

Transference-Focused Psychotherapy in the General Psychiatry Residency: A Useful and Applicable Model for Residents in Acute Clinical Settings

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Abstract: Transference-focused psychotherapy (TFP) is a manualized, psychodynamic treatment for severe personality disorders. Training in TFP during residency can provide a readily applicable model for understanding and treating personality pathology in a variety of settings, even for residents who do not obtain additional training in psychodynamic treatments or go on to practice psychotherapy. Although TFP was developed as a long-term outpatient treatment, the authors have found the diagnostic and theoretical framework and the clinical techniques described in the TFP treatment manual to be useful in acute settings, even when the clinician does not have a clearly established relationship with the patient. In the authors' experience, residents find this model of understanding and working with patients with personality disorders enjoyable to learn and easy to apply.

Residents see a broad spectrum of patients in multiple treatment settings: inpatient psychiatric units, medical/surgical units as part of the consultation-liaison service, the emergency department, and outpatient psychiatry clinics. With the exception of the outpatient clinics, encounters are brief; residents will see many patients only once or at most a handful of times, often within a busy clinical setting with limited opportunity for privacy. In all of these settings, personality disorders (PD) are common (Bender et al., 2001) and affect the presentation

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and management of acute, comorbid problems (Skodol & Gunderson, 2005). Patients with PDs tend to have a more complicated presentation, to require more staff attention and resources, and to merit a more extensive risk assessment than do patients without personality disorders (Black et al., 2006). The behavior of these patients is difficult to understand, difficult to manage, generates logistical problems, and stirs up strong and uncomfortable feelings in the treatment team.

Psychiatry residents are often the "first responders" for the clinical crises that routinely emerge in relation to personality-disordered patients in acute care settings, be it the inpatient unit, emergency department, or consultation-liaison service. While challenging even for experienced clinicians, these clinical situations are especially confusing and overwhelming for trainees. Personality pathology lends an element of urgency to *any* clinical presentation, and typically, by the time the resident arrives on the scene, affects are high and confusion reigns, emanating both from the patient and from the clinical staff.

The ubiquity of personality disorders in acute care settings and the challenges posed by their management focus attention on how we train our residents to work with this patient population. In this article, we present an innovative training model that provides residents with a sophisticated, psychodynamically informed framework from which to conceptualize and manage personality-disordered patients in acute settings.

TRANSFERENCE-FOCUSED PSYCHOTHERAPY IN RESIDENCY TRAINING

Current training for residents on the management of "difficult" patients in acute settings tends to focus on risk assessment and pharmacological de-escalation tools; training in nonpharmacologic interventions is largely limited to recommendations for maintaining safety coupled with general management strategies, such as maintaining a calm demeanor, setting limits, and providing support, validation, and empathy (Riba & Ravindranath, 2010). More advanced and specific training in managing patients with personality disorders is provided in the setting of longer-term outpatient treatment, and often the skills acquired in learning these treatments (e.g., dialectical behavior therapy, cognitive-behavioral therapy, supportive therapy) are not easily translated to the acute setting, and are not readily employed with an uncooperative and often agitated or paranoid patient meeting the resident for the first

time. Training in diagnostic evaluation and classification of personality pathology during residency emphasizes determination of a descriptive, *DSM-IV-TR* diagnosis, an assessment that provides little in the way of an overarching understanding of personality disorders or guide for clinical intervention.

What residents need and what is largely lacking in current models of education is training that provides a way to understand how personality disorders arise in acute medical and psychiatric settings, and a way to organize psychotherapeutically informed de-escalation tools. An ideal model would be inclusive and dimensional, allowing for the full range of clinical presentations to be represented. It should also be advisory, with diagnosis pointing toward a specific set of treatment interventions. In our experience, training in TFP (Clarkin et al., 2010) meets these criteria.

TFP is an evidence-based treatment for borderline personality disorder in particular and severe personality disorders in general (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010). A twice-weekly, long-term, individual psychodynamic psychotherapy, TFP combines contracting and limit setting with psychodynamic interventions. Psychodynamic interventions focus on exploring how the patient is experiencing the therapist in the moment ("transference") and on monitoring and using the therapist's internal reactions to the patient ("countertransference"). The treatment is clearly and systematically described in a principle-driven treatment manual that is an ideal text for training purposes. Learning TFP provides residents with a theory-based approach to conceptualizing and classifying personality pathology that is linked to a coherent, clearly defined approach to treatment.

