Transference Focused Psychotherapy*
TFP

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www.borderlinedisorders.com

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PERSONALITY DISORDERS INSTITUTE

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TFP Manual

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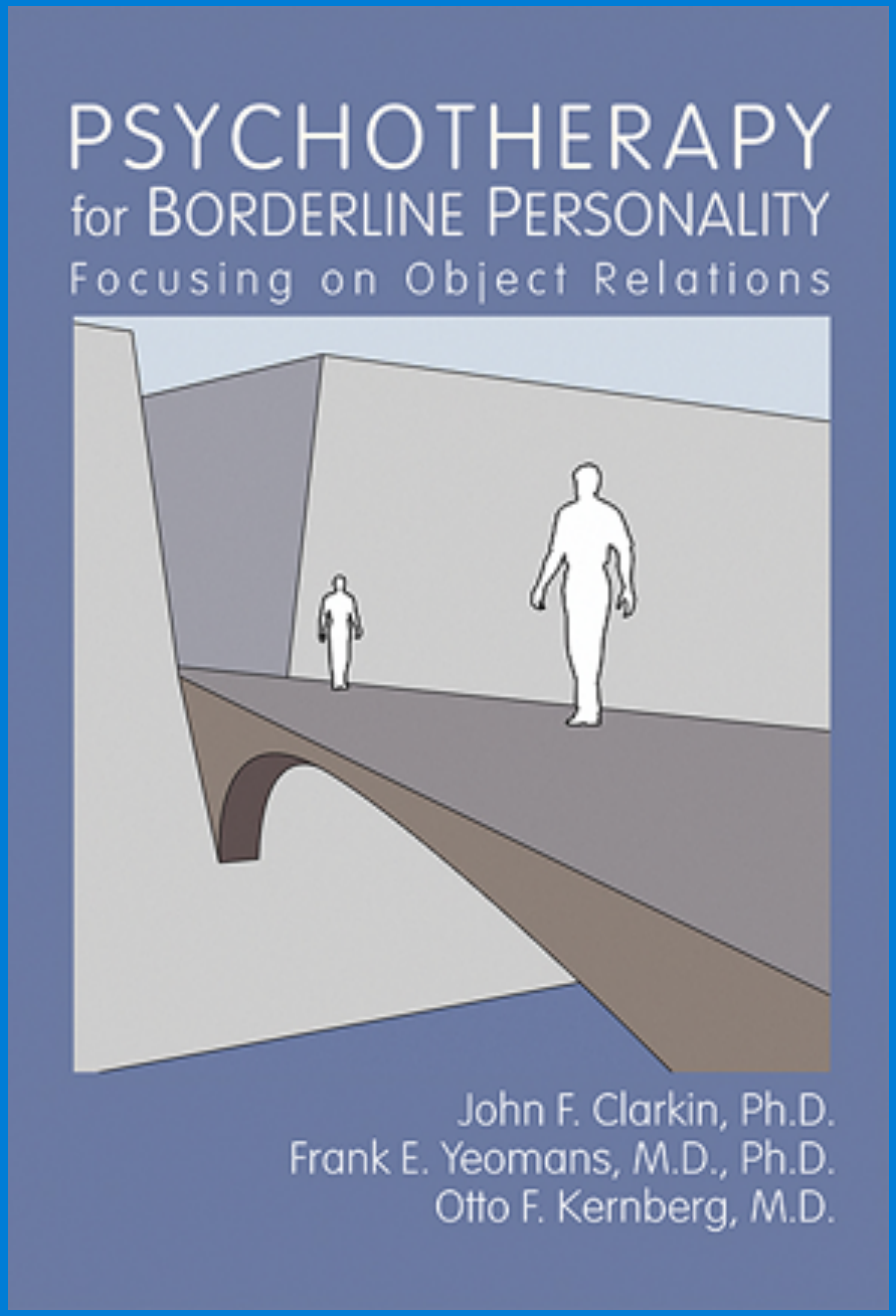
PSYCHOTHERAPY
for BORDERLINE PERSONALITY
Focusing on Object Relations
John F. Clarkin, Ph.D.
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Transference Focused Psychotherapy (TFP)

- Psychodynamic psychotherapy
- Developed to treat severe personality disorders
- Empirical support for treatment of DSM-IV BPD
- Combines dynamic approach with structure, limit setting and attention to secondary gain

Distinction with traditional psychotherapy

- Importance of the frame
- Level of activity of the therapist
- Attention to non-verbal communication and countertransference
- Limitation of free association

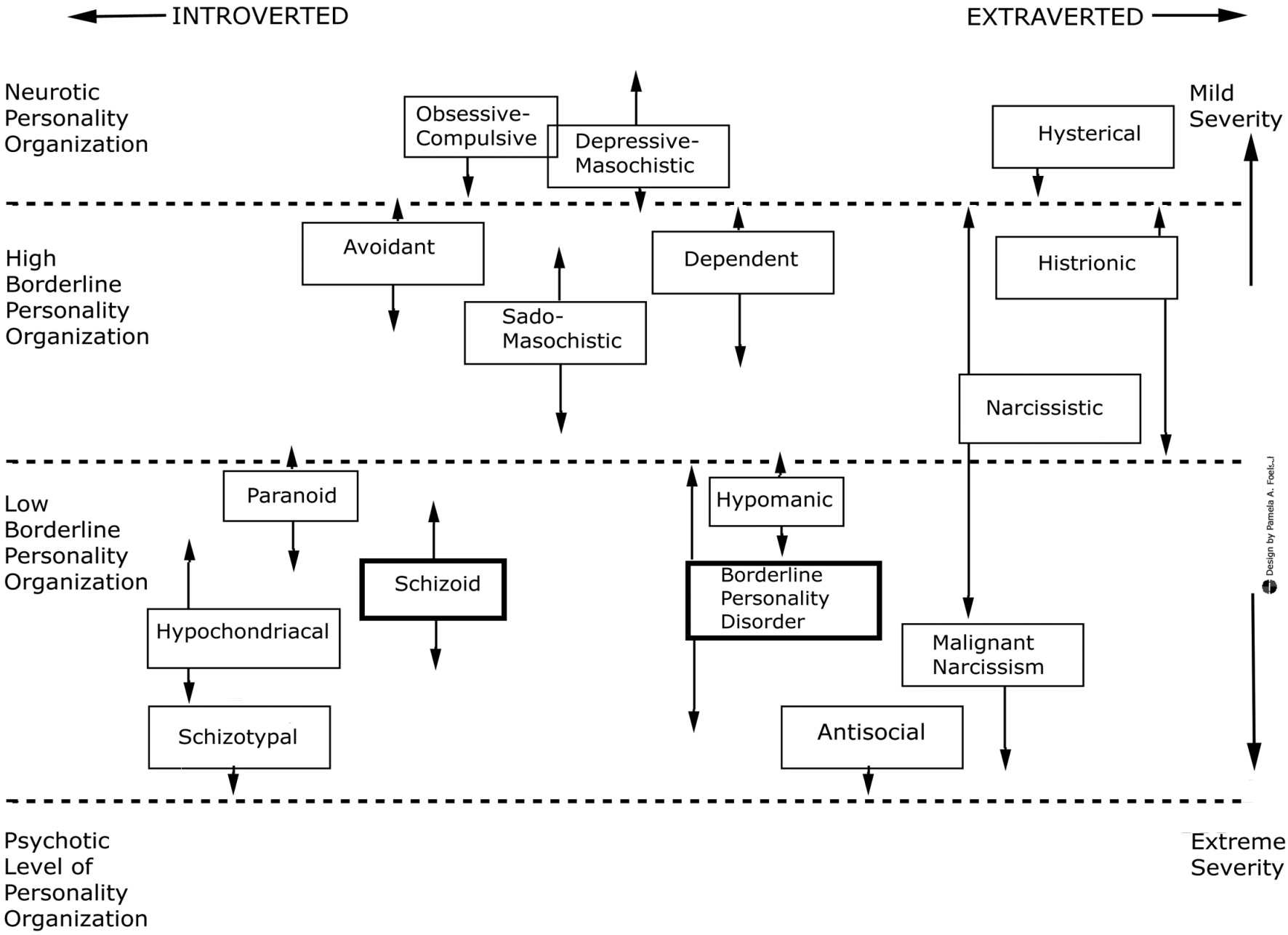
Distinction with traditional psychotherapy (continued)

- Centration on the here and now (transference)
- Notion of aggressivity and rage
- Interpretative process : clarification, confrontation and interpretation.

