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Transference-Focused Psychotherapy

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Transference-Focused Psychotherapy (TFP) is a manualized evidence-based treatment for borderline and other severe personality disorders that is based on psychoanalytic object relations theory. The treatment contracting/setting the frame, managing countertransference, and the interpretative process are three critical components of TFP. We provide vignettes to illustrate these techniques and data that support their role in facilitating treatment outcome.

Keywords: transference-focused psychotherapy, interpretation, contracting/frame, countertransference

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Transference-Focused Psychotherapy (TFP) is a manualized evidence-based treatment for borderline and other severe personality disorders. It is based on psychoanalytic concepts and techniques that have been modified and organized into a systematic approach to address severe personality pathology (Clarkin, Yeomans, & Kernberg, 2006). TFP posits that the specific symptoms of borderline personality disorder (BPD) stem from a lack of identity integration, corresponding with a lack of coherence in the individual's experience and understanding of both self and others. This unintegrated psychological state, referred to as "identity diffusion," is associated with reliance on defensive strategies involving dissociation of conscious aspects of experience that are in conflict ("splitting-based defenses") and with a vulnerability to experiencing cognitive distortions in the setting of affect activation. TFP, based in object relations theory, considers psychological structure to be derived from early interactions with caregivers, which are internalized in the course of development. The degree of differentiation and integration of these representations of self and other, along with their affective valence, constitutes "personality organization" (Kernberg, 1984). The lack of an integrated and coherent sense of self and others is accompanied by the denial of aspects of psychological life, largely aspects of experience involving negative and aggressive affects, that are not accepted as part of the self and are perceived as coming from outside. This confusion regarding the origin of certain aspects of affective experience informs the treatment model. Identity diffusion is seen as contributing, along with biological factors, to problems with affect modulation and to the pattern of unstable interpersonal relationships that characterizes BPD. The lack of an integrated self is also seen as leading to the internal distress and emptiness that lie behind patients' desperate attempts to relieve distress through impulsive acting out.

The technical approach of TFP combines contracting and limit-setting with focused exploration of the patient's internal world. The major objectives of the treatment are to facilitate better behavioral control and to increase reflection and affect regulation, with the ultimate goal of promoting identity integration. The process of identity integration, in turn, will correspond with a developing capacity to live a life "worth living," characterized by investment and satisfaction in relationships and life pursuits. The structured frame established by the treatment contract creates a therapeutic environment that facilitates the activation of the patient's distorted internal representations of self and other in the ongoing relationship between patient and therapist. The engaged, interactive, and emotionally attentive stance of the therapist creates a holding environment, conveying that the therapist can both accept and tolerate ("contain") the patient's negative affective states, without denying them or reacting in a retaliatory way. Within this controlled setting, the therapist calls attention to the different representations of self and other enacted in the treatment relationship, and engages the patient in reflecting on their impact on her emotional responses and behavior. Affects are identified, explored, and ultimately linked to the patient's moment-to-moment experience of herself in relation to the therapist. The safety and stability of the therapeutic environment permit the patient to begin to reflect on her experience with another person in the here-and-now. With help from the therapist, the patient becomes aware of the extent to which her perceptions are based on internal representations, in contrast to viewing her experience solely in terms of a more objective, "accurate" depiction of the current interpersonal reality.

During the first year of treatment, TFP focuses on a hierarchy of goals: containing suicidal and self-destructive behaviors, address-

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ing ways the patient might derail the treatment insofar as it challenges the patient's fragile, but dysfunctional, homeostasis, and identifying and exploring the dominant object relational patterns experienced in the here-and-now of the transference relationship. Three central tasks for the therapist are as follows: (1) maintaining the frame of treatment; (2) containing and making use of the therapist's affective responses; and (3) engaging in the steps of the interpretive process (seeking clarification, confronting contradictions/soliciting reflection, and interpreting motivations for maintaining a poorly integrated "split" psychological organization).

Establishing and Maintaining the Treatment Frame

The frame is established before beginning the therapy per se through negotiation of the treatment contract. The process is a collaborative one in which the therapist presents the rationale for elements of the therapy and the patient discusses any concerns she may have. The therapist combines flexibility and openness to discussion with adherence to essential aspects of the treatment. In addition to defining the responsibilities of patient and therapist, the structure provided by the contract protects the therapist's ability to think clearly and reflect, provides a safe place for the patient's dynamics to unfold, and sets the stage for exploring and interpreting the meaning of deviations from the contract. When there are deviations from the frame, referring back to the contract supports the patient's capacity to step outside of the moment and to view her behavior from alternate perspectives. An implicit message in the establishment of the contract is that all feelings can be experienced and reflected on, in contrast to the patient's felt need to manage threatening aspects of affective experience through acting out and projection.

