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Clinical Practice and Theory

TRANSFERENCE-FOCUSED PSYCHOTHERAPY FOR PATIENTS WITH PERSONALITY DISORDERS: OVERVIEW AND CASE EXAMPLE WITH A FOCUS ON THE USE OF CONTRACTING

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Transference-focused psychotherapy (TFP) is a manualized treatment for patients with a personality disorder based on 18 months of once-weekly or twice-weekly therapy. TFP is suitable for publicly funded psychotherapy and private practice. Devised by Kernberg and colleagues, its conceptual framework is based on Kleinian theory of primitive defences in the paranoid schizoid position. A TFP 'structural assessment' is carried out before negotiating a treatment contract, which must be agreed before therapy can begin. Contracting addresses destructive acting-out and isolative lifestyles, and requires a commitment to active engagement with therapy and its agreed aims. The therapist closely attends to relationships outside therapy and transference parallels. The goal is greater integration of the self and self-object relations. In addition to changes in symptoms, TFP can lead to changes in patients' defensive structures with concomitant shifts in personality structure, improved satisfaction in life, and fuller engagement in work and relationships. A case example is given of a patient with a withdrawn lifestyle. Her object relationships were interpreted as they unfolded in life outside therapy and in the transference, leading to personality structure changes which enabled her to be able to function successfully in work and in her personal relationships.

KEYWORDS: ADULT PSYCHOTHERAPY, NHS PSYCHOTHERAPY, OBJECT RELATIONS, THERAPEUTIC FRAME, BORDERLINE PERSONALITY DISORDER, TRANSFERENCE-FOCUSED PSYCHOTHERAPY

INTRODUCTION

Transference-focused psychotherapy (TFP) is an adaptation of psychodynamic psychotherapy for patients with borderline personality disorder (BPD) and other severe

personality disorders such as narcissistic, dependent, histrionic, schizoid and schizotypal personality disorder.[1] It was developed by Dr Otto Kernberg and his colleagues at the Personality Disorders Institute, New York, and is practiced in many countries. Kernberg developed TFP in response to his view that psychoanalysis was not effective for personality disorder. TFP is an extension of the application of psychoanalytic technique, and is a separate, manualized treatment. TFP was not initially named but was an explanation of applying tools of psychoanalysis to more severely personality disordered patients. During the 1990s Kernberg's group named and defined TFP to research its efficacy for methodological reasons.

This paper is an introduction to TFP for experienced psychotherapists and those in training. Although described in various publications, such as Kernberg *et al.* (2008), there are few published clinical examples. It is hoped that an extended case description will enrich the reader's experience of the model. TFP is underpinned by Kleinian object relations, and many aspects of technique will be familiar to those working within that frame. The third TFP treatment manual delineates its tactics, strategies and techniques (Yeomans, Clarkin & Kernberg, 2015). Strategies involve exploring object relations and primitive defences as they play out in patients' lives and in the transference. There is an emphasis on clarification by asking questions, drawing the patient's attention to aspects that do not match up or contradict each other, known as 'confrontation'. Later, split-off parts of self are interpreted with the aim of increasing the integration of aggressive and libidinal parts of the personality. Therapy includes attending to functioning in three life arenas: social and creative, work and career, love and sex. We will summarize aspects of TFP, notably the therapeutic contract, and illustrate with material from an 18-month treatment.

Contracting

As in many forms of psychotherapy, the TFP therapist adopts 'technical neutrality'. This means not giving guidance or advice, but rather analysing motivations deriving from different parts of the psyche. However, the therapist does not apply technical neutrality to behaviours considered inimical to the therapy. These are spelled out in a therapeutic contract negotiated before therapy can begin. The contract addresses acting-out and avoidant behaviour that would undermine therapy. Destructive acting-out takes many forms: drug and alcohol use, excessive spending, cutting the skin, and self-endangering behaviour. It is viewed as a means of getting rid of unwanted feelings (Bohleber *et al.*, 2013). Contracting was devised because solely interpretative approaches are often ineffectual in stopping destructive behaviour. Asking patients to stop the behaviour only once it occurs without initial contracting can result in them refusing to stop, or repeatedly stopping and restarting. The contract also addresses avoidant behaviour. It is not uncommon for people to withdraw into a hermit-like existence, or 'psychic retreat' (Steiner, 1993), severely restricting interactions that would stir them up, by staying at home, not working, and limiting social and intimate relationships. Patients may intermittently miss sessions for the same reason. Such avoidance can lead to a relatively calm existence, reducing