Structural Classification of Personality Disorders by Severity

- Normal personality
- Neurotic level of personality organization
- Borderline level of personality organization
  - High level borderline
  - Low level borderline

- Psychotic level of functioning


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

Borderline Personality Organization: Clinical Correlates of Structural Features -I

Identity pathology

- Sense of self and others is fragmented, distorted and superficial
- Difficulty "reading" others… and self
- Lack of continuity in time
- Feelings of emptiness

Borderline Personality Organization: Clinical Correlates of Structural Features - 2

Splitting- based /Lower level defenses

- Unstable, black and white experiences of the world (leads to chaotic interpersonal relations)

Variable Reality Testing

- Distinguish internal and external reality
- Deficits in social reality testing
- Can experience gross distortion under stress with micro-psychotic phenomena

Borderline Personality Organization: Clinical Correlates of Structural Features - 3

Pathology of Object relations

- Difficulty appreciating the needs of the other independent of the self, difficulty with healthy dependency, difficulty with intimacy

Pathology of Moral Functioning

- Inconsistent or lacking values and ideals
- Unethical behavior

Why do we need TFP?

- It is more easy to change symptoms and behaviors as opposed to personality…….

- However, a change in personality structure make people more happy and productive

Love & Work

Theory behind the TFP treatment

A review of basic object relations theory and primitive defenses

Identity diffusion is caused by splitted off parts of the patient experience of the world

Theoretical Underpinnings of TFP: Object Relations Theory

The Object Relations Dyad

Development of BPO

Predominance of negative affect over positive leads to reliance on splitting, to protect the good from the bad.

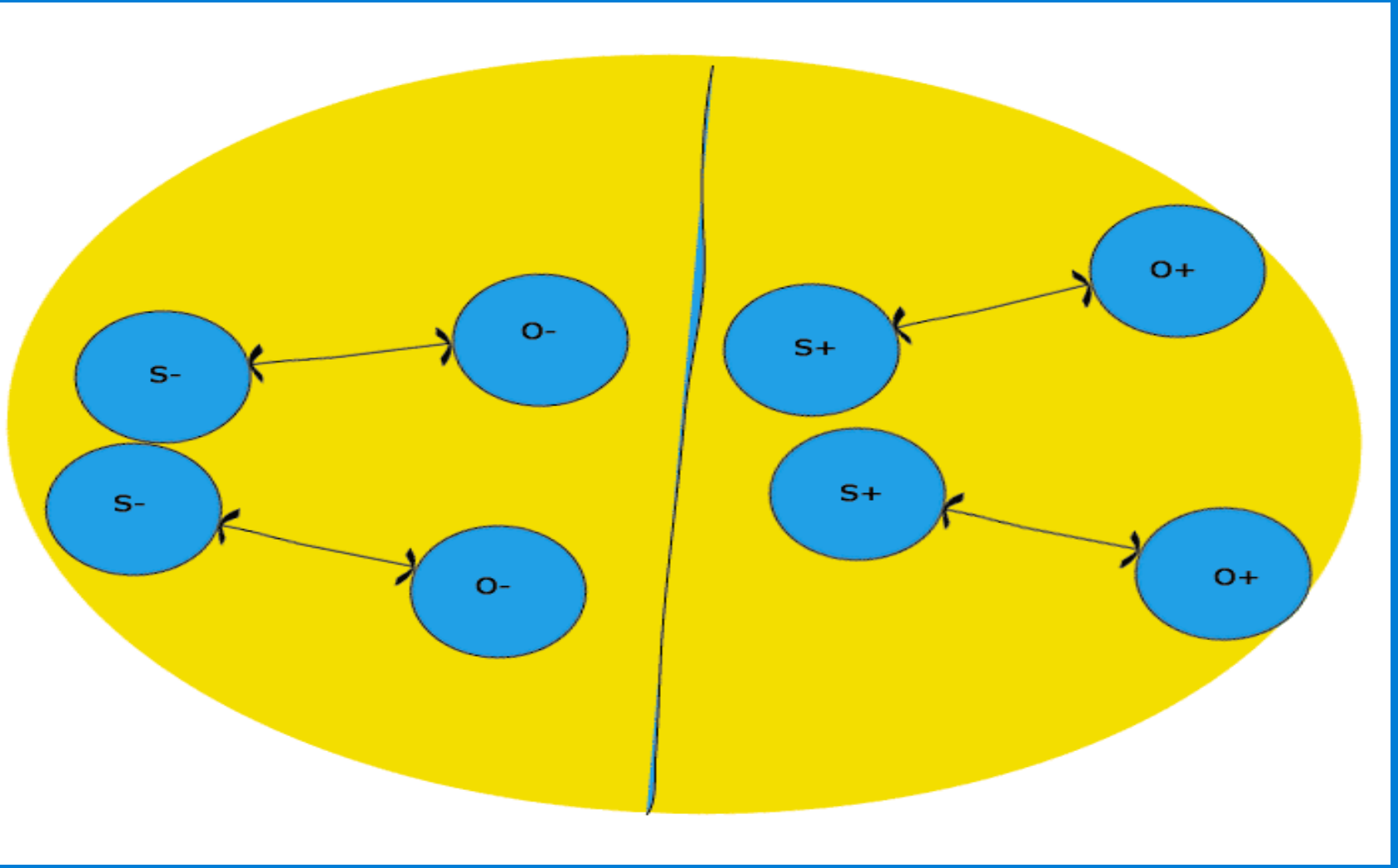
Splitting interferes with integrative processes and advancement from paranoid-schizoid to depressive position

Results in identity diffusion as opposed to identity confusion of normal adolescent.

