

Chapter 2

Transference-Focused Psychotherapy (TFP) and Its Applications: The Initial Stage of Treatment, Interventions Repeated and Refined, and What Happens Over Time in the Therapy Model

1. *The therapist's challenges in the initial phase of TFP include: tolerating the confusion associated with severe PD pathology, "naming the actors" to orient the therapist and give the patient a sense of being understood, and managing affect storms.*
2. *The TFP therapist listens for material and observes interactions reflecting the dominant object relations dyads and begins to speculate about possible role reversals in evidence.*
3. *The TFP therapist uses the tools of clarification, confrontation, and interpretation in probing the areas of conflict, cued by the strongest feelings expressed by and/or those most accessible to the patient, with the aim of deepening exploration over time.*

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4. *The goals of TFP, which include the patient's increased capacity for self-reflection and an integration of positive and negative experiences of self and others, emerge with extended effort and progress that unfolds in a nonlinear way.*

2.1 Introduction

As outlined in Chap. 1, the TFP therapist approaches the process of an individual psychotherapy with a patient with significant PD pathology in a systematic, markedly deliberate manner. The therapist proceeds as follows: (1) the comprehensive diagnostic assessment, (2) discussion with patient about the therapist's diagnostic impression, (3) identification of the patient's personal goals and treatment goals, (4) an extended contracting phase, and (5) a meeting with the patient and important people in his or her life (spouse, parents, children), if indicated. (Chap. 4 on TFP and family involvement describes in detail the indications for such a meeting.) It is important to recall that such a precise set of interventions is *not* considered standard procedure in traditional psychoanalytic psychotherapies or psychoanalysis and differs significantly in content and process from the other evidence-based treatments for BPD.

This chapter will describe the way TFP as an individual psychotherapy unfolds after the initial phases of treatment – diagnostic assessment, discussion of diagnosis, elucidation of goals, and contracting – have been accomplished. This description will closely hew to the outline of the treatment as described in the TFP manual. That said, *the central hypothesis of “applied transference-focused psychotherapy” is that the component parts of TFP on their own can be useful to clinicians of all stripes and that employing elements of TFP can improve clinical care provided by therapists not necessarily wishing to or able to provide TFP as an extended individual psychotherapy.*

The assessment phase of TFP, anchored in use of the structural interview, will often, but not always, help the therapist accurately assess the patient's level of organization and therefore prepare the therapist for what is to come. While the therapist's accurate appraisal of the patient's diagnosis and overall functioning using the structural interview is optimal, the process is not foolproof; the therapist may diligently proceed through an extended assessment phase and arrive at a diagnosis and general appreciation of the patient's level of organization, only to be surprised by the material the patient introduces once the treatment begins. The point of an extended, even painstaking, assessment process is the possible, but not guaranteed, benefit it may give therapists – a way to calculate how the treatment may proceed and, in TFP parlance, how rigorous the treatment frame will need to be. Many trainees are introduced to psychotherapeutic approaches that are premised on a prospective patient's relatively high level of organization. Supportive psychotherapy approaches that might highlight the therapist's role as giver of advice, guidance, or reassurance may assume that the patient has a higher level of organization with routine use of more mature or adaptable defenses. The trainee therapist anticipating work with a "healthier" patient will undoubtedly be flummoxed when experiencing the fragmentation, chaos, and confusion often seen in patients with severe PD pathology. The therapist using the structural assessment process and expecting to work with a patient with a borderline organization, for example, will know to prepare for a treatment that will not unfold in an organized, steady, or easily understood way.

The TFP therapist beginning treatment with a patient with severe PD pathology will expect to experience some degree of confusion. The TFP approach encourages the therapist to surrender to this confusion, to soak it up, as it were, rather than reflexively move to organize the material presented by the patient. The TFP therapist will take this opportunity – surrendering to the confusion generated by the patient – to begin to speculate about the most evident object relations dyads in play. The therapist will use the three channels of communication to consider: "What is the patient saying about his/her

experience of self and others and what is the associated affect?" The TFP therapist doesn't aim to organize the material presented by the patient, particularly if the material is largely inchoate, but the therapist does have the goal of listening for clues about the patient's self-concept, experience of others, and associated feelings, or affects. The therapist anticipating material presented in an easily comprehended manner from a patient with a higher level, neurotic organization might be moved to put in order the chaotic material described by the patient with severe PD pathology; this effort to "fill in the gaps" created by inconsistencies in the patient's presentation distances the therapist from the patient's internal experience. The TFP therapist has a goal only of putting into words the dominant object relations dyads emerging or "naming the actors," as if the therapist were observing a snippet of dramatic dialogue and direction.