We have found that training in TFP enables residents to apply elements of the treatment and the underlying model not just in the setting of long-term outpatient psychotherapy, but also on an as-needed basis in a wide variety of clinical settings. Thus, while TFP has been developed and formally taught to residents as a long-term outpatient treatment, we have found that it also provides residents with a "toolbox" for managing personality disorders that can be used in acute settings. Residents develop knowledge, attitudes, and skills for working with personality pathology, which enable them to do more than oversee medication administration and grapple with the logistics of physically restraining patients. As a result, rather than feeling overwhelmed and defeated when faced with challenging situations in an acute treatment setting, residents can come to experience themselves as able and skilled clinicians.

Knowledge, Attitudes, and Skills

In this article, we focus on the core knowledge, attitudes, and skills acquired by residents learning TFP that can be exported to other settings. We first outline essential aspects of the treatment that are easily applied in acute settings and then provide a series of vignettes, illustrating how residents in their day-to-day practice are able to use what they learn by treating patients in TFP. In particular, we focus on the following central elements of the treatment that can be used piecemeal in a flexible and pragmatic way in a variety of clinical settings:

An Organizing Theoretical Framework for Diagnosis. TFP is based in psychodynamic object relations theory as it has been developed by Otto Kernberg (Kernberg & Caligor, 2005). In this model, diagnostic assessment focuses less on the kind of descriptive features of personality disorders emphasized in the *DSM-IV-TR* (American Psychiatric Association, 2000) and more on evaluating the patient's "level of personality organization," an assessment organized in relation to the severity of personality pathology. In contrast with the *DSM* approach, once a resident learns how to determine a patient's level of personality organization, he or she has learned to make an assessment that has direct implications for treatment planning and clinical intervention. This approach also has the advantage of taking the focus away from counting criteria and trying to shoehorn patients into specific diagnostic categories that they may or may not fit neatly into, and instead focuses on diagnosing the presence of a personality disorder of any kind and its level of severity. Diagnostic evaluation and classification of personality pathology in this model focus on identity formation (to what degree is the patient's experience of self and others stable, realistic, characterized by subtlety and depth, or unstable, distorted and superficial?), defensive style (to what degree does the individual rely predominantly on relatively adaptive, higher-level defenses, or on more maladaptive defenses based on splitting and denial?), and reality testing (to what degree is reality testing stable, or is it vulnerable in a setting of acute stressors?).

An Organizing Theoretical Framework for Clinical Process. TFP is based in psychodynamic object relations theory. Within this frame of reference, psychological experience is organized by internalized relationship patterns, each comprising a representation of the self interacting with a representation of another person, linked to a particular affect state. (For example, we might see a representation of a well-cared-for child in relation to an attentive parent, linked to feelings of gratification, or a representation of a neglected child in relation to an unavail-

able parent linked to feelings of frustration.) These dyadic cognitive-affective units are referred to as *internal object relations*. Different internal object relations will be activated in different contexts, so that at any given moment a particular object relation will organize an individual's subjective experience. In the setting of severe personality pathology and especially during crises, these dyads tend to be especially highly affectively charged, extreme, and unstable.

In learning TFP, residents are exposed to this theoretical model and then learn how to apply it in their clinical work. Having a clearly articulated theoretical framework to fall back on can help residents bind anxiety by providing a vehicle for organizing their thinking in the face of the confusion and chaos that often surround patients with personality pathology in acute clinical settings.

A Focused Approach to Organizing Clinical Data. In TFP, clinical attention and intervention at any moment focus on the "affectively dominant object relation" or the patient's view of himself or herself in relation to another person that is organizing the patient's experience in the moment. Identifying the dominant object relation provides an organizing frame to guide the clinician's thinking. Asking oneself, "What is the dominant object relation?" can anchor and organize the resident's approach to a clinical situation that feels confusing or out of control. When treating patients in TFP under supervision, residents learn how to sift through clinical data, the three channels of communication—what the patient is saying, doing, and making the resident feel—to identify the dyad that organizes the patient's current experience. Identifying this dominant object relation dyad helps the resident formulate an understanding of the immediate clinical situation and serves as the foundation for clinical intervention. This process also leads the resident to reflect upon and empathize with the patient's internal experience in the moment.