immediate distress, but leads to emptiness and depression resulting from missing out on life. Destructive acting-out, withdrawing from difficult interactions and poor engagement with therapy prevent therapy succeeding (Yeomans, Clarkin & Kernberg, 2015). By addressing these problems in the contract, TFP aims to establish the best conditions for success.

TFP contracts are verbal and individualized. Common elements include attending on time, bringing up relevant subjects, not drinking excessively and engaging with the world. The contract is not imposed but is discussed and negotiated over one to three sessions. The therapist explains that destructive behaviours are ways of avoiding difficult feelings, and as therapy is about staying with these, they go against its aims. If patients say they cannot stop, the therapist will point out that people generally have more control over their behaviour than they believe, and therapy will not work if they continue them. After discussing the reasoning behind each part of the contract, the patient is free to choose to accept and begin TFP or to opt for a more overtly supportive psychotherapy with less ambitious goals. While not underestimating the challenge this places on patients with severe, longstanding problems, this seemingly tough approach is considered kinder in the long run as it makes a successful outcome more likely. TFP requires the patient to opt-in to the conditions that will allow therapy to work, recruiting their will in pursuit of its aims.

How much the contract is used later in therapy varies. Many patients routinely break its terms. Some only then realize how tenaciously the therapist will hold them to it. The therapist discusses and interprets the meaning of breaches, reminding the patient what they agreed and why. If a patient continues to break important contractual obligations, ultimately, the therapist may need to end the therapy, explaining the reasons for doing so.

An important consequence of limiting destructive acting-out behaviour is that therapists generally feel less anxious when patients bring emotionally charged issues. Another advantage is that defining the patient and therapist's respective roles represents the reality of how therapy works, and the therapist can observe manifestations of character structure, such as neediness, dependency, passivity or defiance, as these play out in contrast to the defined roles.

In the case of avoidant behaviour, the contract involves patients increasing their interactions with others outside therapy, although this makes them anxious. Repeated exposure to anxiety-provoking situations is the essence of behaviour therapy, often seen as being at the opposite end of the spectrum to psychoanalysis. Cognitive behavioural therapy (CBT) formulates socially avoidant behaviour as follows: when avoidant patients expose themselves to the situations that make them anxious, they tend to stop the exposure too quickly, causing a drop in anxiety and thereby reinforcing the avoidant behaviour. CBT involves helping patients to persevere with exposure long enough to experience their anxiety to reduce to bearable levels, and to discover that the feared imagined consequences do not occur. Patients become less anxious with successive exposures (Beck *et al*., 1985). In TFP, behavioural activation is a vehicle for exploring psychic conflicts (Yeomans, Delaney & Levy, 2017). However, patients also benefit from discovering that the feared imagined

outcome does not occur. Including behavioural exposure within an analytic frame represents a radical adaptation of psychoanalysis.

Paranoid Schizoid Functioning

Kernberg's term borderline personality organization (BPO; Yeomans, Clarkin & Kernberg, 2015) refers to the personality organization underlying several personality disorders, including BPD and narcissistic personality disorder. BPO is based on paranoid-schizoid position functioning (PSP; Klein, 1946; Bott Spillius *et al*., 2011). Object relations theory formulates personalities as partly formed of internalized representations of self and other. These representations or 'objects' are subjective, often partial versions of significant people internalized during childhood through a process of identification. TFP conceptualizes these object representations as relating to each other in pairs or 'dyads', with the patient identifying with one representation at any one time and projecting the other. In the PSP, these representations are either good or bad, rather than a nuanced mixture. During interactions, one internalized representation is silently projected onto the other person, and the patient experiences him/herself as the other. In the case of persecutory dyads, aggression may be experienced when a patient feels victim of a harsh and unfair critic one moment while, in the next, the patient verbally castigates someone they feel has come up short, not meeting their expectations. In libidinally charged, idealized relationships, there is the wish for, and sometimes experience of perfect care-taking and attention from an ideal other. As is the case with the persecutory dyad, the roles can be exchanged.

