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Transference-Focused Psychotherapy

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Transference-focused psychotherapy (TFP) is an intensive, manualized, outpatient, evidence-based psychotherapy for severe personality disorders, such as borderline personality disorder (BPD) and narcissistic personality disorder. Its efficacy has been demonstrated in multiple studies, with regard to both symptom change and changes in personality structure. TFP is recognized as one of the "big four" psychotherapies for treating BPD in a number of treatment guidelines and reviews, including the Society of Clinical Psychology's Committee on Science and Practice, the United Kingdom's National Institute for Health and Care Excellence guidelines, Cochrane Reviews, and the Netherlands' Multidisciplinary Directive for Personality Disorders.

This entry discusses the goals, structure, techniques, and indications for TFP. It also discusses therapist qualifications for treatment and the research supporting the efficacy of TFP.

Goals

TFP represents a modified version of psychoanalytic/psychodynamic psychotherapy designed specifically to treat patients with BPD. TFP was developed by Otto Kernberg and his colleagues, most notably Frank Yeomans and John Clarkin, at the Personality Disorders Institute at Cornell University's Weill Medical College. The treatment is based on Kernberg's object relations model. The broad goals of TFP are better behavioral control, increased affect regulation, more intimate and gratifying relationships, and the ability to achieve satisfactory life goals consistent with one's capacities and interests. Specific goals are a reduction of the symptoms associated with BPD, including suicidality, parasuicidality, impulsive hostility, and angry outbursts. These reductions lead to fewer emergency room visits, hospitalizations, and relationship difficulties. These changes are hypothesized to occur through the integration of disparate and incoherent internal mental representations of the self and others. TFP is based on the view that those with BPD do not develop the complex and realistic internal representations of self and others that characterize mature psychological development. Fragmented representations of self and others are associated with fluctuations between extreme positive or negative affects that influence an individual's perception of day-to-day interactions, often distorting these in a way consonant with extreme "black-and-white thinking." This lack of a complex and coherent sense of self and others is referred to as identity diffusion, and it is similar to identity disturbance described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Identity diffusion is the root of the affect regulation difficulties experienced by individuals with BPD. The integration of one's sense of self, one's sense of others, and the associated affect states that can be achieved with treatment leads to affective experiences becoming more enriched and modulated. The increased differentiation and integration of these internal representations allow patients with BPD to think more flexibly and benevolently about their therapists, significant others, and themselves. The road to achieving integration of these internal representations is centered on observing, exploring, and containing the patient's experiences in therapy sessions. Over time, this process helps patients develop harmonious relationships without the anxiety and aggression that characterized earlier ones. A concomitant reduction in self-defeating and destructive behaviors and general improvements in symptoms and functioning allow for both increased intimacy and independence and thus better functioning in relationships and work.

Structure and Techniques

TFP is a face-to-face outpatient form of psychotherapy occurring in two sessions per week. Similar to most treatments for BPD and other severe personality disorders, TFP is conceptualized as a long-term treatment lasting at least 12 to 18 months. TFP begins with a thorough assessment of diagnostic issues, the patient's difficulties, and his or her life structure. This assessment provides the patient with an understanding of his or her challenges and includes the role of his or her psychological structure (way of perceiving self and others). It also collaboratively sets treatment goals and frames and explicates the therapist's and the patient's roles and responsibilities in the treatment. This verbal agreement is often referred to as the treatment contract. It establishes the conditions or frame of the therapy in a way that emphasizes the experience of emotions within the therapy and curbs the expression of emotions in the form of acting out (e.g., cutting, overdosing, substance abuse, unsafe sex). This contract, in the case of inactive or socially isolated individuals, also establishes the therapeutic value of the patient becoming involved in some form of structured activity involving

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other people, bringing in issues of work, responsibility, and interpersonal relations.