Managing and Making Use of Countertransference. Patients with personality disorders predictably stir up strong reactions in clinicians and clinical staff. In the course of working with a patient with a severe personality disorder, it is common to experience moments of overwhelming confusion and at times to be flooded with intense and extremely uncomfortable affects. One characteristic of these countertransference reactions is that they tend to induce in the clinician a strong impulse to act, to immediately do something to change the situation, and to modify the unpleasant affect state that is being stimulated. Often this demand for action leads to hasty judgments and clinical decision making that can escalate rather than de-escalate a crisis.

In learning TFP, residents develop and practice monitoring their internal reactions to their patients while refraining from immediately act-

ing upon them. The resident learns in moments of confusion and crisis to step back and ask, "What am I thinking and feeling?" leading to the adoption of a stance that involves restraint and reflection. Because patients with severe personality disorders often communicate nonverbally what they are unable to communicate in words, the countertransference serves as an important source of information in the management of patients with personality disorders. In supervision, residents learning TFP are taught to use their countertransference experience to better understand and empathize with the experience of the patient.

Identifying Oscillating Role Reversals in the Clinical Setting. In TFP, clinical interventions are organized around various levels of instability that predictably characterize the therapist-patient interaction. In any clinical setting, it is common for the patient with a personality disorder to experience the therapist in a particular way—for example, as devaluing—while at the same time treating the therapist in an identical fashion—for example, devaluing the therapist. This process can cause a great deal of confusion on the part of patient and therapist alike, reflecting the impact of dissociative defenses, in particular projective identification, on the interpersonal field.

In TFP, the early phases of intervention focus on capturing and articulating this process, calling the patient's attention to split-off aspects of his or her experience that are being expressed behaviorally in the moment. When residents are trained in TFP, they practice identifying these "role reversals," making sense of them, and putting them into words so that the patient can better attend to his or her behavior.

Putting the Patient's Experience into Words. In TFP, the therapist's verbal interventions are conceptualized as a three-step process. The first step the resident learns is to *clarify* with the patient what it is that the patient is experiencing, and then to put the patient's experience into words. This relatively straightforward series of interventions involves focusing the patient's attention on an area colored with anxiety, and helping the patient to think more clearly about the specific nature of his or her experience. In TFP, putting words to the patient's experience provides what is referred to as "cognitive containment of affect." This intervention can at times help patients feel less lost in the moment and better able to think about what is going on, and to distance themselves to some degree from their immediate affective experience. Putting the patient's experience into words also involves the resident's directly addressing the patient's anxiety, while at the same time implicitly communicating empathy for the patient's situation.

Bridging the Split. The second level of intervention in TFP, after putting the patient's experience into words, is to call the patient's attention

to the contradictory nature of his or her experience. Most typically, this involves pointing out the dissociation or "splitting" of two different versions of the current situation, one colored by positive affect ("idealized") and another by negative affect ("paranoid"). Interventions of this kind are described as *confrontations* of the patient's split view of the situation but—contrary to the colloquial implications of the word—confrontation involves tactfully and gently calling attention to discrepancies and contradictions in the patient's thinking and experience. The process of confrontation encourages patients to step back and reflect, and to remove themselves from the immediate emotional situation in order to adopt a broader perspective across time, including a consideration of the current view in light of views held at other times or in other settings. At times of high affect activation, interventions of this kind can help improve patients' shaky reality testing and aid them in behaving in a more adaptive fashion.

It is not only individuals with personality disorders who are prone to splitting. In the clinical management of patients with personality disorders, it is common for "splits" to develop within the treatment team, with one group having a positive or sympathetic view of the patient, and another group a negative or critical view. This group process reflects the impact of the patient's defensive style on the team. In the group supervision that is the cornerstone of residents' training in TFP, it is common for similar divisions to develop. Discussion of this process in the supervision group provides opportunities for residents to develop skills for managing and bridging splitting within a treatment team.