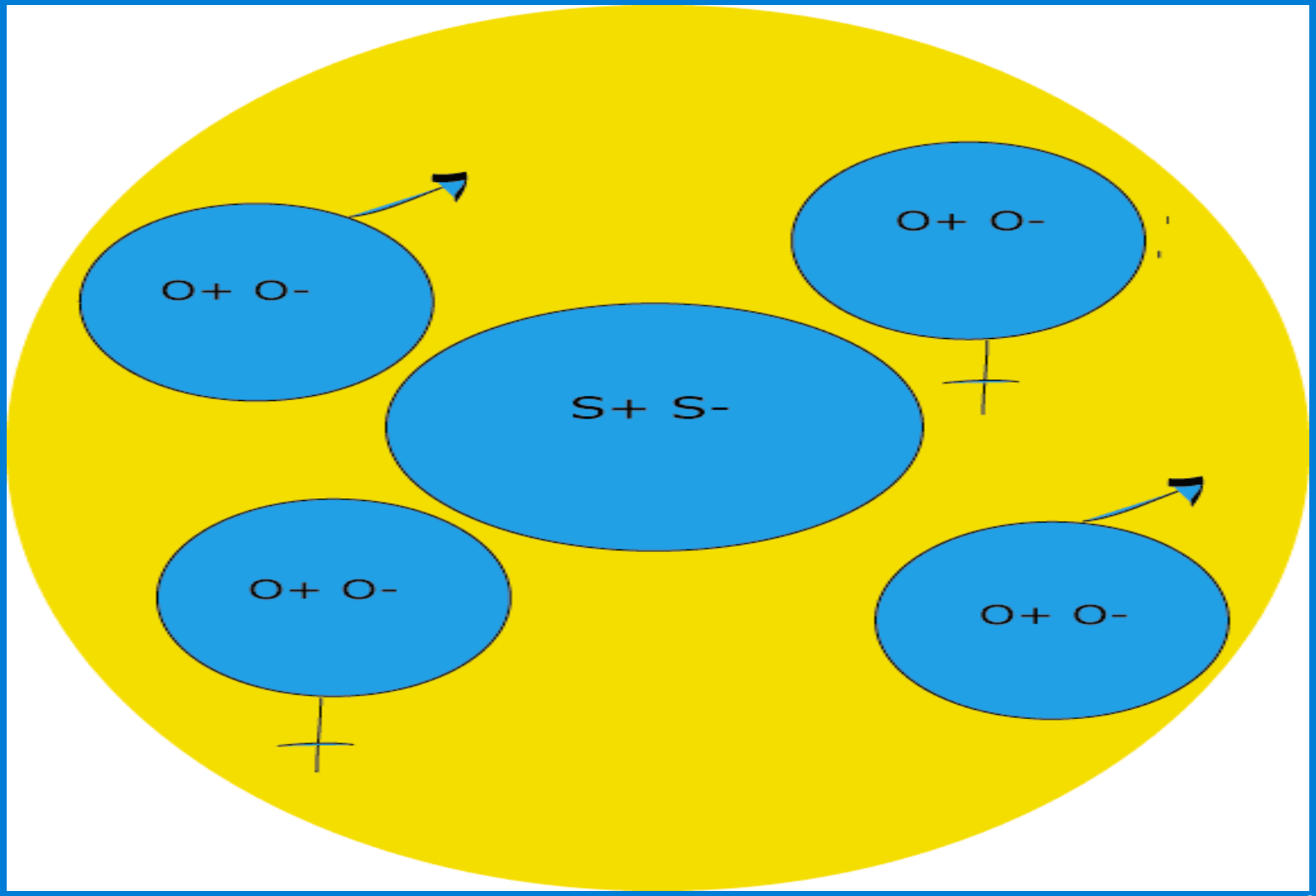
Dyads as Building Blocks

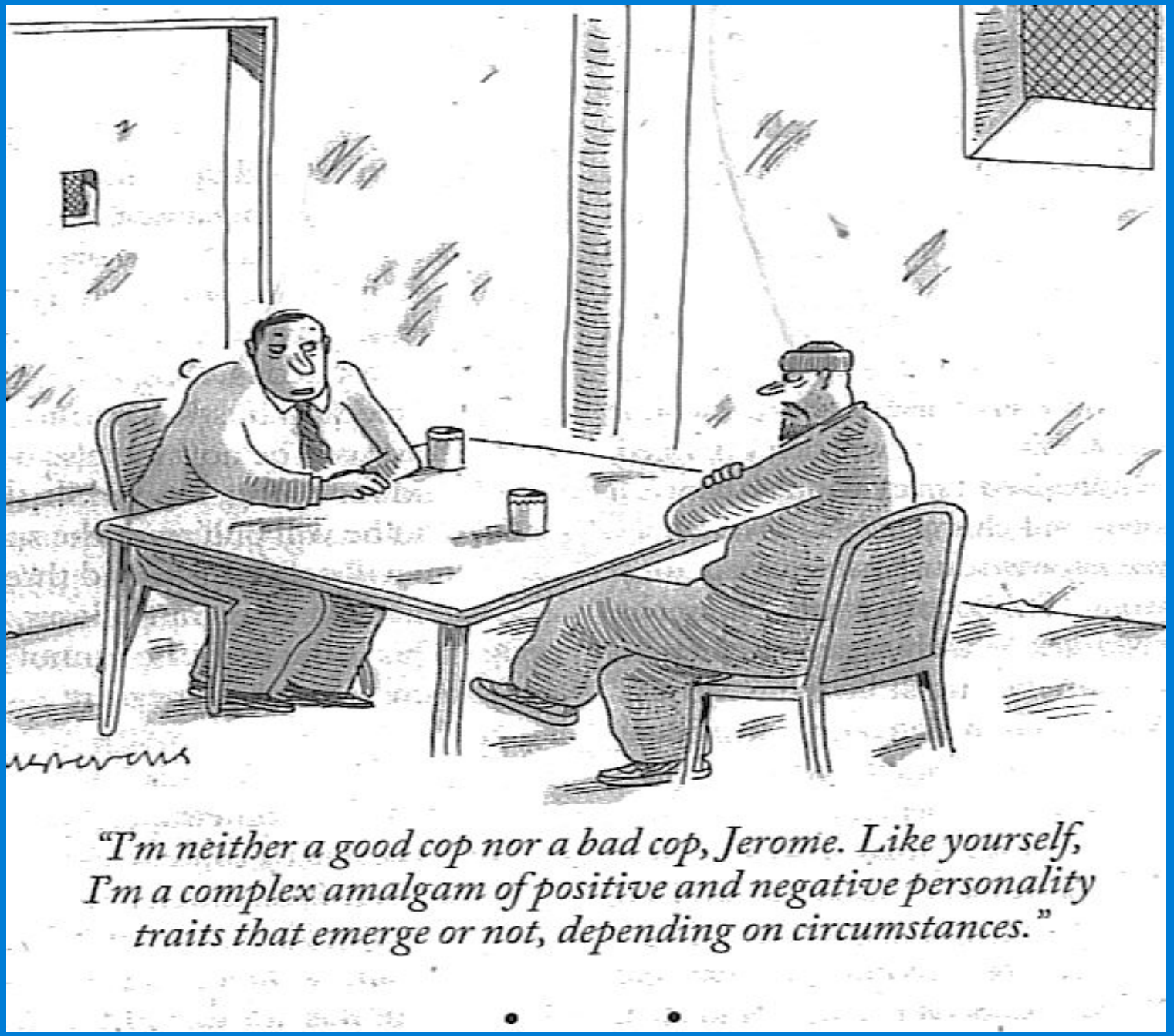
- The individual identifies with **the entire relationship,** not just with the self-representation or the object representation
- The dyad exists within the individual and it's basic impact is on self relating to self, although it regularly gets played between self and others
- Dyads of similar affective charge aggregate

Split Organisation



Normal Organisation





"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."

TFP- What Changes? Evolution of Treatment

- From Splitting and fragmentation 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 TFP facilitate this change?

Transference

- The activation of internal object relations in the relationship with the therapist.
- These internalized relations with significant others are not literal representations of past relations, but are modified by fantasies and defenses
- In borderline patients, internal object relations have been segregated and split off from one another
- Include fantasied paranoid and idealized object relations (“all good” and “all bad”)
- Working with object relations that are activated in the immediate moment creates a therapy that is “experience-near”

Working with Transference

- "An affect is the manifestation of an underlying object relation"
- Since transference is the activation of internal object relations, leads to the activation of affects and conflicts
- Basic strategy:
  - 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