The identification of the emerging dominant object relations dyad begins with the process of "naming the actors" but includes the therapist's speculation about ways the dyad as described or played by the patient may be turned on its head. This "role reversal" assumes that the patient and the other important figures are on a "two-way street" so to speak; the therapist begins to consider ways, at times, "the shoe may be on the other foot," and the attributes the patient may ascribe to others can, at times, be identified in the patient's own behavior, albeit outside the patient's full awareness.

Many psychotherapy trainees will voice a familiar refrain when in supervision: "What am I supposed to say to the patient?" The repertoire of interventions used repeatedly in TFP is central to any psychodynamic psychotherapy intervention – clarification of the patient's thoughts, confrontation of observed contradictions, and interpretations of underlying conflicts. Just as the structural interview is basically an intuitive process, so too these terms reflect the therapist's intuitive response to clinical material. Clarification, in this sense, means the therapist is asking, "Can you tell me more? Can you make this any clearer to me? Can you fill in the details?" Confrontation is the process of asking the patient to reflect on material that somehow seems contradictory or discrepant.

The therapist is asking “I notice you have said two things that seem at odds; have you noticed that too?” An interpretation is a hypothesis about the patient’s motivation; the therapist is offering this as a guess, not making a pronouncement. The therapist is wondering aloud with the patient “Is it possible that you behave this way because of that feeling – that fear, that anxiety, that wish?” The therapist as observer is making a suggestion about the patient’s motivation that may not necessarily be in the patient’s awareness.

The TFP therapist will be faced with the decision of how and when to intervene as the patient follows the TFP agreement to speak freely. The TFP therapist will observe for what seems to be the most affectively dominant material, i.e., the material associated with the strongest feelings. As noted, the TFP therapist will be monitoring the three channels of communication in determining the affectively dominant material, aware that how the patient behaves or how the therapist feels may be as important in this determination as what the patient actually says.

What does the TFP therapist expect to happen over time? The therapist accepts two essential facts of the treatment: the therapist is required to juggle multiple foci of attention at once, and the therapist understands the treatment will progress in an uneven and unpredictable way. What are the “balls in the air” the therapist is juggling? As mentioned, attention to the treatment frame is paramount throughout the treatment, even when there is a well-defined treatment contract in place. In fact, the TFP therapist *expects* challenges to the treatment frame over time. The TFP therapist, as described, monitors three channels of communication continuously with emphasis on how the patient behaves and how the therapist feels. The TFP therapist actively assesses the dominant object relations paradigms as they emerge in the treatment, linking material the patient brings in from his/her life outside of treatment to the transference as it evolves in sessions. The TFP therapist will expect the initial transference to be one primarily informed by vigilance and mistrust or a “paranoid” transference. (A less common pattern would be an initial transference fully dominated by idealizing, positive

feelings, presumably keeping at bay the more negative transference.) This should not suggest the frank paranoia of a primary psychotic disorder, but an attitude that grows out of primarily splitting-based defenses. This expectation of a primarily paranoid transference may be one of the most challenging (and counterintuitive) elements of TFP for novice therapists. The TFP therapist should not expect to be liked or admired or even respected by the patient; the TFP therapist aims to be courteous and curious and consistently *tolerant* of the patient's negativity or mistrust.

The TFP therapist keeps one eye on the patient's articulated goals at all times. The TFP therapist also aims to maintain a neutral stance – warm, interested, but not overtly opinionated unless the therapist feels such an intervention is warranted. What would warrant a departure from neutrality? Any behavior that would threaten the safety of the patient or that would seriously undermine the treatment process and could not be resolved by exploration, interpretations, and understanding.

How will the therapist and patient know if TFP treatment is working? The therapist will expect things to “heat up” in the treatment in the initial period of engagement as things “cool off” for the patient outside of treatment. This might mean the patient becomes more challenging or angry with the therapist as acts of impulsivity or destructiveness outside of therapy begin to diminish. The therapist will expect that the repeated use of clarification, confrontation, and interpretation will lead to a deepening of the material at hand. The patient's increased capacity for self-reflection and growing ability to stand back and observe the consequences of splitting-based defenses should follow. Over time, the therapist will expect improvements in the patient's life outside of treatment; TFP is not done “in a vacuum,” and the therapist will repeatedly ask about the patient's work, friendships, or romance.

TFP theory borrows from the psychoanalyst Melanie Klein the terms of the paranoid and depressive positions [1]. These terms are a shorthand way of describing the patient's evolution in treatment. The paranoid position is understood as experience of self and others dominated by negativity and

mistrust paired with a contradictory experience, often less in evidence, of a wish for ideal caring and unlimited accommodation. This position is rooted in the patient's fundamental denial of his/her aggressive emotions and projection of them on the surrounding world. This leaves the patient with a sense of seeking perfect goodness in a menacing world. The term "depressive position" describes an increased capacity for nuance, albeit associated with depressive affects resulting from two developments. The first is the loss of hope for a perfect caregiver (as well as a perfect self); this loss of hope/belief in the naïve ideal other or self requires a phase of mourning before emotional stability can be achieved. The second cause of depressive affects is the remorse that results from the individual's shift to awareness that aggressive affects exist within the self and are not the monopoly of others. It may be confusing to think of the "depressive" position as the goal of treatment; it may be more useful to think of "depressive" in this case as a synonym for realistic and grounded or complex in contrast to simplistic. Furthermore, a complete treatment helps the patient move the sense of mourning and remorse of the depressive position to full acceptance of the complexity of the human condition.