Helping Patients to Step Back and Better Distance Themselves from the Immediate Affective Experience. The goal of TFP is to help patients better manage painful and anxiety-provoking aspects of their internal experience and to cope with them more adaptively. The overall strategy is to support patients' developing capacity to step back and observe themselves, and to reflect upon their behavior and internal experience during times of stress and heightened affect activation. In long-term outpatient treatment, the TFP therapist promotes this process over time by repeated cycles of clarifying the patient's experience, confronting splitting and related defensive operations, and ultimately interpreting the meanings and motivations driving the patient's defenses, while at the same time maintaining a reflective stance. In order to make use of the final step in the intervention sequence, interpretation, patients must be in a reflective frame of mind in which they are thinking in terms of internal, subjective states. As a result, interpretations are generally not effective in acute settings. However, having developed an understanding of the overall strategy of the treatment in the setting of long-term

TFP treatments, residents then learn to use their interpersonal exchanges with patients in crisis to help the patients develop greater distance from their immediate experience.

CLINICAL VIGNETTES

We will present three clinical vignettes in which the authors describe patient encounters that they had during residency. The vignettes involve three patients with very different types of personality disorder: one borderline, one paranoid and antisocial, and one narcissistic. The patients were seen in three different settings: an inpatient medical service, a forensic medical unit, and an inpatient substance abuse unit. We identify core clinical skills acquired by the resident while learning TFP, which the resident was then able to apply in this diverse array of acute clinical situations. In all the examples, the resident was able to step back from an intense, affect-laden situation to observe the dyad in the moment. From this vantage point, she was able to develop an understanding of what was driving the current crisis and to design an intervention to de-escalate it.

Vignette 1*

Ms. A was a 48-year-old woman with a history of major depressive disorder, irritable bowel syndrome (IBS), and reflex sympathetic dystrophy (RSD). She was admitted to the medical floor for work-up of multiple nonspecific symptoms, such as a burning sensation on her skin, abdominal bloating, and neck/back pain that she rated 10/10. After multiple laboratory and imaging tests were performed, the patient was told that there were no new findings that could be treated on an inpatient basis, and that her symptoms were consistent with RSD and IBS. It was suggested that she follow up with her neurologist and gastroenterologist as an outpatient. Upon hearing the team's plans for her discharge, the patient became quite angry, yelling at the nurses, doctors, and her roommate, and refusing to leave the hospital. A psychiatry consult was called without a specific question; the team simply stated: "The patient is being very rude and yelling at us and she refuses to leave. Can you help us?"

*Names have been changed and personal clinical material has been disguised.

The patient initially refused to speak with the resident after she introduced herself as a psychiatrist, yelling, "Another stupid doctor who doesn't know anything! I'm not crazy, I need help, and I'm not leaving until someone helps me." The resident answered, "Can you tell me what kind of help you'd like?" The patient responded by mocking this question, repeating it in a sing-song voice, and saying, "I bet you don't even know what RSD is—you probably have no idea, all your education and you people can't help anyone."

Diagnosing a Personality Disorder and Managing Countertransference. The resident felt a wave of irritation rising and began to entertain a multitude of defensive responses to the patient's attacks on her intelligence, ability to help her, and the utility of the entire medical profession. The resident was, at the same time, immediately able to make the diagnosis of a personality disorder. Armed with this understanding, she was able to take note of her feelings and restrain herself from acting on them. Reflecting on what she was experiencing, she recognized that the responses she was tempted to make would be counterproductive, creating the kind of escalating, hostile interactions that the patient seemed highly skilled at engineering. The resident stood by the bedside quietly as she thought this through. The patient continued to yell, "Why are you just standing there? You don't know shit, you and all these idiot doctors who can't do shit!"

Once the resident had made the diagnosis of a personality disorder, she was able to organize her approach to the patient. Her first objective was to contain and observe her own emotional responses. Managing her countertransference allowed her to avoid immediately acting on her feelings and potentially further escalating the patient's agitation. As she was able to step back from the transference-countertransference, she could consider the situation more objectively and think more clearly. This freed the resident to make use of an organizing framework.