Vignette: Contracting[1]

A young woman who had a history of quickly and abruptly dropping out of treatments began in TFP. As part of the contract, therapist and patient came to the agreement that the patient would consistently attend her sessions and would provide the therapist with 24 hr notice of cancellations.

T: You skipped your last two sessions and didn't call me, as we had agreed you would. I called you, but you did not return my call.

P: (Sounding glib) *No worries. I skipped because I'm feeling fine. I don't need therapy.*

T: Well, it's good to hear you're feeling well. And you're free to choose to be in treatment or not. But I want to remind you that when we decided to work together we agreed that committing to a more consistent longer-term approach was the most likely way for you to meet your treatment goals; we talked about how this therapy is about more than crisis management, and that it would be important for you to try to stick it out even though you may be feeling better at a given moment. (Patient looks away) *I see you're looking away. What are your thoughts about what I have said?*

P: (Sounding conciliatory) *I know, I always do this in therapy.* (Pausing and then abruptly seeming suspicious and accusatory.) *But how do I know I can trust you? Maybe you're just manipulating me to stay because you don't want to lose a patient.*

T: You're raising important questions that you have about me. Let's see if we can't look at them together since I suspect they're related to issues you have in other relations.

Data. Data support the importance of setting an explicit frame and utility of the contracting process. Yeomans and colleagues (Yeomans et al., 1994) in a sample of 36 patients with BPD found that the quality of the therapist's handling of the contract and the patient's response to it correlated with treatment alliance and the length of treatment. Additionally, comparisons between our earlier research on TFP (Smith, Koenigsberg, Yeomans, Clarkin, & Selzer, 1995), which did not stress treatment contracting, and our later studies, after our group further systematized and stressed the importance of the treatment contract, show large decreases in dropout (31%–36% vs. 0%–25%) (Clarkin et al., 2001; Clarkin, Levy, Lenzenweger, & Kernberg, 2007). Finally, it is worth noting that all of the empirically supported treatments for BPD emphasize the importance of establishing an explicit frame. These findings support the view that sensitively and explicitly negotiated treatment contracts may have the desired effects of enhancing the therapeutic alliance, reducing dropouts, and promoting efficacy.

Containing and Making Use of the Therapist's Affective Responses (Countertransference)

An essential task of the TFP therapist is to contain and make use of the often powerful affect states that emerge in the treatment of patients with BPD. Patients' defensive operations can lead to a process in which the patient dissociates and projects unpalatable internal states, often provoking the experience of that state in the therapist. The objective is to maintain an accepting and reflective stance in relation to one's own internal experience, in contrast to resorting to denial or action. In TFP, although the therapist for the most part does not reveal his internal experience directly to the patient, he relies on his experience to gain awareness and understanding of aspects of the patient's internal world that she may currently be keeping out (i.e., splitting off) of her awareness.

Vignette: Containing and Making Use of the Therapist's Affective Responses

On the eve of her therapist's vacation, a patient whose experiences of others were generally organized in relation to expectations of being hurt began a session in a hostile and rejecting state.

P: What are we doing here? This therapy is useless—it isn't helping. I'm no better than I was when I started . . . . Just like all the others, this treatment is a failure.

T: (Realizing he is feeling somewhat warmly toward the patient, and sensing in his own emotional response to the patient a trace of positive contact between them that her verbal communications and manifest attitude belied.) *I understand you're feeling angry but I also wonder if this type of anger and rejection may be your response to beginning to feel attached to someone.*

P: (Sounding less belligerent and more sad) *What do you mean?*

T: Well, I think it's difficult for you to be here today when I'm about to go away. It's hard to feel connected and to feel safe with that feeling when we won't be meeting next week. It probably feels safer to decide there's no connection or value here than to feel a

[1] All vignettes are fictionalized amalgams from our clinical experience representing good exemplars of each technique according to TFP. As they are not verbatim or specific to any particular patient, these vignettes protect confidentiality.

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connection that you doubt. But that position may explain why you always end up alone, and we've agreed that's sad.