2.2 The Initial Phase of TFP: Tolerating the Confusion, Naming the Actors, and Managing Affect Storms

- *The TFP therapist anticipates the initial confusion frequently encountered in the treatment of patients with severe PD symptoms.*
- *The process of "naming the actors" allows the therapist to describe to the patient the emerging dominant object relations dyads as a first step in the patient reflecting on them.*
- *The management of highly charged exchanges or "affects storms" requires the TFP therapist to focus on the patient's specific, intense experience of the treater.*

An understanding of the likely patterns of fragmentation and discontinuous affect states often observed in patients with severe personality disorder pathology will cue the therapist to expect a degree of confusion at the beginning of any treatment. What is meant by fragmentation? In this case we mean rapidly shifting experiences of self and of others, often associated with intense affect. The discontinuity in affect states over time closely correlates with the DSM-5 diagnostic criteria of mood reactivity in BPD. Let's look at two different patients who contact Ms. D., a social worker with a private practice, with the same chief complaint: "I may have depression."

Ms. A. is a 30-year-old nurse who describes a low-grade depression resulting from dissatisfaction in her work. Ms. A. feels she is not well treated by her supervisor, whom she previously admired, and believes she is unfairly faulted for errors at work that are not within her control. Ms. A. reports she is actively applying for other positions in the hospital but in the mean time has felt "low" with a diminished appetite, some difficulty falling asleep, and less than usual interest in being intimate with her fiancé. She tells Ms. D., the social worker, that she would prefer to avoid taking medication if possible, but worries that her mood disorder symptoms will compromise her ability to study for her upcoming master's degree exams.

Ms. B. is a 30-year-old nurse who describes a low-grade depression resulting from dissatisfaction in her work. Ms. B. feels she is not well treated by her supervisor, whom she previously admired, and notes her "depression" has increased since she threatened to punch her supervisor leading to her current probation. Ms. B. reports she has been distraught after this incident, particularly because she had long felt her supervisor to be a close ally and confidante. While Ms. B. suggests she may have symptoms of depressive disorder, she reports that an active sex life with her downstairs neighbor has been a notable source of pleasure while she has been off from work. Ms. B. says she is particularly disappointed in her internist who prescribed an

antidepressant that she took “for one night – it almost killed me and I may have to sue him!”

A TFP therapist beginning treatment with Ms. B. might be tempted to organize the confusing material offered in the first sessions, but following TFP protocol would instead accept the inevitable confusion offered in the narrative and use the time to begin to consider the most prominent object relations dyads described. This would be in contrast to the therapist’s attitude when meeting in the initial stages with Ms. A., who is able to lay out a coherent, cohesive story. Ms. A.’s cohesive story and understanding of the various strands of her life suggest an integrated identity and thus would situate her at a neurotic level of personality organization. When meeting with Ms. A., the therapist would ask questions to further organize the material offered; given Ms. A.’s higher level of personality organization, the therapist might feel comfortable offering a more clearly supportive treatment with an expectation that Ms. A. would be capable of using the therapist’s suggestions and insights in a productive way. With Ms. B., the therapist would begin to consider the dominant dyad, say, dependent, needy childlike figure mistreated by a careless, callous adult. The therapist might respond to the kind of chaotic material offered by a patient like Ms. B. by “naming the actors” or putting into words elements of the scenarios of self and others.

The process of “naming the actors” has two goals: it should communicate to the patient a sense of being understood, and it should help the therapist orient him/herself in a sea of confusing clinical data. The intervention of “naming the actors” is offered to the patient as a guess; the patient may accept or reject the therapist’s understanding. The therapist doesn’t stand on ceremony but invites the patient to correct any errors. If Ms. D., the social worker, were to say to Ms. B. “You describe a situation with your boss and your internist as if you’re a vulnerable child who is poorly cared for by an oblivious parent,” then Ms. B. might accept or reject this hypothesis. Ms. B. might correct Ms. D. stating: “No, that’s not it at all. It’s like I’m abuse victim who suffers

at the hands of a sadistic monster.” As noted, the TFP therapist would not correct the patient but would continue to try to refine the emerging object relations dyad as additional clinical material is offered. In the case outlined, the therapist would continue to listen for similar episodes that might confirm this pattern as a recurrent experience of self and others referenced by Ms. B.

