INTRODUCTION TO TRANSFERENCE-FOCUSED PSYCHOTHERAPY (TFP)

John F. Clarkin, Ph.D., Calgary, 2013
borderlinedisorders.com
PERSONALITY DISORDERS INSTITUTE

Weill Medical College of Cornell University
New York Presbyterian Hospital

Otto F. Kernberg, M.D., Director
John F. Clarkin, Ph.D., Co-Director

Eve Caligor, MD
Jill Delaney, MSW
Diana Diamond, PhD
Karin Ensink, PhD

Kay Haran, PhD
Mark Lenzenweger, PhD
Kenneth Levy, PhD
Lina Normandin, PhD
Frank E. Yeomans, MD
Today’s Agenda

• Lecture 1: Borderline Pathology and Strategies of TFP
• Lecture 2: Assessment: Symphora tape
• Lecture 3: Contract setting and early treatment
• Lecture 4: Midphase; empirical development of TFP
THEORY OF PERSONALITY
Goal (Mischel, 2004)

• To identify and understand the consistences in personality, i.e., stable patterns of the individual across situational variability, rather than constancy
• Assessment of the individual as an organized, dynamic, agentic system functioning in the social world
• Trait approach: aggregate the individual’s behavior on a given dimension (e.g., rejection sensitivity) across many different situations and estimate an overall “true” score
• Alternative approach: how the person encodes or appraises situations (including the self and other people) and beliefs, expectancies, goals, and self-regulatory competences that are activated within the individual in particular situations
Route to Finding Invariance in Personality

- Find invariance in personality by taking into account the situation and its meaning for the individual
- The invariance can be seen in the stable interactions and interplay between them
- Research shows that:
  - behaviors are highly variable across different situations
  - Individuals show temporal stability in their behavior within particular situations
- The pattern of variability from one type of situation to another is not random
Behavioral Signature of Personality

- Individuals are characterized by stable, distinctive, and highly meaningful patterns of variability in their actions, thoughts, and feelings across situations.
- The “if…then..” situation-behavior relationships provide a behavioral signature of the individual.
- Personality relevant processes—such as memory, attention control, planning, conflict-monitoring, emotion, self-regulation, meta-cognition, unconscious automatic processing—operate “in concert.”
Cognitive-Affective Processing System (CAPS) (Mischel, 2004)

- The personality system contains mental representations (cognitive-affective units) whose activation leads to behavioral consistencies that characterize the person.
- These cognitive affective units include the person’s representations of the self, others, situations, and enduring goals, expectations and beliefs, feeling states, and memories of people and past events.
- Individuals differ stably in this network of interconnections or associations. Differences in the chronic accessibility of the CAUs and in the distinctive organization of interrelationships among them.
- Personality components do not operate in isolation, but organized hierarchically in terms of their importance for the functioning and priorities and goals of the person as a whole.
Conflict and Self-Regulation

- An organized, coherent system does not imply the absence of internal conflicts, i.e., conflicting goals and inconsistent behavioral tendencies.
- What are the cognitive, attention, and brain processes essential for adaptive self-regulation in the face of strong, immediate, “hot” situational triggers?
- Example: the intersection of rejection-sensitivity and self-regulatory competences.
- Highly rejection-sensitive individuals who are also high on self-regulatory competencies do not develop expected negative outcomes associated with rejection sensitivity (Ayduk et al, 2002).
A Clinically Useful Conception of Personality Functioning (Mischel & Shoda, 1999)

- Organized pattern and sequence of activation of cognitive-affective mental representations
- Behavioral expressions of individual’s processing
- Perceptions of self across situations
- Particular environments the individual seeks out and constructs
CAPS Model of Personality

7. Toward a Unified Theory of Personality

WHAT OBJECT RELATIONS THEORY BRINGS TO UNDERSTANDING PERSONALITY FUNCTIONING
Object Relations Theory

- Object: for historical reasons, the term “object” refers to a person with whom the subject has a relationship
- Object relations: quality of the subject’s relationships with others
- Internal object: representation of another within the mind of the subject
- Object relations theory: psychodynamic models of psychological motivation and functioning that view the internalization of early patterns of relating as a central feature of development and functioning
Psychological Structures

- Structures: stable patterns of psychological functioning that are repeatedly and predictably activated in particular contexts
- Descriptive features of personality pathology reflect the nature and organization of underlying psychological structures
- Psychological structures cannot be observed directly; inferred and assessed on the basis of their impact on descriptive aspects of personality functioning
Psychological Structures

- Structure: stable patterns of psychological functioning that are repeatedly and predictably activated in particular contexts
- Psychological structures cannot be directly observed but inferred
- Interested in the relationship between observable behavior and internal, unobservable, cognitive affective structures
- Most basic structure: image of self interacting with an image of another linked by affect state
Component Structures of Personality - 1

1 - Temperament / Reactivity (a genetic disposition) – thresholds and rhythm of perceptual, behavioral, cognitive and affective intensity.
2 – Character: The combination of temperament and interactions with caregivers leads to the internalization of perceived interactions. These determine habitual behaviors, or character traits.