Relying on an Organizing Theoretical Framework and Asking, "What is the Dominant Object Relation?" The resident asked herself, "What's the dyad here?" In asking the question, she noticed a palpable sense of relief, as her feelings of anxiety and defensiveness diminished. By focusing on a cognitive task and trying to organize the clinical data, she was able to better manage and distance herself from the affects induced by the patient, and to avoid reacting to them in a potentially harmful fashion. She invoked months of TFP supervision in which repeated practice in applying the question to different clinical situations allowed for it to arise spontaneously and reflexively in this one. As she was exploring the dyad in her mind, she became aware of feeling herself a skilled psy-

chiatrist. This was in contrast with how she had felt in similar situations in the past, which was more like an untrained security guard called upon to de-escalate a conflict between a patient and the medical team.

The resident's ability to ask the question "What's the dyad?" organized her thinking and grounded her in an affectively charged situation. She felt herself fully engaged in working toward fuller understanding rather than simply focusing on de-escalation.

Identifying the Dyad, Observing Role Reversals, and Empathizing with the Patient's Internal Situation. Reflecting upon the patient's situation, the resident realized that the patient must feel frustrated by her illness and by having a complete lack of control over her medical management. Her understandable anger in this setting extended to those who, from her perspective, were withholding treatment and failing to help her. The resident was able to reflect on what had happened and to appreciate the fact that at the same time the patient was making the medical staff feel powerless and frustrated, the patient herself felt powerless and frustrated as well.

With her countertransference successfully managed, the resident was able to imagine the patient's experience and to recognize the patient's feelings of powerlessness and her wish for the doctors to feel in kind. The resident could distill out of the clinical process a dyad of a powerless and helpless patient facing a dismissive and frustrating medical system, and could see how the patient's behavior reflected role reversal within this dyad. The resident was struck by the degree to which the patient was able to induce the same feelings of powerlessness and frustration in her treatment providers that the patient herself was experiencing.

Intervening: Putting the Patient's Experience into Words, Directly Addressing the Patient's Anxiety, and Using Empathic Confrontation to Bridge the Split. Calmly, the resident said to the patient, "Ms. A, I can see that you are in tremendous pain, and it must be horrible to be in that much pain and not get any answers from your doctors about why you are in this pain or how to make it better."

The patient said, "That's fucking right!"

"But yelling at your doctors doesn't make them any smarter or any better at helping you. In fact, it probably makes them feel pretty awful."

"I don't care how they feel."

"Well, maybe you do—maybe you want them to feel as badly as you do. I can see why you would. They have failed you on a certain level."

"They should feel bad. They are idiots who can't help anyone."

"Yes, that has been your experience, it seems. But I can assure you, they are actually trying to help you, and the fact that they can't is prob-

ably frustrating for them as well. It's hard for a doctor not to know how to help someone."

And there the patient stopped yelling. She said quite calmly, "Well, they should feel bad. I'm in a lot of pain. But I guess if they can't find anything else wrong to explain it, it's not their fault."

Armed with a hypothesis about the dyad being enacted, and a sense of calm brought about by her ability to think in this chaotic situation, the resident decided to intervene by putting the patient's experience into words while empathizing with her. The resident then went on to provide a confrontation, calling into question the patient's split, paranoid orientation toward her doctors, and bringing a more sympathetic view into the discussion. The resident was pleasantly surprised by the positive response to her intervention; she could see that the patient had experienced the intervention as helpful, and that it had supported the patient's reality testing and enabled her to calm down.

Vignette 2

Mr. B was a 29-year-old African American male with no formal past psychiatric history who was currently incarcerated in a local jail. He had been transferred to the forensic medical floor of the hospital after his jaw was broken, reportedly by corrections officers at the jail during a violent altercation. He had a long history of polysubstance dependence, including stimulants and PCP, and had spent a significant amount of time incarcerated for robbery, assault, and various other crimes. He remained on the medical floor awaiting surgical correction of his jaw. He had repeatedly been provocative with staff and often appeared highly aggressive.