Patient's Internal World

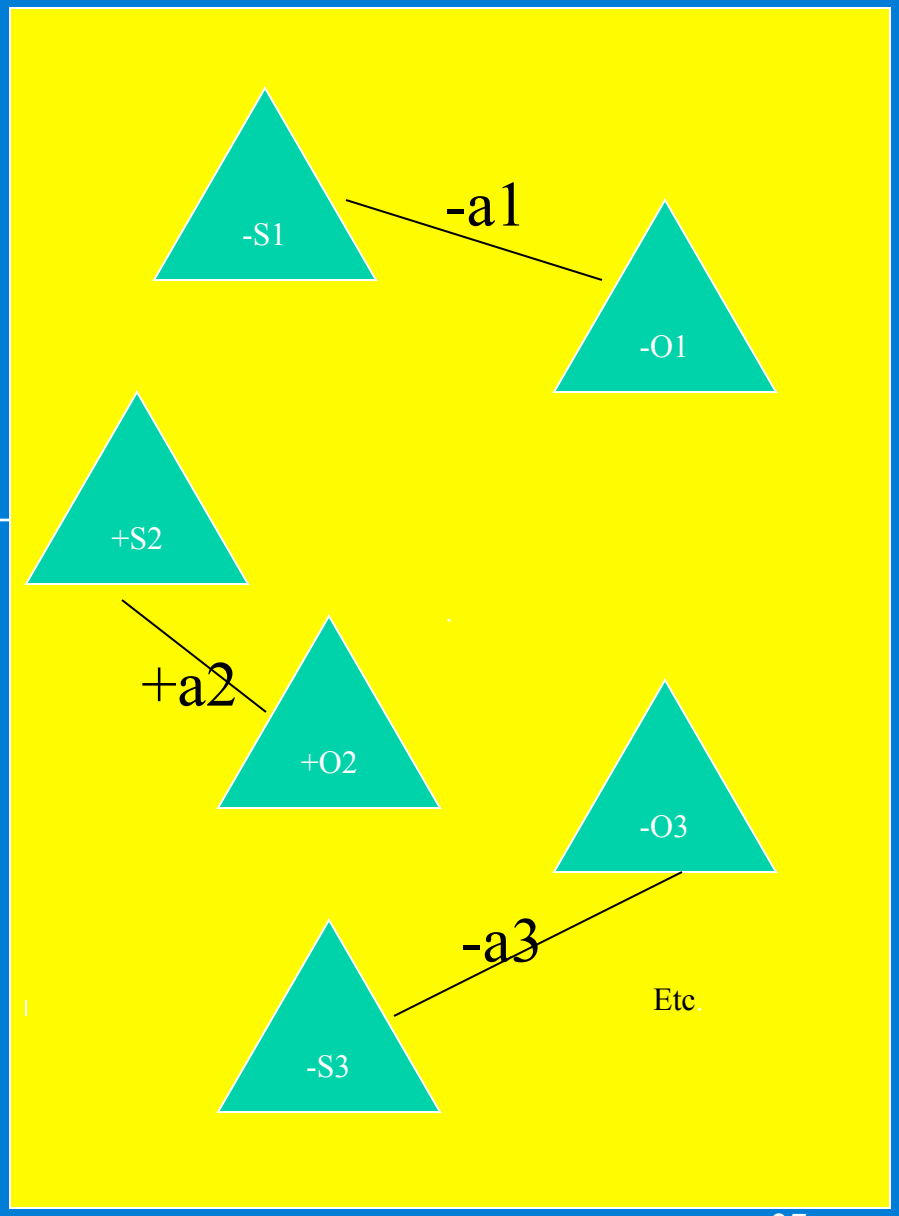
S = Self-Representation
O = Object - Representation
a = Affect

Examples

S1 = Meek, abused figure
O1 = Harsh authority figure
a 1 = Fear

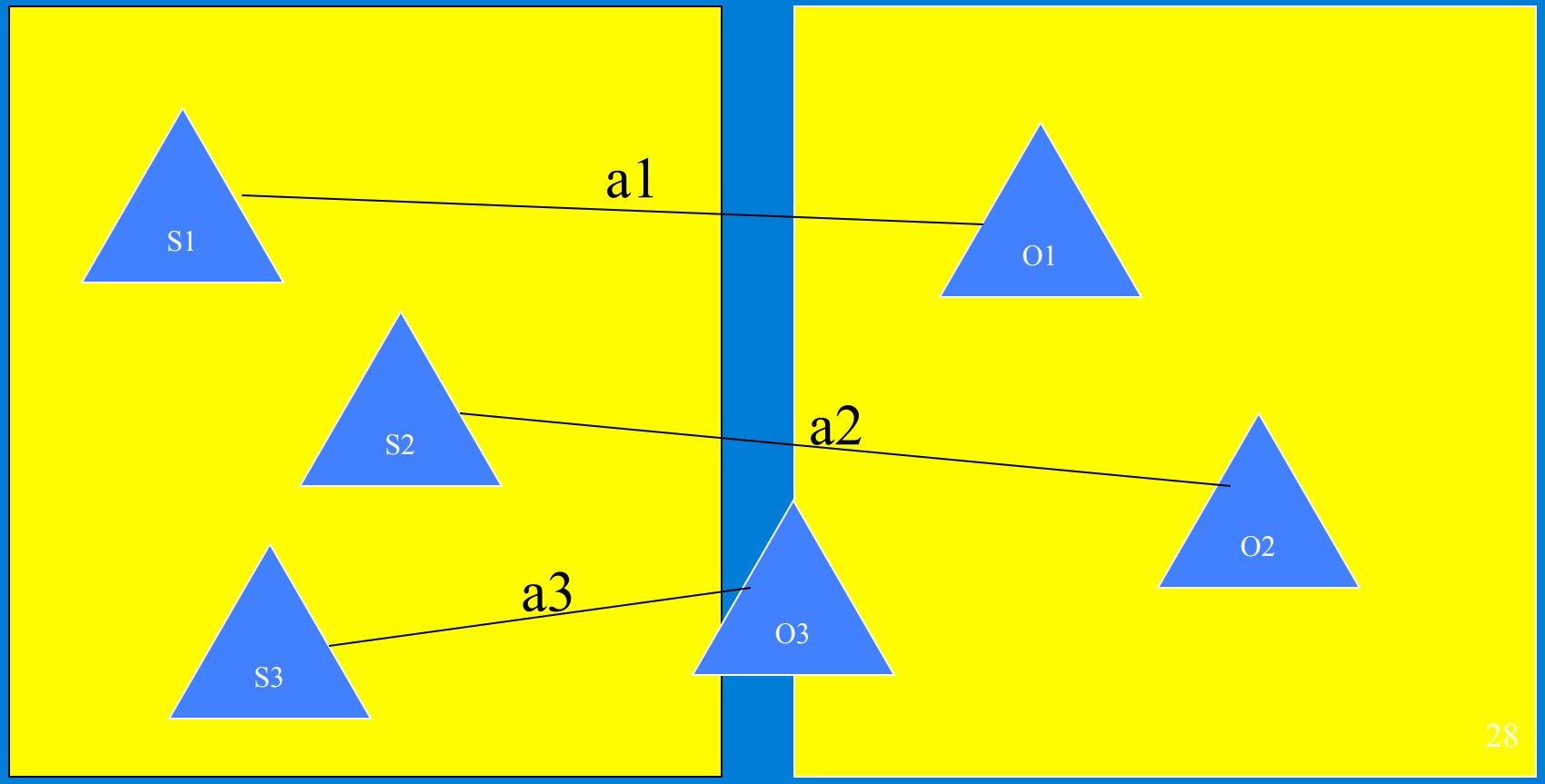
S2 = Childish-dependent figure
O2 = Ideal, giving figure
a2 = Love