- Character structure determines one’s reaction to the trigger event.
  - Character is observable by behavior, affective responses, and the perception of the environment.
  - Character is the behavioral manifestation of Identity: ways of thinking, feeling, and relating to the world.
Component Structures of Personality - 3

3 - Intelligence: the potential for cognitive assessment

4 - Ethical value systems ("superego"): a hierarchical organization of dispositions influenced by value systems that are dynamically integrated

--------------------------------------------------------

Personality is the supraordinate structure that involves all of the above: temperament, character, cognitive structure, and ethical values
Object Relation Theory

- Object Relations Theory focuses on how the interaction between temperament and early experience creates internalized relationship paradigms – object relations dyads - that are linked to intense affects.

- The term “object” refers to the object of a libidinal or an aggressive drive. The drive is directed to a real other person in the world, but is also linked with an internal representation that may differ from the reality of external objects.
Theoretical Underpinnings of TFP: Object Relations Theory

The Object Relations Dyad
Split Organization: Consciousness of all-good or all-bad
Normal Organization: Integration and Complexity
Key Psychological Functions or Structures

- Identity formation: sense of self and others
- Predominant level of defensive operations
- Reality testing
- Quality of object relations
- Moral functioning
1. Identity

- Identity is the structural correlate of the subjective sense of self and the experience of others.
- Normal identity: an integrated sense of self and others that is complex, differentiated, flexible, and realistic, has subtlety and depth, and is continuous over time.
- Identity diffusion: the experience of self and others is fragmented, extreme, unstable, and lacks continuity; there is difficulty understanding one’s own internal states and that of others.
2. Defensive Operations

- Defenses are individuals automatic psychological responses to stress and/or emotional conflict – they attempts to resolve conflicts to reduce anxiety

- Mature defenses are flexible - without distortion of external reality

- Repression - or neurotic defenses - avoid distress by repressing or banning from consciousness aspects of experience that are conflicted

- Borderline pathology is characterized by *splitting defenses*—mutual dissociation of sectors of 1) experience associated with positive affect (idealized representations) and 2) experiences of negative affects (persecutory representations)
3. Reality Testing

- Differentiation of self from non-self, of internal from external reality
- Empathy with social criteria of reality
  - Affect
  - Thought content
  - Way of talking
- Involves social reality testing – reading social cues, understanding social conventions, responding tactfully in interpersonal settings.
- When evaluating this, look at what’s inappropriate in affect, thought, and behavior. Borderline patients may behave inappropriately in social settings, misinterpreting others without awareness.
4. Quality of Object Relations

- The capacity to establish and sustain mutual and intimate attachments.
- Normal: appreciate and care for needs of others, maintain relations based on understanding of give and take.
- Borderline: need-fulfilling orientation to relations; predominance of aggression in relations (extreme in antisocial individuals).
5. Moral Values

- A commitment to values and ideals that is consistent, flexible, and integrated into the sense of self

- Neurotic level: moral rigidity, excessively self-critical

- Borderline level: variable degree of moral functioning; from rigid and severe to lack of guilt
ETIOLOGY OF BPD
Etiology of BPD

• A complex etiology: no single pathway
• Genetic Disposition, involving:
  • Temperament
  • Neurotransmitter Systems
  • Abnormal Affectivity: Negative affects, aggression, and abnormal control of affects
• Environment Influences:
Object Relations/Pathology of Attachment
  • Chronic chaotic relations and blurring of generational boundaries
  • Neglect
  • Trauma/Abuse
In normal infant development:
1. In peak affect states, the infant internalizes a memory of self in relation to other.
2. These experiences coalesce into those with pure positive affect and those with pure negative affect. At this stage, self and others are perceived in extreme, absolute terms.
3. In normal development, the extreme positive and negative segments of the mind become integrated into more complex and nuanced representations of self, others, and affects. Ambivalence, acceptance, flexibility and the notion of “good enough” guide the individual's perceptions of self and others.
Normal Organization: Integration and Complexity
THE DEVELOPMENT OF PSYCHOLOGICAL STRUCTURE IN THE INTERNAL WORLD – 2
THE PERSISTENCE OF THE SPLIT STRUCTURE

Borderline pathology develops when:

4. Under the stress of maltreatment or aggressive constitutional loading, the negative experiences outweigh the positive experiences.

