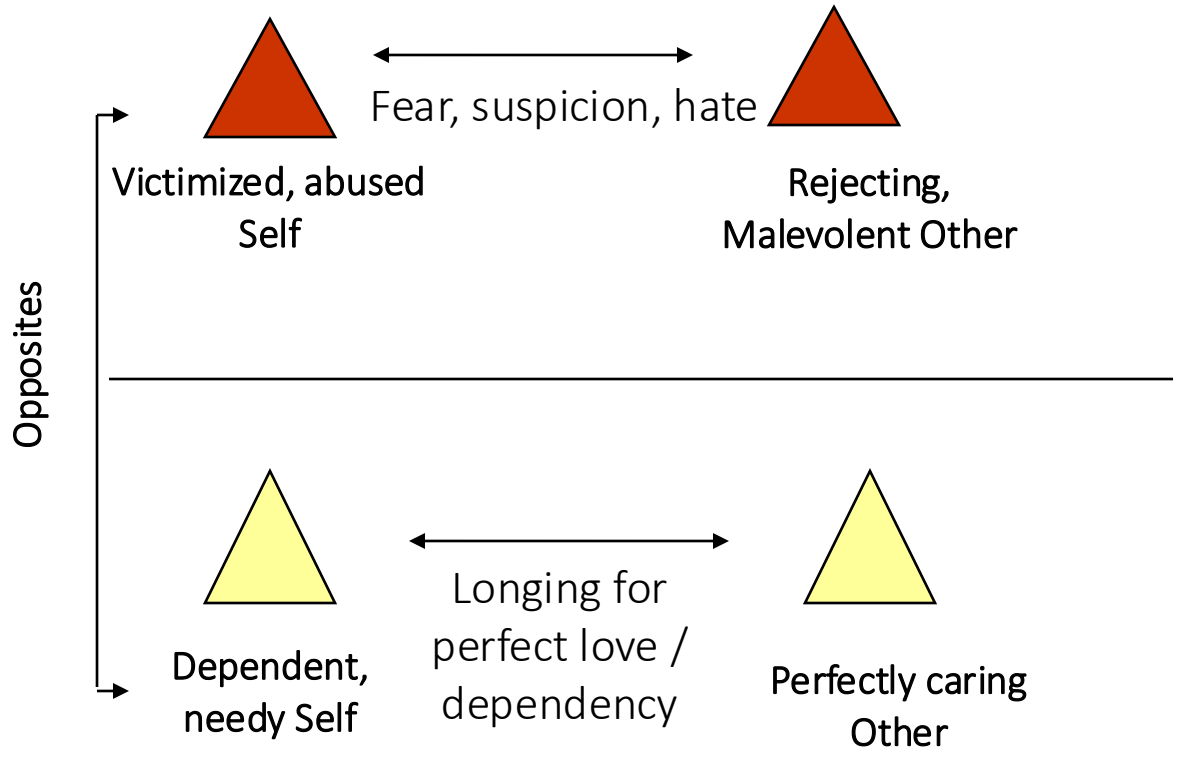
# OBJECT RELATION DYAD INTERACTIONS: OSCILLATION




**(Oscillation is usually in behavior, not in consciousness)**

# Exploring Dyads Defending Against Dyads

- More like an interpretation of unconscious material
- Bringing to the patient's attention something that may be partially, or not at all, in his/her awareness
- A familiar pattern, the patient who is on the surface mistrusting or rejecting, but whose behavior suggests some kind of dependence or vulnerability


Fear, suspicion, hate
Victimized, abused Self
Rejecting, Malevolent Other
Opposites
Dependent, needy Self
Longing for perfect love / dependency
Perfectly caring Other

# Technical Neutrality

- The therapist is not “technically neutral” about the patient’s pursuit of goals
- The therapist does attempt to avoid taking one or another side of the patient’s conflicts
- The therapist will deviate from technical neutrality in any situation that involves the patient’s safety or clearly self-destructive acts
- In general, in TFP the therapist is more likely to intercede that in other exploratory therapies that do not have the same clarity about goals and treatment contract details

# Summary

- TFP straddles the worlds of psychanalysis and psychoanalytic psychotherapy and the evidence-based treatments for BPD
- TFP is a highly structured treatment, with a keen focus on diagnosis, goals, and patient responsibilities
- TFP is not the best fit for every patient; it can be used in sequence with other interventions
- TFP principles are likely useful for clinicians even if they do not offer extended individual psychotherapy

# How I Think About TFP Now

# Thank You For Your Interest!