S3 = Powerful, controlling figure
O3 = Weak, Slave-like figure
a3 = Wrath

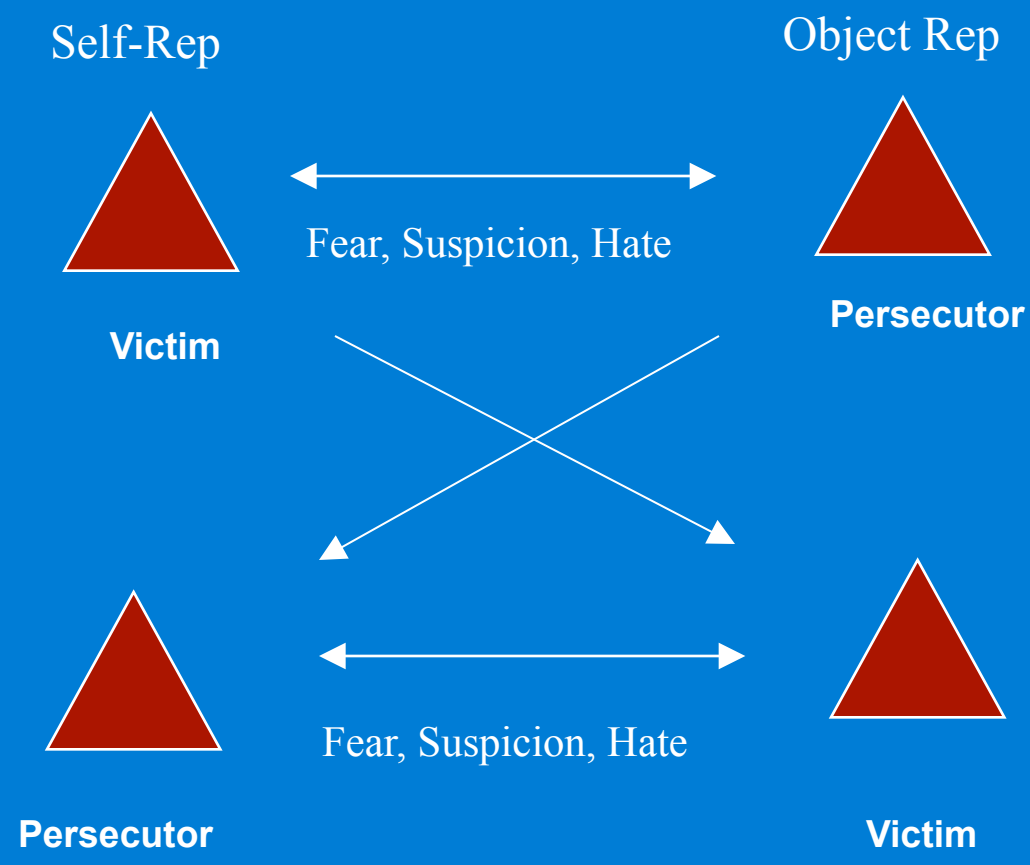


Why focus on TRANSFERENCE? (ref: Donegan)

- Experience of Self
- …and of therapist



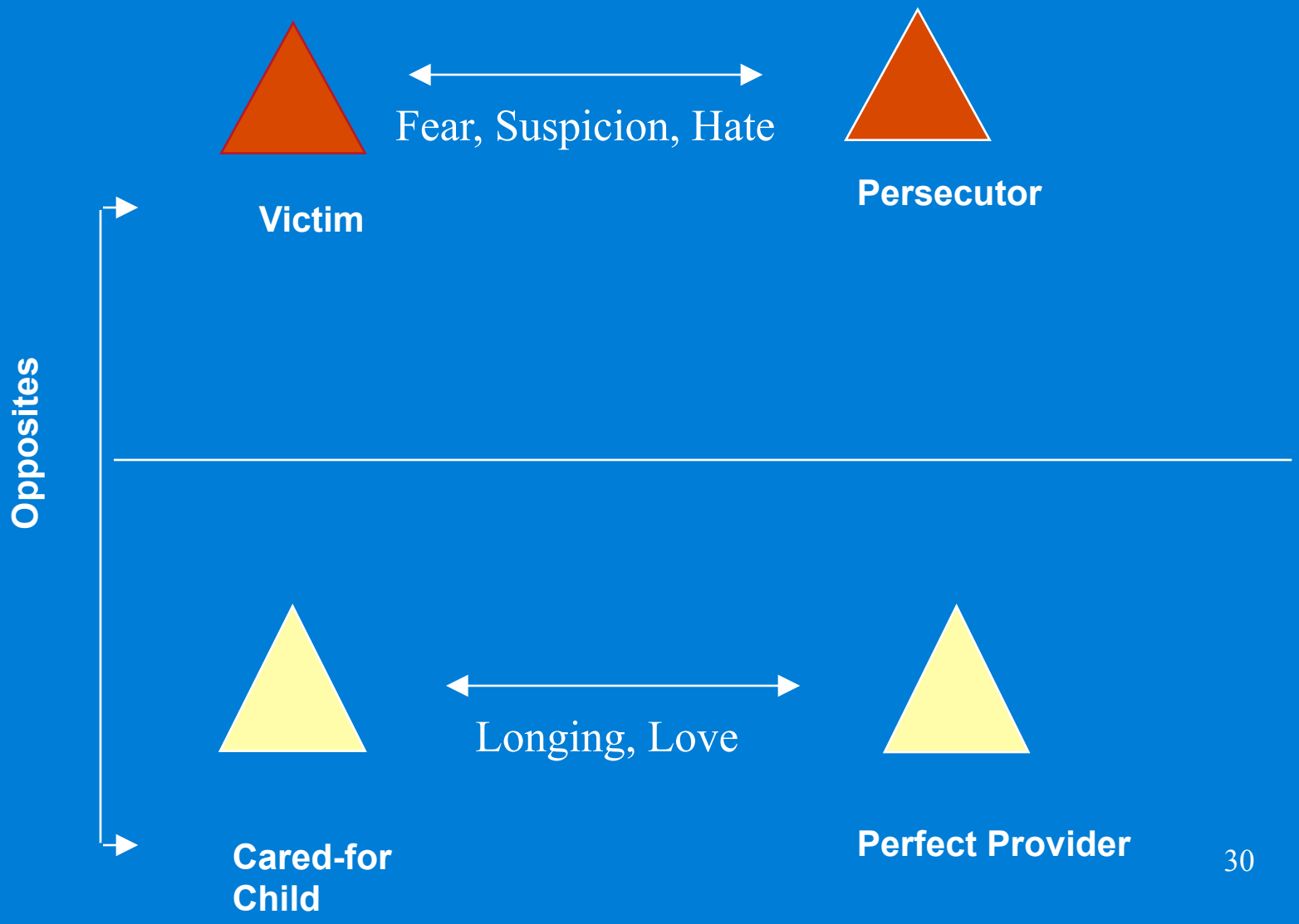
OBJECT RELATIONSHIP INTERACTIONS: OSCILLATION



(Oscillation is usually in behavior, not in consciousness)

OBJECT RELATIONSHIP INTERACTIONS:

DEFENSE



COMMUNICATION CHANELS

- Verbal
- Non-verbal
- Countertransference

BEGINNING TREATMENT

N.B.:
Often a Sense of Urgency

Goal: To move from Acting Out to Transference

Structural Assessment

Clinical Assessment = Structural Assessment

Assess:

- Identity
- Object relations
- Defenses, *coping,* defense rigidity
- Value system and ethics
- Reality testing

Structural Interview

Kernberg, Severe Personality Disorders (1984)

Definition:

Method of clinical assessment that focuses on the patient's present and past symptomatology, the patient pesonality organization. The quality of the here and now interactions between the patient and the therapist and highlights the patient family and personal history.

It is a tactful assessment of the main defenses, identity, cognitive or affective conflicts, social reality testing.

Maintain enough tension so that the predominant conflict will emerge.

Structural Interview

- Three main questions:
  - Why are you here?
  - What is the nature of your difficulties and how do you understand it?
  - What are you expecting from the treatment?
  - How are you now ? (optional)
- Detailed description of Self and Other.

Few notices

- Channels of communication
- Therapist neutrality
- It raise anxiety
- Empathy

Splitting

- All Good is not necessary Good.
- Agressivity is not necessary bad.
- Usefulness of negative transference.

Structural Interview as a microcosme of TFP

- Progress from
  - Clarification, to
  - Confrontation, to
  - Trial interpretation

STIPO : *Structured Interview of Personality Organization*

Mesure la structure et les dimensions de la personnalité

- **Structure :**
  - **Normal**
  - **Névrotique**
  - **Limite**
  - **Psychotique**
- **Dimensions:**
  - **Consolidation de l'identité,**
  - **Qualité des relations d'objets**
  - **Usage de défenses primitives ou évoluées**
  - **Nature du contact avec la réalité et symptômes dissociatifs**
  - **Qualité de l'agression**
  - **Intégration du Surmoi**

Identité

Identité intégrée

- Expériences de Soi et de l'Autre intégrées, subtiles et avec profondeur
- Objets entiers
- Stables

Identité fragmentée

- Expériences de Soi et de l'Autre polarisées, contradictoires et superficielles
- Objets partiels
- Hautement instables

Mesures de l'identité avec STIPO

- **Implication dans le travail, les études et les activités de loisirs**
- **Degré d'intégration et de stabilité du sens de Soi**
- **Nature de la régulation de l'estime de soi**

Questions

- Quel sorte de travail (rémunéré ou bénévolat) avez-vous fait au cours des 5 dernières années ?
- Quel est votre degré de stabilité au travail ? Au cours du dernier mois, combien de jours avez-vous manqués?
- Avez-vous des loisirs qui nécessitent un investissement régulier?