Data. There is a small, but robust, body of research suggesting that aspects of the patient's presentation evoke countertransference (CT) reactions in the therapist (Betan, Heim, Conklin, & Westen, 2005; Betan & Westen, 2009; Brody & Farber, 1996; Hayes, Gelso, & Hummel, 2011; Meehan, Levy, & Clarkin, 2010; Rossberg, Karterud, Pedersen, & Friis, 2008, 2010) and that therapists' personal conflicts influence their response to patients' presentation (Henry, Schacht, & Strupp, 1990). Findings in the literature consistently report that patients with BPD or traits associated with BPD evoke the most CT responses, in particular the most anger and the least liking, empathy, and nurturance. Additionally, there is evidence that CT reactions are ubiquitous in psychotherapy, irrespective of theoretical orientation (Prasko et al., 2010). In a recent series of meta-analyses, Hayes and colleagues (Hayes et al., 2011) found that CT reactions were moderately and inversely related to psychotherapy outcome ($r = -0.16$, $p = .002$, k = 10 studies, $N = 769$ participants). They also found a large and significant relation between CT management with outcome ($r = .56$, $p = .000$). Moreover, two independent studies (Latts & Gelso, 1995; Robbins & Jolkovski, 1987) found an interaction between having a theoretical framework and self-awareness, such that high use of theory coupled with high self-awareness resulted in the fewest CT behaviors, whereas theory without self-awareness led to the most CT behaviors.

Engaging in the Interpretive Process

Using the triad of clarification, confrontation, and interpretation, the TFP therapist engages the patient in observing and reflecting on what is going on between them, as well as in other arenas of the patient's life, with the objective of promoting understanding and integration of experiences of self and other.

Clarification involves drawing attention to an area of psychological conflict by tactfully and specifically exploring the patient's conscious experience. In TFP, the objective of clarification is to help the patient elaborate the representations of self and other along with associated affect states dominant in the clinical material, thus promoting mentalization of internal states.

Vignette: Clarification

P: My boyfriend John and I had another fight. He texted to say he had to work late—again! *He didn't get home until 10:00! I can't stand him.*

T: What's your view of him in that moment, when you can't stand him?

P: It's obvious—he's withholding and totally selfish! He used to be so caring, but now he only thinks of himself.

T: What were you feeling, when you read that text, when he sounded so selfish?

P: Frustrated! Mistreated! Disgusted!!

T: So last night you felt mistreated and frustrated, while John seemed selfish and to care nothing for your needs. Do I have that right?

P: You do.

After clarifying the patient's internal state, the next step in the interpretive process is to challenge or "confront" aspects of the patient's verbal and nonverbal communications that are in contradiction with each other and that represent internal states that are segregated from each other. By doing this, we are calling attention to the way that the patient identifies at different moments in time with both representations in a particular object relation dyad. For example, patients who regularly experience themselves as the object of others' mistreatment come to be aware that there are moments when they act in aggressive ways toward others. This type of intervention represents a bid for reflection, encouraging awareness of, and reflection on, how it is that contradictory internal states can coexist. The intervention helps the patient to step back, view her own behavior, and encourages her to entertain an alternate perspective.

Vignette: Confrontation

P: (Picking up where she left off) *You have it right. I was very frustrated, disgusted with him, but I tried! I told him if he would just give me a hug and tell me it was his fault that I'd feel better and we could talk. But he wouldn't do it! He just got upset and left. All I wanted was a hug! He's so selfish, doesn't listen. I am soooooo frustrated!*

T: I understand you felt John's behavior was selfish and withholding. At the same time, I'm trying to imagine how he may have felt, when you wouldn't listen to him unless he did as you asked—give you a hug even though he might not have felt like it, or tell you it was his fault that you were angry, when he may have felt he had no control over the situation. (Therapist pauses) *You know, I wonder if the two of you, you and John, aren't kind of in the same boat; that at the same time you experience him as selfish and refusing to care about your needs, he may experience you in the same way when you refuse to discuss things with him until he does what you want.*

P: You mean he could think I'm selfish? After he treated me like that? It sure doesn't feel that way—I just was angry and frustrated!

T: I understand. It's lousy to feel that way, and also very familiar; but you might consider that sometimes the way you behave may leave John feeling much as you feel, frustrated or dismissed, even though this isn't your intention.

P: . . . . If I really think about it, I see what you mean. Maybe that's why people get fed up with me . . . .