A crisis code was called one morning because the patient had been pacing the hallway and threatening staff loudly, refusing to go back to his room. By the time the resident arrived with the crisis team, the patient had retreated to his room, but he continued to yell and pace. He was angry because he had been invited to the law library by a staff member just minutes before, but had sent her away in his grogginess upon waking; realizing his error, he attempted to run after her down the hallway but was stopped by staff. He quickly became agitated and a corrections officer had to physically restrain him. In the process, the patient's face had been inadvertently touched. He was yelling, "How could he touch my face? He knows my jaw is broken and he's trying to make it worse for me!"

Arriving on the scene, the resident immediately felt threatened by the patient's intensity and by his size. As he paced around his room he was a formidable presence, and he appeared tense, as if he were ready to strike. The resident said, "Mr. B, can you please sit down so we can talk about this?"

"No! I didn't even do anything, why am I always the one that has to calm down?! That guy knew what he was doing, he's slick like that, he's got it out for me."

"At least lower your voice a little so we can try to discuss this."

"I told you, there's no point! Why are you even talking to me—go talk to that officer!"

Managing Countertransference and Making Use of It to Empathize with the Patient's Internal Situation. The resident was aware of feeling physically vulnerable and frightened. In addition, she found herself confused, unclear about what had actually happened. She felt an urge to turn around and go find the officer, to see if he had in fact been sadistic to this patient. She felt a mix of emotions: a combination of fear and anger in relation to the patient, concern that something unjust had happened, and mistrust of a large forensic system over which she had no control. Meanwhile, she was well aware that the entire crisis team was waiting and watching, and she felt pressure to handle the situation quickly.

Tolerating her confusion and reflecting on her own feelings of vulnerability and fear, anger, and mistrust, the resident began to appreciate that her feelings must mirror what the patient was feeling. She remembered what she had learned about projective identification in her TFP seminar.

The resident inquired of the patient, "How did you break your jaw?"

"The guards at [the local jail] put me in a cell and beat me for half an hour. They have it in for me, just like this guy does. I know they all talk, I know he knows about me and has it out for me. The other day, I heard him say 'yeah, just take him in the back.' There's no cameras back there. He wanted to get me alone just like they did [at the jail]."

Identifying the Dyad and Observing the Oscillation of Roles. Listening to the patient, the resident was able to appreciate the degree to which he was feeling not only enraged, but also powerless and vulnerable, how frightening it must be to anticipate that an officer would attack you, and to feel helpless to defend yourself within a large, uncaring system that you knew to be corrupt. The resident was struck by the oscillation of roles, with the patient feeling abused and threatened while in reality behaving in an abusive and threatening fashion.

Stepping back from the situation and observing her countertransference objectively allowed the resident not only to empathize with the

patient, but also to identify the dyad organizing his experience. The resident was able to sidestep this affectively charged interaction, and instead to make an intervention that could reduce the affective intensity rather than contributing to it.

Intervening: Putting the Patient's Experience into Words, Modeling/Helping Patients to Step Back and Distance Themselves from the Immediate Situation. The resident said, "It seems like there's a lot going on here right now. You're not feeling that safe."

"Of course I'm not. I can't feel safe here, these guards have it out for me."

"You know, though, it might not be the best idea to be storming around and giving them even more opportunity to put their hands on you. If you have a complaint, they'll probably take you more seriously if you stay calm and put it in writing."

"I'm gonna call my family up right now, they'll do all that for me—they're not going to get away with this!"

"I think that sounds like a fine idea. But if you're raging around like this, they're going to call a crisis team and have 10 people come up here. That makes you look like the violent, crazy one, right?"

The patient began to calm down. "Well, yeah, I guess that's right. It probably doesn't look too good."

As the patient became calmer, the resident discerned that this was an opportunity to help him process his own intense affect, and to suggest a way in which he might rationally deal with the situation more effectively. The resident was able to point out that the patient's abusive behavior was obfuscating whatever abuse he had suffered; he couldn't act abusively and then expect others to see how he had been abused. The resident's intervention invited the patient to step back and consider the situation from another vantage point and to entertain alternative perspectives, and in the process she helped him move beyond his immediate affective experience.

Vignette 3

Mr. C was a 35-year-old Caucasian male with a history of major depressive disorder and alcohol and cocaine dependence. He was admitted to the dual diagnosis inpatient unit after a near-suicide attempt while intoxicated with alcohol and cocaine, in the context of a recent breakup. He came from a wealthy family; he felt ashamed that he had "fallen to this level" and was now hospitalized in a public hospital.