- Parlez-moi de vous en tant que personne. Comment vous décririez-vous?
- Quelles sont vos ambitions et buts dans la vie? Est-ce qu'ils changent souvent ou demeurent stables?
- Dans vos relations intimes, avez-vous peur de perdre votre sens de vous-même?
- Comment décririez-vous votre état lorsque vous êtes seul?

- Comment vous situez-vous en comparaison avec les autres? Inférieur, similaire ou supérieur aux autres?
- Est-ce que votre estime de vous-même est affectée par la perception des autres?
- Est-ce que votre estime de vous-même tend à alterner entre des sentiments d'être une personne spéciale et merveilleuse et une personne inférieure et sans valeur?

Défenses primitives / évoluées

- **Clivage**
  - Est-ce que vous vous comportez de façon qui apparaît aux autres comme imprévisible et désordonnée?
  - Avez-vous tendance à voir les choses en noir et blanc (ou « tout ou rien »)?
- **Idéalisation/dévalorisation**
  - Avez-vous déjà senti que quelqu'un ou quelque chose, qui vous apparaissait merveilleux, devient soudainement inintéressant et sans valeur?
- **Déni primitif**
  - Avez-vous tendance à éviter de sentir les choses qui vous dérangent de sorte qu'elles semblent ne plus exister? Est-ce que cela vous cause des problèmes tels que oublier des échéanciers, ne pas faire de suivi médicaux?
  - Est-ce que les gens mentionnent que vous avez tendance à blâmer les autres?
- **Externalisation**
- **Anticipation/Humour**
  - Si quelque chose vous dérange et que vous n'y pouvez rien pour l'instant, êtes-vous capable de mettre ça de côté?
  - Êtes-vous capable de rire de situation triste? Êtes-vous capable de rire de vous?

Épreuve de la réalité

- Dépersonnalisation
- Perceptions de sensations corporelles
- Compréhension de l'impact de Soi sur l'Autre

- Est-ce qu'il vous arrive de ne pas vous sentir vous-même?
- Est-ce qu'il vous arrive d'entendre ou de voir des choses que personne n'entend ou voit?
- Est-ce que votre façon d'entrer en relation avec les autres peut parfois être perçue bizarre?
- Est-ce que vous vous considérez différent du monde ordinaire?

Qualité des relations d'objet

- Relations avec la famille d'origine
  - Est-ce que vous maintenez des contacts avec votre famille? Est-ce que vous vous tenez loin d'eux ou avez-vous été exclu par eux?
  - Est-ce qu'il y a beaucoup de conflits dans la famille? (batailles, argumentations, rejets, etc.)?
- Relations d'amitié
  - Est-ce que vous avez des amis intimes? Donnez-moi un exemple.
  - Est-ce que vous faites des efforts pour maintenir et entretenir vos relations d'amitié?
  - Diriez-vous que vous avez des problèmes avec vos amis?
- Relations au travail
  - Est-ce que vous vous entendez bien avec vos collègues de travail?
  - Comment décririez-vous votre relation avec votre supérieur (batailles, arguments, menaces, etc.)?

Qualité des relations d'objet (suite)

- Relations intimes
  - Parlez-moi d'une relation amoureuse que vous considérez avoir été la plus importante pour vous.
  - Est-ce qu'il est difficile de faire preuve d'intimité dans cette relation?
  - Est-ce que vous considérez pouvoir dépendre de cette personne?
  - Est-ce que vous pensez que cette personne peut dépendre de vous?
- Sexualité
  - Au cours des 5 dernières années, combien avez-vous eu de partenaires sexuels?
  - Est-ce que vous sentez souvent le besoin de changer de partenaire? Si oui, pourquoi?
  - Considériez-vous être inhibé dans votre façon d'établir ou de maintenir des relations intimes sexuelles?
  - Êtes-vous celui qui initie les contacts sexuels?
  - Aimez-vous l'expérience sensuelle de la sexualité?
  - Est-ce difficile de combiner des sentiments tendres avec la gratification sexuelle?

Qualité des relations d'objet (suite)

- Est-ce que vous vous décririez comme une personne empathique? Pourriez-vous me donner un exemple.
- Est-ce qu'il vous arrive de vous mettre en colère lorsque quelqu'un ne se comporte pas de la façon que vous croyiez qu'il devrait?
- Est-ce que des gens vous ont déjà décrit comme quelqu'un de contrôlant?

- Avez-vous tendance à vous associer à des gens mieux que vous de sorte que vous vous sentez plus important?
- Avez-vous tendance à percevoir les relations en terme de ce que l'un peut apporter à l'autre?
- Est-ce qu'on vous dit parfois être égoïste ?
- Est-ce que vous avez tendance à vous ennuyer en présence des gens?
- Avez-vous tendance à laisser tomber des gens envers qui vous avez pu être proche?

Agressivité / Rage

- Agressivité contre soi
  - Est-ce que vous négligez votre santé?
  - Faites-vous parfois des choses dangereuses telles avoir des relations sexuelles non-protégées, consommation abusive d'alcool, vitesse excessive?
  - Est-ce que vous vous coupez ou infligez des douleurs?
  - Avez-vous fait des tentatives de suicide? Est-ce que votre vie a été en danger?
- Crise de rage (Tamper Tantrum)
  - Est-ce qu'il vous arrive de perdre le contrôle envers les autres? Comment vous sentez-vous après?
- Agressivité envers autrui / absence de remords
  - Avez-vous déjà blessé sérieusement et intentionnellement quelqu'un ?
  - Est-ce que vous prenez plaisir à faire souffrir les autres?
  - Avez-vous des activités sexuelles qui sont physiquement dangereuses?
- Sadisme
  - Est-ce que vous prenez plaisir à voir l'autre souffrir?
  - Est-ce que vous avez déjà blessé quelqu'un?
  - Est-ce que vous aimez sentir que l'autre vous craint?
- Haine
  - Est-ce que vous nourrissez des sentiments de haine ou de mépris envers quelqu'un?

Aspects moraux / Surmoi

- Comportements
  - Est-ce que vous mentez aux autres?
  - Avez-vous déjà commis des actes illégaux? (vols, prostitution, trafics de drogue)?
  - Avez-vous des problèmes avec la justice?
  - Avez-vous déjà triché dans des examens ou plagié?
- Culpabilité
  - Est-ce que vous ressentez de la culpabilité parfois? (dans quelles circonstances?)
  - Est-ce que vous avez tendance à vous fixer des standards moraux très élevés et irréalistes?

Therapeutic Frame Contract

Contract Principles

0. Agreement on the nature of the problem

I. Define therapist and patient responsabilities

II. Protect the therapist's capacity to think

III. Permit the evolvement of the patient dynamic

IV. Threats to the treatment

V. Transitional space

Contract: Standard Content

Patient Responsibilities

- Attendance and participation
- Paying fee
- Reporting thoughts and feelings without censoring

Therapist Responsibilities

- Attending to the schedule
- Making every effort to understand and, when useful, to comment
- Clarifying the limits of the therapist's involvement – (for patients with earlier experiences of challenging boundaries)

Predicting Threats to the Treatment, and establishing parameters to address them

Treatment Contracting Process

- 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 Threats to the Treatment

- Suicidal and self-destructive behaviors
- Homicidal impulses or actions, including threatening the therapist
- Lying or withholding of information
- Substance abuse
- Eating disorder - uncontrolled
- 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

Contract around Suicidality in a Chronically Suicidal Borderline Pt.

Pt. feels urge to kill self between sessions

Scenario I

The patient experiences suicidal ideation and feels he can control his behavior

The patient does not call the therapist and discusses it in the next session

Scenario II
Pt. feels cannot control impulse

Patient takes self to ER.