An especially challenging situation encountered by the TFP therapist often, but not always, in the early stages of treatment is the “affect storm.” This expression aims to capture a patient’s especially intense reaction to the therapist, often infused with paranoia or rage. The TFP therapist does not attempt to “talk the patient out” of an affect storm, does not try to reason with the patient, or to introduce leavening or distracting material. The management of the “affect storm” requires the therapist to use “therapist-centered interpretations.” This concept, from the contemporary British psychoanalyst John Steiner, orients the exchange between patient and therapist in an affect storm to emphasize the patient’s negative, often paranoid, feelings about the therapist [2]. If Ms. B. were to explode at Ms. D. during an early session, to accuse her of being just as callous or sadistic as her boss or her internist, Ms. D. might be tempted to respond defensively, saying “I’m only trying to get the full story from you!” If Ms. D. were to use a “therapist-centered interpretation” she might respond: “It’s as if you see me as a cruel and hurtful authority figure, who really doesn’t care about you at all.” The goal of such an interpretation is not to change the patient’s mind or make a case for the therapist’s general good will but, rather, to contain the explosive affect and to assure the patient that the therapist, to some extent, can understand how the patient is experiencing the therapist at that moment. The therapist describes the patient’s perception without denying it or confirming it; the ability to *consider* it can help the patient begin to reflect on, rather than simply react to such ideas.

2.3 Listening for the Dominant Object Relations Dyads as They Emerge and Speculating About Patterns of Role Reversal

- *The TFP therapist will begin to appreciate the dominant object relations dyads as they emerge in material from the patient's life and become evident in the transference.*
- *The TFP therapist will repeatedly articulate the most prominent dyads, refining description of the dyads in reaction to the patient's response.*
- *The TFP therapist will expect to identify patterns of role reversal within the dyads, meaning the patient behaving in specific ways that had routinely been ascribed to important others.*

As noted, the TFP therapist's initial response to the confusion often seen with patients with severe PD pathology is to tolerate the confusion and contain the impulse to make confusing material more logical. At the same time, the therapist will begin to pick out from the confusing material the emerging dominant dyads or the patterns of the patient's experience of him or herself and others in his or her orbit.

Let's return to Ms. B., the nurse on probation from her job. Ms. D., her therapist, begins to hear a familiar story involving Ms. B., often with a different cast of characters but the general pattern remaining consistent. In Ms. B.'s case, Ms. D. begins to hear material suggesting Ms. B. sees herself as unprotected and wanting and others in her world as callous and mean. Ms. D. also identifies a persistent affect state, in Ms. B.'s case feeling hurt and angry, in these situations. Ms. D. puts her observations into words and offers them to Ms. B., open to any disagreements or modifications Ms. B. might offer.

The TFP therapist listens closely for the emerging dominant object relations dyad in the material the patient brings into the session, but also begins to consider how such dyads might emerge in the relationship with the therapist. With Ms. B., for example, the therapist begins to see how some of the same elements evident in Ms. B.'s relationship with her supervisor and internist are perceptible in their developing relationship. This focus and speculation distinguish TFP from other treatments; this is the *focus on transference*, as advertised, based on the view that the transference is a direct window into the patient's internal world. How might Ms. D. introduce to Ms. B. the transference elements she observes in their interactions? Not in a presumptuous or authoritative way, to be sure. Not in a manner suggesting superiority or weighted down with jargon, either. The TFP therapist over time will weave into discussion of the patient's life outside of treatment pertinent observations about the patient's attitude toward and behavior with the therapist.

One key element of the TFP approach to treating patients with severe PD pathology that has been an area of controversy over the years is the TFP focus on the patient's aggression. This can be a confusing subject; what is meant by aggression, anyway – is it pushing into lines, getting into fights, or driving fast? Identifying aggression in this context is less obvious or concrete; it may be better understood as identification of an impulse to victimize others in those whose chief concerns or complaints relate to the experience of feeling victimized themselves. It should also be understood that aggressive affects are not, by definition, bad. Aggressive feelings, when successfully integrated into the personality, can be sources of ambition, competitiveness, and creativity.

As mentioned, Ms. B. recounts to her therapist in almost every session some variation on a theme of a vulnerable "victim" suffering at the hands of an irrational, cruel authority figure. Ms. B. began her treatment with such a story related to her supervisor at work; over time her therapist hears of other comparable scenarios – Ms. B. mistreated and maligned. As their treatment progresses, the therapist becomes aware of a

growing sense of vulnerability *she* is feeling with Ms. B., as Ms. B. seems to find any number of faults in her therapist's behavior, often attacking her directly with caustic, taunting language. Here the patient exhibits behaviors she had previously ascribed to others and does so in a way that reflects such a pattern is outside of her awareness; this is the "role reversal" the therapist might expect in patients with severe PD symptoms.