5. The negative experiences remain isolated and split off from the positive experiences, preventing integration and leading to the fixation of the originally normal developmental split. This perpetuates perceiving self and others in extreme, absolute terms.
Split Organization: Consciousness of all-good or all-bad
How can psychological structure change?

- 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?
“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.”
Prognostic Factors

• Pervasive aggression
• Antisocial features
• Secondary gain (chronic support system)
• Severely restricted object relations
• No love life; low attractiveness
• Low intelligence
• No work or shifting lifestyle
• Negative therapeutic reaction
IMPLICATIONS FOR TREATMENT

TFP and the domains of dysfunction
What Do We Know About Treatment of BPD?

- Many treatments (TFP, MBT, DBT, General Psychiatric Management) show significant reductions in symptoms.

- Treatment effects on social functioning (love & work) are generally poor (e.g., McMain et al, 2012: 51% not working; 39% on disability at end of DBT or Management).

- While many treatments work, implying common strategies, we know less about the mechanisms of change.
TFP: The Focus on Real-Time Functioning

- TFP is as effective as DBT (Clarkin, et al, 2007), and better than community expert therapists (Doering et al, 2010)

- TFP can be effectively exported from New York to Europe (Doering et al, 2010)

- TFP has effects beyond just symptom change, e.g., changes in Reflective Functioning and changes in personality functioning
Real-Time Functioning and Observation in TFP

Therapist observer

Patient

Therapist participant
The Essence of Transference Focused Psychotherapy (TFP)

- A psychodynamic psychotherapy
- Based on object relations theory
- 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
Common Elements Across Effective Treatments

• Clarity about the borderline pathology
• Clear rationale for the treatment approach
• Structure in the treatment process
• Presence of a consistent, supportive therapist
• Focus on the here-and-now, not the past
• Expectations for change
Unique Aspects of TFP

- Goal: change beyond symptoms including reappraisal of representations of self and others
- Focus on both the interpersonal behavior between patient and therapist, and social behavior of patient outside of the sessions
- Frequency of sessions (2 times a week) encourages growing attachment between patient and therapist
- Salience of the therapist in the patient’s life encourages transference
- Transference interpretations around the current interactions
## Domains of Change as Approached by Three Treatments

<table>
<thead>
<tr>
<th>DOMAINS</th>
<th>DBT</th>
<th>MBT</th>
<th>TFP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal behavior</td>
<td>Contract</td>
<td>Structure</td>
<td>Contract</td>
</tr>
<tr>
<td>Interpersonal behavior</td>
<td>Role playing</td>
<td>Mentalization</td>
<td>Examination both with others and with therapist</td>
</tr>
<tr>
<td>Emotion regulation</td>
<td>Skill development</td>
<td>Mentalization</td>
<td>Re-interpretation</td>
</tr>
<tr>
<td></td>
<td>Distraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mindfulness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conception of self and others</td>
<td></td>
<td>Mentalization</td>
<td>Examination in the patient-therapist interaction</td>
</tr>
</tbody>
</table>


Treatment Manuals

Borderline Level Personality Organization

Neurotic Level Personality Organization
TFP Manual

• This is not a step-by-step how to manual
• This is impossible because every patient is unique
• This is impossible because we always allow the patient to take the lead
• In a free-associative manner, the patient leads with impulse and containment and/or defenses
• TFP manual is a compilation of principles of intervention
• The art of therapy is the application of the principles to the individual patient in all of his/her individuality
What do we mean by a treatment manual?