↓

I. Pt. is discharged from ER and attends next session

OR

II. Hospitalization recommended

a) Pt. agrees and resumes therapy upon discharge

OR

a) Pt. refuses, ending the therapy

Patient calls therapist, who reminds him of contract.

↓

I. Patient goes to ER

OR

II. Pt. refuses. Tpist does what is necessary in the moment, then, when the treatment frame is back in place, discusses with the patient if therapy can continue

Scenario III –
Pt. has taken suicidal action

Pt. calls family, friend, 911, etc. to get to hospital for eval.

Decision to admit or not admit

Pt. calls therapist, who does all he can to help save the pt's life. Then, when calm and neutrality re-instituted, therapist addresses possibility of continuing treatment or not

Offering a Second Chance

- Some patients do not believe that others mean what they say
  - Therapist response: Point out the risk and consequences of this
- Breaking the contract may be an attempt to get out of the therapy and "blame" the therapist for it
  - Therapist response: interpret the patient's ambivalence about therapy and reasons for resistance

Once the Contract has been agreed upon…

- The patient will often test or challenge an element of the contract to:
  - see if he or she can control the therapist (which is wished for AND feared)
  - see if the therapist "cares enough" maintain the contract
- 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

TFP
Strategies, Tactics, Techniques

Relation between strategies, tactics and techniques

THE STRATEGIES OF TFP - I

STRATEGY 1: Defining the dominant object relation

Step 1: Therapist experiences and tolerates the confusion of the patient's inner world as it unfolds in the transference

Step 2: Therapist identifies in his mind the object relation that is dominant in the moment

Step 3: Therapist names the actors as they are played out

Step 4: Therapist attends to the patient's reaction

THE STRATEGIES OF TFP - II

STRATEGY 2: Observing and interpreting patient role reversals (the patient identifies with the entire relationship/dyad – not just with one side of it)

STRATEGY 3: Observing and interpreting linkages between object relation dyads which defend against each other, with the goal of integrating the paranoid and idealized segments of experience. This resolves identity diffusion.

STRATEGY 4: Experiencing a relationship as different from the transference: working through the patient's capacity to distinguish the transference from the real interpersonal relationship with the therapist and expanding this to relationships outside the therapy.

Tactics - function

Therapist 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 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
- 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

Techniques

- The interpretive process:
  - Consists of clarifying, confronting, and interpreting
  - Is a means of enhancing mentalization
- 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

Clarification

- This technique is requesting clarification, not offering clarification
- Provides material for interpretation by clarifying
  - The patient's perception of self in the moment
  - The patient's perception of the other/the therapist
- This technique sheds light on the patient's internal world and helps to elaborate distortions (i.e., enhances mentalization)

Confrontation – a "bid for reflection"

- This technique is not a hostile challenge, but rather an honest inquiry into an apparent contradiction in the patient's verbal and non-verbal communication
- It is an invitation for the patient to reflect on different aspects of the self that are split off from one another

Confrontation

- The contradiction can be within one channel of communication: “You said earlier that I was a terrific therapist, now you’re saying I’m worthless….”
- Or the contradiction can be between different channels of communication: “You’re saying you’re furious, but you’re looking at me with a smile….”

Transference Interpretation Process

- Conceptualized as a series of interventions that build on one another
- May take many sessions to complete a single cycle of interpretation or may have many completed cycles in one session

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

Goal of the Interpretative Process

- To interrupt cycle of dysregulation and pathological defense
- To Integrate dissociated aspects of experience
- To replace splitting based defenses with repression
- To resolve identity diffusion.
  - Identity consolidation in turn leads to improved capacity for affect regulation and symbolic management of psychological conflict
- To enhance the capacity to self reflect and contextualize experience

BPD Patient's Experience of the Transference - 1

- Primitive object relations are activated in the transference – but experienced as strong AFFECTS
- Patient's experience of the therapist is concrete (e.g. patient has limited capacity to appreciate the distinction between internal and external reality)
- Patient's experience of transference shows a predominance of primitive affect (hatred or idealization) without cognitive representation of object relation activated

BPD Patient's Experience of the Transference - 2

- Intense affect floods clinical setting
- Patient is unable to to establish any distance from or perspective on his immediate experience in the transference
- Both therapist and patient experience a sense of confusion and anxiety
- Transference dispositions may be most clearly expressed in patient's behavior or in the countertransference

BPD Patients' Experience of the Transference - 3

- Patient is not able to make use of traditional interpretations of underlying anxieties and defenses organizing his or her experience initially
- May experience any sort of intervention as a criticism or an assault
- Patient may be able to use more basic interventions to contain/hold affective experience and to promote the capacity to cognitively represent it
- Leads gradually to capacity to symbolically manage and reflect on experience in the transference

The Focus of Interpretation with Borderline Patients

Because of the predominance of splitting-based defensive operations (rather then repression-based defenses) in BPD patients:

- Interpretation focuses on mutually dissociated aspects of experience that are accessible to consciousness, though at different times (rather than consistently repressed)
- As treatment progresses, dissociative defenses give way to repressive defenses, when interpretations can shift to focus on repressed mental contents

In General, Interpretation with Borderline Patients…

1 first spells out the nature of the dominant object relation and the patient's difficulty identifying with both poles of that dyad

2 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.

Steps of Interpretation - I

- Understand/Identify self state in the moment (first level of mentalization)
- Elaborate understanding of the therapist
- Consider therapist's/other's experience of the moment, and that it may be different from the patient's
- If necessary, offer the patient a version of how the therapist experiences the moment

Steps of Interpretation - II

- **Put the moment in a broader context:** Contrast the immediate experience of self and of therapist with that seen at other times. (second level of mentalization)
- Address splits/conflicts by
  - Clarifying the oscillation between identifying with the self representation and then the object representation
  - Interpreting the motivation of the split between dyads with opposite affective valences

Therapist-Centered Interpretations

- Therapist-centered interpretations (Steiner, 1993) put patient's concrete and affectively charged experience of therapist into words
  - Without suggesting alternative point of view
  - Without suggesting patient has anything to do with the experience
- Provides cognitive containment of concretely experienced affect states
- Provides patient with experience of being understood and the therapist of genuinely attempting to understand

Summary of the Interpretation Cycle

- Begins with efforts to help patient clarify his conscious emotional experience in the transference at different points in time, elaborating the particular representations of self and object respectively enacted and projected onto the analyst
- Next, confronts the patient with his experience of this same object relation enacted in the transference at other times but with roles reversed
- Subsequently, interpretively links idealized and persecutory relations with the analyst that have been conscious, but defensively split off by mutual denial – also attempts to shed light on the reasons for the defensive splitting

Characteristics of Interpretations

- Depth of interpretation
  - Surface to depth = defense before impulse, with maximum depth in crises
- Timing and tempo of interpretations
  - related to the patient's rapid shifts; we must try to follow each shift
- Early interpretations focus on the "here and now"
- Later interpretations link the "here and now" to the past
- Accuracy of interpretation: judged by whether new material or awareness emerges

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?")
- Link these distortions to similar distortions in the patient's relations outside of the therapy
- The difficulty with narcissistic patients (the non-relation is the relation)