As Ms. D., the therapist, becomes aware of this pattern of role reversal, she begins to compose a description of such behavior to propose to her patient Ms. B.

Ms. D. (therapist): "I've noticed since today's session began you've been raising your voice when describing the ways your sister is mistreating you; you seem particularly frustrated with me, feeling I'm not sensitive enough about the effects of her mistreatment."

Ms. B.: "You're just exasperating! I'm coming here for help; I'm telling you how my sister tortures me and you sit there with that ridiculous look on your face. You charge me money and end up siding with her, blaming me for everything."

Ms. D. (therapist): "You often tell me I act in the same way that your sister does, that I'm just as hurtful and abusive as she is, and we can look at that. However, I've been thinking about the nature of our communication here and what I'm about to say may come as a surprise. If you take a step back and look at the ways you've been acting toward me – raising your voice and dismissing my efforts – it's like the shoe is on the other foot, meaning your behavior toward me has some of the quality of mistreatment that you find in me with regard to you."

Here the therapist is attempting to bring to the patient's awareness aspects of her aggression not in the patient's awareness and likely to be a source of distress and dysfunction for her in her life outside of treatment. The therapist makes such a comment only after identifying the dominant dyad (in this case vulnerable patient victimized by cruel authority figure) and monitoring *her own* countertransference feeling of vulnerability, which inform her intervention.

2.4 How to Intervene: Identifying Affective Dominance and Repeatedly Using the Tools of Clarification, Confrontation, and Interpretation

- *The TFP therapist listens for the material associated with the strongest feelings expressed by the patient.*
- *The TFP therapist uses the tools of clarification, confrontation, and interpretation repeatedly over time.*
- *The therapist offers interpretations at a level of depth deemed most tolerable to the patient.*

Thus far, much of the description of TFP underscores the ways it fundamentally differs from traditional psychoanalytic psychotherapies. While this is definitely the case, TFP shares with psychoanalytic approaches the expectation that a patient will speak freely during sessions. The TFP contract reinforces this expectation; the therapist will not ordinarily direct the patient during their time together, although there are exceptions to this policy, as in any crises that might arise, or with direct threats to the treatment. The format of sessions will differ markedly from the standard medical or supportive psychotherapy model of the clinician determining the topic of conversation and asking the patient a series of related questions. For many, maybe most, patients, the expectation to speak freely and the absence of direction by the therapist is met with trepidation or laughter. “Am I just supposed to talk?” the patient may ask nervously. The TFP therapist may need to reinforce this expectation repeatedly and may need to reassure the patient that while it is common to find this process challenging, at least at the start, this method of participating in therapy helps gain access to deep levels of emotion and conflicts.

As the patient begins to speak freely, the therapist will try to determine the material offered by the patient that has the

greatest affective intensity. Sometimes this may be obvious, easily determined by the content, by the patient's tone of voice, or by the patient's facial expressions. Sometimes determining the material of greatest affective intensity may be more challenging, particularly when there may be a discrepancy between an *absence* of expressiveness in evidence when the content of the material offered by the patient seems clearly fraught to the therapist. (For example, the patient who communicates in a dispassionate monotone, "Today is my twenty-fifth wedding anniversary." The therapist's observation about the patient's blunted affect when introducing this particular content would prompt the therapist to point out this discordance.) This process of identifying the material of affective dominance helps to orient the therapist; this should prompt the therapist to use the intuitive interventions of clarification and confrontation to bring critical aspects of the patient's internal world that might be shut out of awareness by dissociative defenses to light.

The presence of severe PD symptoms often has an impact on a patient's ability to share material in a coherent and easily understood way. Patients with BPD may demonstrate rapidly shifting experiences of self and others, making it almost impossible for the therapist to follow. Some patients with narcissistic traits may present material as if it were *assumed* that the therapist has the pertinent background information or knows the players involved in any particular story. The TFP therapist may spend much of the time in initial meetings asking for clarification of details. The therapist does so with genuine curiosity and thereby conveys to the patient a sincere interest in the details of the patient's life. The therapist will repeatedly intervene, asking "Can you tell me more? Can you be more specific?" The therapist will ask the patient to supply details to make clear any material that is vague or puzzling. There may be times when the patient will communicate that a particular subject is too difficult or distressing to explore; the TFP therapist will be respectful of the patient's wish to set limits on certain areas of exploration, but will remain curious about all subjects going forward, even those particularly sensitive or upsetting.