• A book: derived from discussing videotapes of analysts’/therapists’
• Viewing videos
• Peer supervision, with an emphasis on countertransference and projective identification
• Overarching concept: principle-driven
• Rating adherence and competence
TFP CAPITALIZES ON THE TRANSFERENCE PROCESS
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 each other;
  - include fantasied persecutory and idealized relations.
- Working with object relations that are activated in the immediate moment creates a therapy that is “experience-near”
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
Patient’s 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, controlling figure
O3 = Weak, Slave-like figure
a3 = Wrath

Etc.
Why focus on
TRANSFERENCE?
(the immediate experience of self and other)

- Experience of Self
- …and of therapist
OBJECT RELATIONSHIP INTERACTIONS: OSCILLATION

(Oscillation is usually in behavior, not in consciousness)
OBJECT RELATIONSHIP INTERACTIONS: DEFENSE

Victim

Fear, Suspicion, Hate

Persecutor

Longing, Love

Cared-for Child

Perfect Provider
TFP - What Changes?

Clinical improvement results from structural change

- Increased reflection, facilitated by:
  - Holding function of therapist
  - Interpretation
- Decreased splitting
- Identity consolidation
The Evolution of Treatment in TFP

We try to bring the person 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?
TFP- Summary of the Process of Change

- Exploration of internal object relations as activated in interpersonal relations
- Focus first on the transference, then on other affect-laden material
- Enhance mentalization through exploration of internal states; this provides cognitive containment of affect through exploration of psychological experience in the “here-and-now”
- Promote integration by confronting and interpreting splitting and associated defensive operations
- Integration and decreased splitting enhance
  - The capacity to contain affective states and reflect upon them
  - The capacity to appreciate self and others in more fullness and depth
STRATEGIES 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
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 describes the actors and the action as they are played out

Step 4: Therapist attends to the patient’s reaction
**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.
ILLUSTRATIVE ROLE PAIRS FOR PATIENT AND THERAPIST

Unwanted, deprived child  Absent, neglecting parent+

Defective, worthless child  Contemptuous parent

Threatened, abused victim  Sadistic attacker/persecutor

Controlled, enraged child  Controlling parent

Attacking, angry child  Controlled, submissive parent

+It must be remembered that the role pairs alternate. The therapist and the patient become, in turns, the depositories of part self and object representations. Often the parents are not clearly differentiated as a mother and father, but are merged as a single parent fragment.
Illustrative role pairs.... Cont’d

Naughty, sexually excited child  Seductive parent
Dependent, gratified child       Perfect provider
Child longing to be loved       Withholding parent
Controlling, omnipotent self    Impotent parent
Friendly, submissive self       Doting, admiring parent
Aggressive, competitive self   Punitive, sadistic parent
The Initial Situation

A Sense of confusion or chaos in the Session

Fragmented part self and object representations are activated in rapid succession. The tactics and techniques of TFP help the therapist make sense of the chaos and use it interpretively.
The Interpretive Process  *(Caligor, Diamond, Yeomans & Kernberg, 2009)*

- Interpretation is not a discrete event, but rather a series of interventions that build on one another
- With severe personality disordered individuals, the process begins with bringing attention to aspects of the patient’s communication that are vague, contradictory or seemingly omitted
- In the early phase of the interpretive process, the borderline patient’s experience of the therapist often becomes grossly distorted, affectively charged, and very concrete, i.e., limited capacity to appreciate a distinction between internal experience and external reality (e.g., I am frightened because I believe you might hurt me → You are trying to hurt me → You are hurting me)
Interpretive Process: First Phase

• First phase: defining the dominant object relation
• Initial efforts at clarification typically leads to anxiety and sometimes paranoia
• This process can quickly lead to activation in the transference of primitive object relations
• It is the central task of this first phase in the interpretive process to identify and elaborate these object relations
• It is the task of the therapist to put the patient’s experience of the therapist into words; this corresponds to what Steiner (1993) has referred to as analyst-centered interpretation
Interpretive Process: Second Phase

• Identifying and pointing out role reversals within a particular object relation

• The therapist is introducing a new perspective on the patient’s experience: inviting the patient to transcend her immediate, concrete experience in the moment, and begin to form cognitive links between aspects of her experience that have been dissociated.

• The therapist is taking a preliminary step toward suggesting that the patient has an image of a relationship in her mind; the patient has an organized inner world and this world has organized features that can be examined

• The therapist is implicitly inviting the patient to step back and observe herself
Interpretive Process: Third Phase

• Third phase: identifying splitting and dissociation among different object relations

• This step entails pointing out the relationship between two contradictory object relations, i.e., idealized and persecutory experiences of self and other that have been dissociated

• This is an invitation to the patient to observe and reflect on the polarized and contradictory nature of his/her experience
Interpretive Process: Fourth Phase

- Therapist explores hypotheses about the meanings of the patient’s experience in the transference