While he initially appeared to adjust well, the unit staff had increasing difficulties with him as time progressed. He was rude to other patients in group settings, taunted several patients who were clearly mentally ill, and disparaged the medical students about their limited clinical role and their lack of training.

The resident psychiatrist did not see any of this behavior. In individual sessions with the resident, the patient was vulnerable and dysphoric, and the resident found him highly sympathetic. The growing chasm between her impressions and those of the staff became evident during team meetings; the resident advocated for the patient to continue on Level 2 (which carried higher privileges), while the medical students were uncharacteristically passionate that he should be dropped back to Level 1. The psychologist, social worker, and creative arts therapist all felt similarly about him and found him insensitive and arrogant in groups. The resident felt they were letting their countertransference reactions drive them to be unfairly critical of the patient. While she had previously felt that the team consisted of highly skilled clinicians, she began to feel emotional and angry about their reaction to this patient and to question their clinical judgment. As the patient continually complained about the social worker's lack of skill in formulating a disposition plan, the resident began to silently wonder if the patient had a point.

Identifying and Bridging a Split. When the resident stepped back and thought about the situation, she recognized that a split was forming within the treatment team. Although this split should have been easy to see, it had not been. She was struck by the degree to which she had held the conviction that she was *correctly* readjusting her opinion of her colleagues, and that they were not as clinically sophisticated as she had originally thought. She had believed that she was incorporating new, accurate information into her reappraisal of the staff. It was only by stepping back from her own immediate emotional experience, while at the same time observing and reflecting upon what was happening in the group, that could she see she had been swept along by feelings generated by a personality-disordered patient who was struggling with a narcissistic injury.

Working with patients with personality disorders is challenging. Even in the best of circumstances, clinicians are vulnerable to distortions in judgment and thinking. Experience with TFP enables residents to appreciate how difficult it can be at times not to get caught up in the splitting and projections that organize and distort our patients' experience.

Counteracting Splitting Defenses by Maintaining Cohesion Among the Treatment Team; Empathic Confrontation. The treatment team decided to address the patient together as a group, in a nonconfrontational manner, with the hope of bridging the split. In the meeting, the social worker raised with the patient his challenging and dismissive behavior around discharge planning. In response, the patient was disdainful and rude to the social worker and to other members of the treatment team. The resident had not seen this before, and she was surprised by the intensity and depth of his disdain; it became much easier for her to understand the staff's frustration with the patient.

Confronting the patient's inappropriate behavior when all were present enabled the resident to see a side of the patient he had previously kept out of their interactions; he could no longer maintain an idealized doctor-patient relationship with her, while keeping it split off from a hostile, devaluing relationship with the rest of the treatment team.

After starting off derisively and defensively, the patient eventually became more vulnerable, and he appealed to the group for help: "I don't know what I'm supposed to be doing here; you guys are supposed to help me. This is just the way I've always been." He also revealed concerns about sharing his own experiences in the group, because "the people here have real problems, they don't even have a home—they don't want to hear about my stuff."

After this intervention, the patient's behavior on the unit improved considerably. He became more respectful and appropriate, and he began to genuinely participate in group therapy. He was able to express frustration with the resident more directly when he met with her, and he also began to speak more highly of other treatment team members. He later shared how pleased he was to have reestablished a working relationship with a creative arts therapist whom he had previously decided "hated" him.

By meeting together with the patient, the treatment team was able to address the patient's splitting defenses in real time and to "bridge the split" by remaining unified. Although uncomfortable for the patient at the time, it subsequently improved his relationships with team members and allowed him to reduce his reliance on splitting on the unit. Although inpatient units are generally not considered therapeutic environments for patients with personality disorders, a psychodynamically informed treatment approach can guide effective therapeutic interventions even in this setting.