It should be apparent that the process of clarification, likely considered routine or benign in many clinical situations, could have considerable significance in the emerging transference in a TFP treatment. How might a relatively straightforward request for more information have such significance? A patient's lack of clarity may reflect shame or mistrust or dishonesty or the assumption that the therapist is omniscient and can understand without full explanation; the TFP therapist's request for more information may feel accusatory or intrusive with some patients. Alternatively, the patient with a more idealized experience of the therapist in the beginning of treatment may experience clarification questions as highly gratifying or even seductive. The point here is that consideration of transference and countertransference currents is part of TFP treatment from the very earliest stage of treatment. How and in what way the patient presents even the most basic material will have clinical significance.

The intervention of confrontation follows closely on the heels of clarification; confrontation will have particular resonance with severe PD patients because the process aims to bring into the patient's awareness aspects of his experience that are, at baseline, kept apart. Confrontation in this context has a different meaning than the more common definition that implies conflict or dispute; in this case, confrontation means the process of bringing to the patient's attention any information that might be at odds or discrepant. Again, the process of confrontation in TFP isn't a preamble to the treatment – it is *part* of the treatment, albeit in the guise of the therapist's data collection. Inquiring about a discrepancy in the patient's communication is an invitation for the patient to reflect. When the therapist points out to the patient, "You're saying now you feel this way about Maria; I'm struck because during our last meeting you said something very different about Maria," the therapist may be addressing aspects of the patient's splitting or alternating idealization and devaluation of another over time. The patient's reaction to such a confrontation may reflect a capacity for self-reflection, "I see that doesn't quite add up"; on the other hand, the patient could react with anger, responding: "I said that about Maria last time because she was so awful

to me then; today I'm talking about how sweet she is. Can't you understand the difference?" Either response is useful information for the therapist; the latter response offers the therapist an opportunity to explore the patient's negative transference, considered essential in a TFP treatment.

Many novice therapists may feel a particular pressure to make "important" or "deep" interpretations, almost along the lines of now caricatured orthodox psychoanalytic pronouncements from another era. Often these novice therapists feel compelled to include in these interpretations material from the patient's distant past, as if the importance or depth of an interpretation requires it to include material from the patient's childhood. In TFP an interpretation is considered the therapist's hypothesis about the patient's motivation proffered only after an extended period of clarification and confrontation. The TFP therapist is always asking: If I offer the patient a hypothesis about his or her motivation, am I doing so in a way the patient can tolerate and use what I'm offering? This question reflects the overall stratagem of approaching the patient with a "surface-to-depth" appreciation of the patient's defenses. The defenses are there for a good reason; staying too long on the surface, the therapist might be focusing on material that is obvious or inconsequential; going too deep, the therapist might dismantle much-needed defenses, offering a hypothesis before the patient is ready to use it.

TFP interpretations will target distinct levels of the patient's functioning. These interpretations may include:

- The direct interpretation of particular primitive defenses and the ways certain maladaptive behaviors may help patients manage specific internal experiences
- The interpretation of the active object relations dyad and, if applicable, its reverse, as already described
- The interpretation of the way a particular object relations dyad, clearly evident on the surface, may keep at bay a contemporaneous object relations dyad that might be more anxiety producing for the patient

Let's return to Ms. B. and her therapist Ms. D. in discussion of these different subtypes of interpretation. Early in their work together, Ms. D. learns enough about Ms. B. and the particular primitive defenses she uses (and associated maladaptive behaviors) to feel confident enough to offer an interpretation to Ms. B. about specific internal experiences she speculates might be a particular source of distress to her. In Ms. B.'s case, one primitive defense identified might be splitting, or an alternating experience of another as either purely idealizing or devaluing, as in the case with Ms. B.'s supervisor at work. The associated maladaptive behavior in this case might be the acting out of threatening violence, a behavior with a variety of concerning repercussions. Ms. D. may interpret for Ms. B. that her growing attachment to her supervisor made her feel vulnerable in ways not fully in her awareness and that her intensely destructive outburst was a reaction to that vulnerability.

As outlined, the process of identifying a role reversal in an object relations dyad is a way the therapist can acknowledge a behavior split-off from the patient's awareness. The intervention of identifying such a role reversal in the patient's relationship with the therapist can be an unusually powerful and effective interpretation of this sort. In this case, the therapist is offering a hypothesis along the lines of: I'm wondering if the distress you describe as a steady barrage of ill will from others might, in fact, reflect a two-way street?

Over an extended period, when the TFP therapist has repeatedly focused with a patient on an object relations dyad on the surface, such as that observed in the case of Ms. B. and her therapist Ms. D., the therapist will begin to consider what defensive purpose it serves the patient to be mired in such a routine. It seems Ms. B., at least on the surface, can only operate on "two speeds," as it were; she is either feeling mistreated and rejected by others or, as her therapist points out, Ms. B. herself is mistreating and rejecting others with an equal, if not greater, vehemence. This possibility suggests one dyad, infused by paranoid thinking and negativity, may be a comfort of sorts in its own way. Ms. D. suggests this to Ms. B.:

“I’m wondering if being in a state of constant vigilance and mistrust, despite the toll it takes, confers some kind of comfort and reassurance for you. At least you know where you stand, as with your supervisor, your sister, or with me. I’m aware that despite your stated displeasure with me and with our work together, you nevertheless come to every session. This suggests to me you have some good feelings for me, maybe even a growing dependence, and that these positive feelings are threatening in their own way. If you have positive feelings for me you’re *really* vulnerable; you just don’t know what I might do to you in that case.”