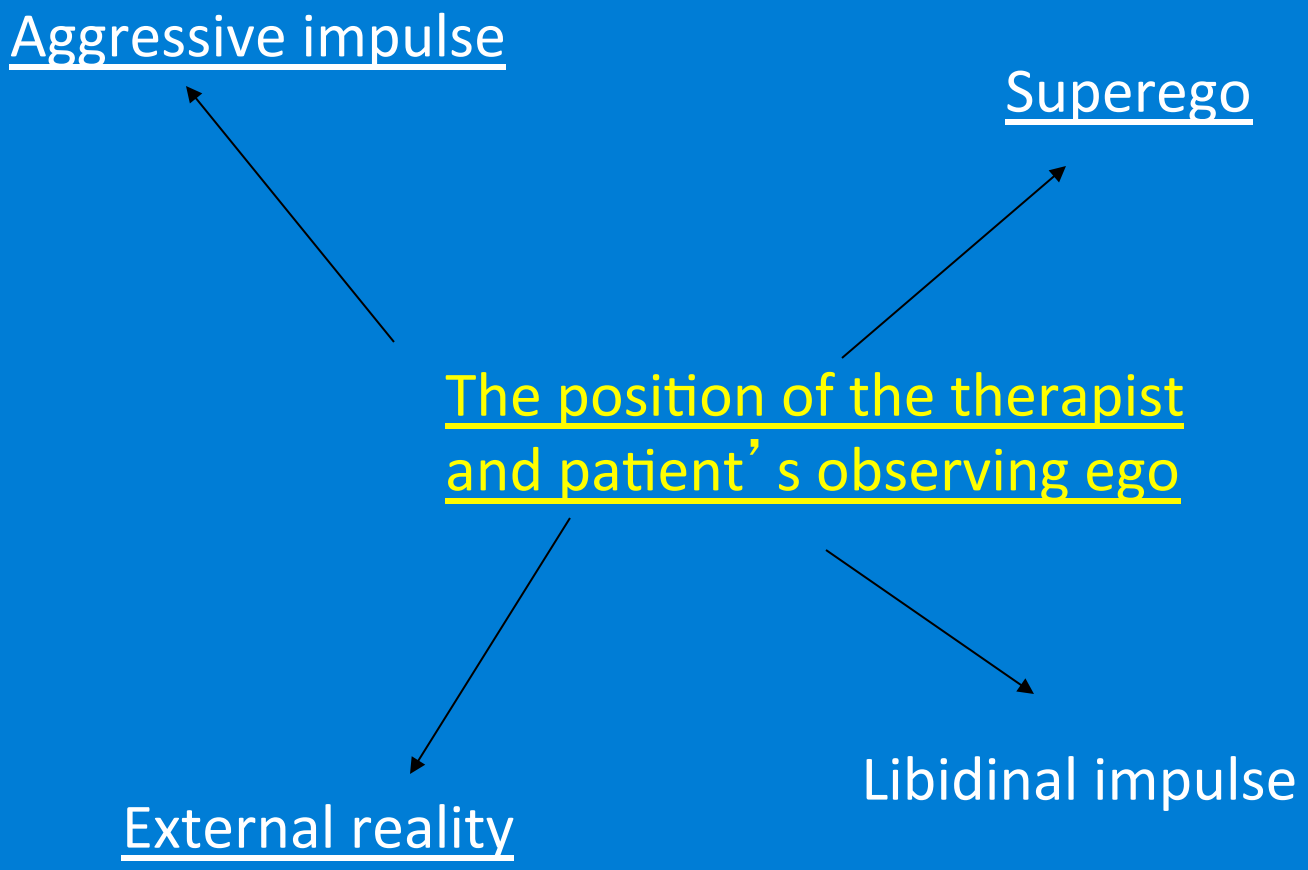
TECHNICAL NEUTRALITY

- A therapist who intervenes from a position of technical neutrality avoids siding with any of the forces involved in the patient's conflicts
- Neutrality means maintaining the position of an observer in relation to the patient and his difficulties
- When working from a position of technical neutrality the therapist is aligned with the patient's "observing ego"

TECHNIQUES:
TECHNICAL NEUTRALITY IN TFP

- Equidistance between :
- Impulse (Id)
- Acting Ego
- Superego
- External reality

It is not indifference nore distant, monotonous.


Aggressive impulse
Superego
The position of the therapist and patient's observing ego
External reality
Libidinal impulse

DEVIATIONS FROM TECHNICAL NEUTRALITY

- Deviations from neutrality are part of the treatment strategy of TFP
- Control dangerous acting out that cannot be contained by confrontation and interpretation
  - Threat to safety of patient
  - Threat to safety of others
  - Threat to continuation of the treatment
  - Confrontation and interpretation fail to contain acting out

DEVIATING NEUTRALITY (continued)

- Introduce a parameter to limit acting out
- Point out that the therapist is stepping out of role and explain why s/he has chosen to do so
- Return to transference, making link between deviation from neutrality and self and object representations externalized and enacted in the transference

DEFINING COUNTERTRANSFERENCE

- Therapist's total emotional reaction to patient
  "Countertransference in the broad sense"

- Therapist's transference to patient
  Classical view is "therapist-focused"

- Therapist's reactions to patient's transference
  Kleinian view is "patient-focused"

COUNTERTRANSFERENCE

- Countertransference is "Third channel of communication" serving as essential source of information about patient's inner world and object relations activated in the transference

- Countertransference can disrupt therapist's ability to understand patient's inner world and to effectively communicate with patient

THE THIRD CHANNEL OF COMMUNICATION

- Borderline patients express in action what they cannot express in words
- Dominant affective themes and object relations are expressed through inducing thoughts and feelings in therapist
- To clarify how patient is experiencing therapist in the transference ask, “How am I being made to feel?”

INTERPLAY of COUNTERTRANSFERENCE & 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

COUNTERTRANSFERENCE IN TFP

- Countertransference to borderline patients says more about patient than it says about therapist
- Borderline patients defensively project aspects of their inner worlds into therapist
- Primitive defenses involve affecting therapist

COUNTERTRANSFERENCE

Concordant Identification

Therapist identifies with patient's self experience

Complementary Identification

Therapist identifies with patient's internal and external objects

COMPLEMENTARY IDENTIFICATIONS IN THE COUNTERTRANSFERENCE

- Predominate in the treatment of patients with borderline personality disorder
- Reflect the impact of projective identification on the clinical process
- Can interfere with therapist's capacity to empathize with patient's immediate emotional situation

CONCORDANT IDENTIFICATIONS IN THE COUNTERTRANSFERENCE

- Are the basis of ordinary empathy
- "Putting ourselves in the patient's shoes"

COUNTERTRANSFERENCE TO BORDERLINE PATIENTS

- Rapidly developing
- Intense
- Unstable
- Confusing
- Pressure to “Do something”

CONTAINMENT OF COUNTERTRANSFERENCE

The therapist "mentalizes" the patient's projections in the countertransference

- Allows patient to understand himself internally
- Tolerates his emotional experience without turning to action
- Reflects upon what the patient has stimulated in him and what this might say about the object relation enacted in the transference

ACUTE and CHRONIC COUNTERTRANSFERENCE

Acute countertransference reactions

- Affect the therapist moment-to-moment
- Rapidly shifting with borderline patients
- Mirrors shifting developments in the transference
- Affective intensity
- Can be difficult to contain

Chronic countertransference reactions

- Affect the therapist over periods of time
- Stable attitude on the part of the therapist
- May be subtle / typically not highly affectively charged
- Can be difficult to notice / often with the aid of a consultant
- Reflects therapist's characteristic response to transference

Hierarchy of Thematic Priorities

Obstacles to Transference Exploration – Resistances to explore

- Suicide or homicide threats
- Threats to treatment continuity (inc. financial probs, plans to move, requests to meet less often)
- Dishonesty or deliberate withholding in sessions (e.g., lying to the therapist, refusing to discuss certain subjects, silences occupying most of the sessions)
- Contract breaches (e.g., failure to act on other parts of treatment such as AA, failure to take prescribed meds)
- In-session acting out (e.g., abusing office furnishings, refusing to leave at the end of the session, shouting)
- Narcissistic resistances
- Non-lethal between-session acting out
- Non-affective or trivial themes

Therapist

Sets frame via contract

Patient

Experiences safe haven to express self

↓

Expression of affect includes actions and interactions based on implicit OR dyads

Observes the action without judging or reacting

Tries to understand/explicate the OR underlying the actions, using

1 – Clarification

2 - Confrontation

3 – Interpretation

(these appeal for reflection & address obstacles to it)

Increases reflection

Further reflection, with increased contextualization

Progress toward integration

Increased modulation of affects