TABLE 1. TFP-Based Skills for the Resident

Processing Internally
Tolerate confusion
Tolerate strong affect
Step back
Observe (what am I thinking and feeling?)
Reflect (put thoughts and feelings into words to cognitively contain one's own affect)
Identify the dyad
Intervening
Communicate empathy
Ask for clarification of the patient's experience
Directly address the patient's anxiety
Contain the patient's affect by putting his or her anxiety into words
Confront in an empathic manner
Provide modeling for the patient by distancing yourself from your own affect
Model/teach patient to step back from the immediate situation and affect state
Provide interpretation (generally not used in a crisis setting)

A MODEL OF TFP TRAINING IN GENERAL PSYCHIATRIC RESIDENCY

Training in psychodynamic psychotherapy is a Core Competency required in all ACGME-accredited residencies. Since this requirement was introduced in 2001, it has proved both problematic and controversial (Yager, Mellman, Rubin, & Tasman, 2005). The traditional model of teaching psychodynamic therapy in residency requires a significant commitment of time and a cadre of individual supervisors experienced in psychodynamic psychotherapy, resources often not available even in large academic medical centers. To further complicate matters, despite the fact that most residents report wanting to incorporate psychodynamic practice into their careers, they describe learning psychodynamic therapy as “daunting” (Cohen & Hatcher, 2008), and only a minority feel competent as psychodynamic therapists and with psychodynamic concepts (Katz & Kaplan, 2010).

TFP is a psychodynamic treatment that lends itself well to resident education. It is evidence-based and diagnosis-driven treatment, a treatment model that is familiar to residents, and TFP treats a challenging

population of patients commonly encountered in residents' caseloads. The treatment is tied to an organizing theoretical and clinical framework that residents can understand, and the TFP treatment manual provides clear, systematic, and explicit descriptions of how to do the therapy. In learning TFP, residents are exposed to an intensive psychodynamic treatment for personality pathology, and at the same time develop knowledge, attitude, and skills that they can apply in the management of patients with personality disorders in acute settings.

We have developed a model of TFP training during residency that requires only a few experienced clinician-educators to serve as instructors and provide supervision. The model of pathology and treatment is taught sequentially over the residents' second, third, and fourth years of training, focusing on different aspects of the model in different PGY years, and allowing for immediate clinical application in residents' day-to-day work with patients according to their level of clinical sophistication. In the PGY-2 year, residents are taught basic psychodynamic principles in didactic seminars, and in this setting we focus on object relations theory and constructs related to personality organization (identity, defenses, reality testing, levels of personality organization). Residents find that the model of personality organization is easily applicable to many of the patients they treat on inpatient rotations, bringing psychodynamic theory "to the bedside." In the PGY-3 year, when residents are learning outpatient assessment, they learn how to evaluate personality organization in all their patients, not just those treated in dynamic therapy. Assessment is taught as a structured, step-by-step series of questions that are easy to apply in a clinical interview.¹ Assessment, as well as considerations of differential treatment planning based on assessment, is illustrated in clinical case conferences in which an experienced clinician interviews a patient.

Training in TFP proper is introduced in the PGY-3 didactic curriculum in five 2-hour didactic sessions, making use of illustrative videotapes and using the TFP manual as a text. This introduction to the treatment is followed by a year-long elective opportunity in the PGY-4 year. All participants in the weekly elective seminar treat a patient in TFP and present clinical material, either videotape or process notes, to the group. The group setting allows residents to hear about a variety of cases, and group supervision facilitates containment of countertransference. The seminar leader provides group supervision, modeling interventions for the resident whose case is being supervised and rehearsing

1. Training in the clinical interview can be complemented by introducing residents to the Structured Interview of Personality Organization (STIPO; Stern et al., 2010), a semistructured interview for assessment of personality organization. The STIPO is available at <http://psinstitute.org/pdf/Structured-Interview-of-Personality-Organization.pdf>.

the intervention with the resident. The resident returns the next week to the supervision group to report the results of his or her efforts and to receive additional feedback. The elective has been extremely well received; many have described the experience as a highlight of training.

CONCLUSION

Learning TFP provides residents with an overarching model of personality disorders and their treatment. The knowledge, attitudes, and skills residents acquire in the course of learning TFP are valuable tools, not only in the setting of long-term outpatient therapy, but also in many of the acute settings that residents encounter during training. Training residents in TFP effectively conveys the utility and power of psychodynamic concepts, principles, and techniques in general psychiatric practice.

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