An interpretation like the one above is done only after considerable preparation; the therapist wants to know if the patient can tolerate such an exchange and wants to have some optimism such a hypothesis if offered might be useful to the patient; this is the “surface-to-depth” concept. The therapist may have had an inkling for some time about the way the object relations dyad on the surface helped the patient manage anxieties associated with the object relations dyad kept outside of her awareness; following the TFP approach, the therapist would have waited patiently until she had confidence the patient could hear and use such an observation.

2.5 What Happens Over Time: Increased Self-Reflection, Integration of Positive and Negative Feelings, and Improved Functioning Outside of Treatment

- *The overarching goals of an individual TFP treatment are the modulation and integration of extreme positive and negative experiences of self and others: the integration of identity.*
- *The patient’s increased capacity for self-reflection should follow the deepening of treatment over time.*

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- *The TFP therapist will expect positive changes in the patient's life outside of treatment.*
- *The TFP therapist will monitor for evidence of the evolving depressive position as it replaces the generally dominant paranoid position over time.*
- *While TFP has a specific trajectory for an individual treatment, the component parts of TFP have value on their own.*

TFP as an individual treatment has a defined trajectory; the TFP therapist has a number of aspirations for the treatment, a combination of personality changes (perhaps more simply described as the patient's improved coping strategies and an appreciation of the depth and complexity of self and others) and actual changes in aspects of the patient's life outside of the treatment. TFP is not, by any means, a brief treatment intervention; the TFP therapist will estimate the duration of the treatment to be somewhere between 1 and 3 years, sometimes more. Obviously such an extended treatment might not fit well when a "quick fix" is expected. Regardless of the duration of the treatment, an "applied TFP" philosophy would identify potential gains for the patient at every step of the treatment, even if it were not to unfold in a "platonic" or ideal way.

When Ms. D., the social worker, first encountered Ms. B., the nurse on probation from her job following a threat to harm her supervisor, Ms. D. immediately sensed she would need to proceed with TFP "by the book" given the acuity of the case and her own countertransferential anxiety. Ms. D. proceeded stepwise with the many required elements of the treatment including:

1. Assessment using the structural interview.
2. Generation of a differential diagnosis including standard DSM-5 nosologic categories, as well as specific personality disorder traits and diagnoses.
3. Explicit discussion with the patient about the personality disorder diagnosis made and the ways its course and treatment would differ from a primary mood disorder presentation. (Recall Ms. B.'s chief complaint that she believed she might be suffering from "depression.")
4. An extended contracting phase with ample opportunity to air Ms. B.'s objections to elements of the treatment frame as outlined by Ms. D. Given Ms. B.'s history of a threat of violence toward her supervisor, Ms. B. stressed the treatment-threatening potential of similar behavior going forward.
5. An explicit discussion of Ms. B.'s personal goals and treatment goals.
6. Ms. B.'s consent for Ms. D. to review the case with Ms. B.'s prescribing internist.
7. A meeting with Ms. B.'s sister, her closest family member, to review the diagnosis, details of the treatment, and risks and benefits of alternative treatment interventions.

Ms. D. began her work with Ms. B. aware of the multiple elements of the treatment that she would be required to monitor as the treatment unfolded. These elements included:

1. Orientation to Ms. B.'s personal goals (returning to her work as a nurse and developing a career, finding a relationship that would allow her to combine passion and companionship) and treatment goals (understanding her pattern of self-defeating behavior and difficulty combining closeness and sexual satisfaction)

(continued)

(continued)

2. Ms. D.'s attunement to the three channels of communication
3. Identification of the affectively dominant material during each session
4. Continued attention to the treatment frame and exploration of challenges to the frame as they arise
5. Continued refinement of Ms. D.'s identification of the dominant object relations dyads in evidence and consideration of role reversals
6. Use of clarification, confrontation, and (eventually) interpretation to expand the material offered by the patient and to engage the patient by offering speculation about unconscious processes
7. Ms. D.'s priority of maintaining a neutral stance, unless some aspect of Ms. B.'s behavior (e.g., a threat to physically harm someone) required deviation from this neutrality
8. Speculation about contemporaneous dyads and the interplay between dyads, more specifically, the ways a dyad on the surface might be shrouding a coexisting dyad, which might somehow be more threatening or less tolerable

As will be outlined in the coming chapters, clinicians may apply these individual elements in varying clinical situations. Clearly some of the TFP interventions are likely only useful when applied during the course of an extended individual psychotherapy, while others will have more broad utility.