In the advanced phases of the interpretive process, the TFP therapist continues to support reflection, while calling attention to the dissociation of positively and negatively colored aspects of affective experience and ultimately exploring the patient's motivations for keeping them apart. In the process of interpretation, TFP emphasizes a persistent focus on the here-and-now and an empathy with the total internal experience of the patient, which is to say, with the patient's identifications with both the persecutory as well as the persecuted object, and with the idealized as well as idealizing object. Because interpretation in TFP typically (though not exclusively) focuses attention on the relationship with the therapist, this means that the TFP therapist explores both the negatively colored thoughts, feelings, and fantasies about the therapist, as well as the defensive function of idealized exaggeratedly positive views of the therapeutic relationship. At the same time, interactional patterns played out with the therapist are consistently linked with the patient's other relationships and long-term goals.

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Advanced Phases of Interpretation Vignette

T: (building on earlier interventions) *You know, you're suggesting that we've identified something that causes problems in most of your relationships. Having said this, it strikes me that it doesn't seem to happen here with me.*

P: But you give me no cause to feel frustrated or disappointed.

T: Well, this kind of reminds me of how things were with John in the beginning—and now it feels different with him, as you point out. It's almost as if you have two options, two entirely different and contradictory views of your important relationships. There's the negative view, which we've talked a lot about, in which you feel angry and frustrated. But we've talked less about the other view, the positive view, where it seems all of your needs can be met . . . where there is absolutely no frustration or cause for resentment. This seems to be the view you are holding onto here with me.

P: What are you saying? You want me to be angry with you?

T: No. I'm just saying that I can see how appealing it must be to see our relationship in this way. It's as if you are finally getting the kind of caretaking and attention to your needs that you are always looking for, and usually get frustrated trying to find.

P: It feels so nice

T: Yes, but, I wonder if it isn't also somewhat extreme, that you make it that way because you are afraid that if there is even a hint of frustration here, the whole thing will fall apart, you will totally lose the feeling of our positive connection—it would disappear.

Data. The evidence on transference interpretations is complex. Early correlational data from psychotherapy research found that transference interpretations were negatively correlated to outcome, particularly for those with low quality of object relations. However, more recently, studies suggest that treatment including transference interpretations may be useful, especially for patients with poor quality object relations and personality disorders. Our group (Clarkin et al., 2007; Levy et al., 2006) found that clinically referred, highly comorbid, highly traumatized, BPD patients with a history of engaging in self-injurious behaviors showed significant changes in 1 year of TFP, particularly in suicidality and anger. Although these findings are not specific to transference-based treatments, our findings run counter to the early correlational data that suggested the use of transference interpretations was related to poorer outcome. Further, Levy et al. (2006) found that compared with the two other treatments (Supportive Psychodynamic Therapy and Dialectical Behavioral Therapy), TFP uniquely led to increases in structural variables such as attachment security (Main, Goldwyn, & Hesse, 2002) and reflective function/mentalization (Fonagy, Target, Steele, & Steele, 1998). These findings regarding change in symptoms and attachment security were replicated (Doering et al., 2010; Buchheim, Hörz, Rentrop, Doering, & Fischer-Kern, 2012) in a study comparing TFP with treatment delivered by experienced community psychotherapists (ECP) who treat BPD. The Doering et al. (2010) and Buchheim et al. (2012) studies not only found, like Clarkin et al. (2007), that TFP reduced depression, anxiety, impulsivity, anger, and suicidality and increased social and global functioning, but they found significant differences favoring TFP in comparison with ECP treatment as well for suicide attempts, BPD symptomatology, inpatient hospitalizations, and dropouts, and for increasing global functioning, personality organization, and attachment security. Regarding attachment security, there are now two separate studies of TFP in which similar levels of change in attachment status were found (Buchheim et al., 2012; Levy et al., 2006). The evidence from RCTs for TFP indicates that there are both statistically and clinically significant changes in BPD patients over 1 year of treatment and that changes are at the level of both symptoms and social–cognitive constructs such as personality organization and attachment security. The changes in personality organization and attachment security thus far have been unique to TFP relative to comparator treatments.

Our findings support the value of a transference-based treatment for BPD patients who have difficulty with relationships. Although our work has not directly tied transference interpretations to outcome, the treatment contracting/setting the frame, managing one's affective responses, and the interpretative process are three important components of TFP. We have provided vignettes to illustrate these techniques and data that support their role in facilitating treatment outcome.

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