In the course of the therapy, the therapist follows the patient's narrative, attending to a hierarchy of priority issues based on the treatment contract. An issue becomes a priority if it serves as an avoidance of experiencing and exploring the intense affects that emerge in the patient. Some examples of this include suicidal and homicidal thoughts and urges, overt threats to the treatment continuity, treatment-interfering behaviors, withholding or lying, and dwelling on trivial themes in session. As therapy continues, the therapist follows the patient's affect and helps explicate his or her experience, with special attention to contradictions and aspects of the patient's experience of which he or she is unaware. The patient with BPD lacks awareness about aspects of himself or herself, stemming from splitting and dissociative defenses. The focus of treatment is on the dominant relational patterns as they are experienced and expressed in the present relationship with the therapist. The therapist assists in clarifying the patient's subjective experience and tactfully points out discrepancies in what the patient is saying, doing, or expressing. The therapist then utilizes timely, clear, and tactful interpretations of the affect-laden themes and enactments in the present transference. The goal is to help the patient achieve integration through the acknowledgment and acceptance of internal affect states previously experienced as intolerable and dealt with by acting out or projecting. In this process, the patient moves away from being distrustful and confused, and toward a more benign perception of others and self and an improvement in mentalization.

Indications for TFP

TFP is suitable for outpatients with a DSM-5 diagnosis of BPD, histrionic personality disorder, narcissistic personality disorder, avoidant personality disorder, or antisocial personality disorder (in some cases) and for patients with a nonspecific personality disorder that includes characteristics of the aforementioned personality disorders. These personality disorders have in common an underlying borderline personality organization or personality structure. This consists of an inner psychological structure characterized by a nonintegrated identity (identity diffusion), with splitting (black-and-white thinking and feeling) as the main defense against overwhelming anxiety, and largely intact but fragile reality testing (e.g., under stress, the internal images of self and other overwhelm more accurate data from the objective outside world). Modified versions of TFP have also been developed for patients with a complex posttraumatic stress disorder or dissociative disorders and for working with children and adolescents.

Therapist Qualifications for Treatment

Similar to other structured treatments for BPD, TFP is carried out by qualified psychotherapists, clinical psychologists, and psychiatrists. It is highly recommended that the therapist participate in a supervision or intervision group in which he or she can regularly discuss his or her work with patients. Therapists wanting to practice TFP can receive specific training by certified trainers through the International Society for Transference-Focused Psychotherapy.

Research Support

TFP has been tested for efficacy in patients with BPD in three independent, international, randomized controlled trials (RCTs)—the best criterion for evidence of efficacy. In two out of the three studies, TFP was associated with significantly better results than the control conditions in important areas—for example, if the patient decided to cut.

In the first study, the treatment was compared with both dialectical behavioral therapy and a supportive form of psychodynamic therapy. Both of these treatments were also efficacious but in significantly fewer symptom areas than TFP. In the second study, TFP was compared with treatment by therapists who were experienced in using a range of other therapies to treat patients with BPD. In this study, the comparison condition showed a much higher rate of dropout than TFP. Moreover, TFP contributed to significant improvements in the borderline symptoms, psychosocial functioning, and personality organization. It was also associated with fewer suicide attempts and fewer psychiatric admissions than the control condition. In another RCT study,

TFP was compared with schema therapy (ST). Both methods were efficacious with large effect sizes. ST in this study showed better results in the intent to treat analyses, mainly due to the difference in dropout rates. In addition, the randomization had failed with patients in the TFP condition on average, as patients were more self-destructive than those in the ST group and, therefore, more seriously ill in a manner that is related to worse outcome. Based on these three studies, the Society of Clinical Psychology Science and Practice committee concluded that TFP is a treatment with strong evidence.

Structural (Personality) Change

Personality change, often referred to as rehabilitation in the psychotherapy literature and structural change in the psychodynamic literature, has rarely been examined as an outcome but is particularly important for disorders such as personality disorders in which the central problems are conceptualized as rooted in personality proper. Personality or structural change is one area of functioning in which TFP has consistently demonstrated unique benefits. In two RCTs and a pre-post study, TFP has shown changes at both the symptom level and with structural changes in personality. Across these studies, only in the TFP condition did the patients show a significant increase in mentalizing and attachment security, indicating increased insight into themselves and their relationships with other people. Such improvements were not found in the comparison conditions. These results are important since these changes in the personality structure are associated with lasting changes in terms of coping better with self, others, and major life challenges of love and work.

See alsoBorderline Personality Disorder; Borderline Personality Disorder: Treatment; Empirically Supported Treatments; Interpretation, Psychoanalysis and; Narcissistic Personality Disorder; Object Relations Theoretical Framework; Psychodynamic Therapy; Transference

- transference
- psychotherapy
- personality disorders
- patients
- personality
- disorders
- treatment

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Further Readings

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