What are Ms. D.'s overarching goals for her treatment with Ms. B.? How will she know if TFP is working as a treatment? As noted, Ms. D. expected the treatment to "heat up" in the initial stages as things "cooled off" in Ms. B.'s life outside of treatment. In the early stages of treatment, Ms. D. received concerned phone calls from Ms. B.'s sister; over time she stopped receiving those calls. Ms. B. followed the contract she

and Ms. D. established and returned to her job part-time. As Ms. D. anticipated, the early months of the treatment were marked by repeated exploration of Ms. B.'s paranoid transference toward Ms. D.; Ms. B. came to their sessions, but she repeatedly questioned Ms. D.'s motives and faulted her for what Ms. B. perceived to be "errors" in her approach. Ms. D., rather than shying away from Ms. B.'s criticism and suspicion, mined Ms. B.'s complaints for additional information.

Ms. B.'s treatment proceeded with a typical "saw tooth" pattern. She would make some improvements in her outside life (she returned to work, she started dating) and seem to settle into the treatment, only to miss a number of appointments or challenge some other aspect of the treatment contract. Again, Ms. D. made such behaviors the focal point of their sessions; she repeatedly and consistently conveyed to Ms. B. in her actions that she could tolerate her negative feelings and aggression as long as they continued in their work with a sturdy frame intact.

Ms. D. began to observe in Ms. B. the gradual development of a more self-reflective perspective. The repeated use of clarification and confrontation contributed to this process; Ms. D. would consistently ask to learn more from Ms. B. and would bring to Ms. B.'s attention material that seemed somehow contradictory to her therapist. Ms. D.'s interpretation of the role reversals she witnessed, while at first a source of surprise and protest from Ms. B., appeared to take hold and lead Ms. B. to a pattern of increased self-awareness. Ms. B.'s increasingly regular attendance and growing capacity to speak freely about important and difficult subjects suggested to Ms. D. that despite her continued superficial antagonism toward her therapist, she was, in fact, growing more comfortable and even dependent. Ms. D. offered this observation to Ms. B. only after many months of treatment and only as Ms. B. continued to consolidate the gains she was making outside of treatment.

As described, the TFP therapist will actively monitor the critical elements of the patient's life outside of treatment. While it is true that the patient is expected to speak freely at each session, the TFP therapist will initiate discussion of

topics critical to the patient's functioning outside of treatment if the patient does not spontaneously raise such matters. In the clinical material supplied above, for example, Ms. D. would routinely ask Ms. B. about her work performance or her dating life, if material related to these topics was not initiated by Ms. B.

The TFP therapist expects that much of the work done with patients with severe PD pathology in the early and mid-phases of treatment will be marked by a predominantly paranoid transference. This particular observation may seem misguided, if not downright mistaken, by many clinicians unfamiliar with TFP. Very often clinicians who engage with patients in an extended, supportive treatment dominated by the patient's superficial idealization of the therapist will find the idea that a paranoid transference – wariness with regard to the therapist – should predominate to be absurd. This is the familiar scenario of the therapist who feels he/she has a “good” relationship with the patient, who has endeavored to “work hard” on the patient's behalf over an extended period, only to find the treatment is not progressing and that the patient's aggression (e.g., a wish to defeat or humiliate the treater) has been driven underground (such a clinical situation is included in an article on the use of TFP concepts in consultations for *Overwhelming Patients and Overwhelmed Therapists*) [3]. Extended work in the paranoid transference is the expectable part of work with patients in what Melanie Klein called the “paranoid position [4].” As TFP treatment progresses, the therapist begins to notice elements of the “depressive position” that while not wholly dominating, become more apparent. The therapist will begin to appreciate the patient's more integrated and nuanced experience of self and others. Harsh, caricatured, or one-dimensional appraisals are softened; the patient is increasingly able to hold on to positive experiences of self and others, even in more stressful situations. It is, of course, somewhat counterintuitive to suggest that a “depressive” state would be the result of a helpful treatment. In Ms. D.'s treatment of Ms. B., the therapist recognized aspects of the emerging depressive position as Ms. B.

came to terms with the loss of the previously held wish for an experience of an ideal boss or boyfriend. The loss of the transiently intoxicating “all good” or “all bad” experiences is only partially cushioned by Ms. B.’s new stability. Ms. B.’s wistful recall of that old order suggests to her therapist the emergence of a kind of “depressive” state, while as a result of their work together, Ms. B. is showing evidence of an increased capacity for integration of feelings; it comes with the loss of a hoped for ideal but with a much-improved relationship with reality.

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