In the PSP these feelings are all consuming. Kernberg (2006) terms the personality structure primarily functioning in the PSP as creating 'identity diffusion', referring to the lack of integration between libidinally and aggressively charged representations of self associated with excessive projection onto the other. In the more mature depressive position, self and other representations are a more integrated and realistic mix of good and bad. PSP defences, known as the primitive defences, include projection, projective identification, splitting, idealization, denigration, denial and omnipotent control. Childhood development consists of a move from mainly PSP functioning to mainly depressive position functioning. Where neglect or abuse disrupt development, especially combined with a constitutional loading of negative and aggressive affects, PSP continues to predominate (Yeomans, Clarkin & Kernberg, 2015). Exaggerated, dichotomous PSP internal representations lead to distorted perceptions of self and others, leading to poor reality testing. Disconnected, caricatured internal images of self and others create problems with work, social and love relationships. Identity diffusion, the primitive defences, and poor reality testing are the three elements of BPO. Patients with BPO are primarily operating in the PSP when relating to others and themselves. The aim of therapy is to prevent pervasive, rigid splitting between aggressive and libidinal representations of self and other, leading to a more integrated personality and more connected and satisfying relations with others.

In the authors' views, some psychological treatments focus on selected specific symptoms of personality disorder rather than the disorder itself. Following purely symptom-focused therapy, patients report improvement in the specific areas of focus

such as self-harm, the need for hospitalization, depression or anxiety, but generally report that they continue to feel bad about themselves and to have trouble getting close to others and engaging in work (Levy *et al*., 2006). Also, the benefits from symptom-focused treatments often tail-off when treatment ends (Linehan *et al*., 2006). TFP aims to treat the structure underlying the personality disorder.

RESEARCH EVIDENCE FOR TFP

TFP has been tested for efficacy DSM-IV borderline patients in two independent international randomized controlled trials (RCTs; Clarkin *et al*. 2007; Doering *et al*., 2010). In the first study, TFP treatment was compared with dialectical behavioural therapy (DBT) and a form of supportive psychodynamic therapy. Although both comparators proved effective, improvements were found in significantly fewer symptom areas than for TFP. In the Doering study, TFP was compared with treatment by therapists who were experts in treating borderline patients using a range of other therapies. In this study, the comparison condition showed a higher drop-out rate than TFP. Moreover TFP contributed to significant improvements in the borderline symptoms, psychosocial functioning, and personality organization. It was also associated with fewer suicide attempts and fewer psychiatric admissions than the control condition. On the basis of these two studies, it can be concluded that TFP treatment has been proven effective, with potential for greater patient retention and wider symptom improvements than some other treatments for BPD.

In another study (Giesen-Bloo *et al*., 2006), TFP was included in an RCT with schema therapy (ST). Both methods had large effect sizes (the borderline features: ST effect size 2.96; TFP effect size 1.85). ST showed better results, but this was mainly due to differing drop-out rates combined with the fact that the study reported only an 'intent to treat analysis' and not a 'completer analysis' (Yeomans, 2007). In addition, this RCT failed to ensure equivalent patient groups; the patients in the TFP condition were, on average, more self-destructive than those in the ST group.

Further data analyses of the first two studies (Levy *et al*., 2006; Buchheim *et al*., 2017; Fischer-Kern *et al*., 2015) showed that TFP is effective not only on the level of treating symptoms, but also with regard to structural change in the personality, and movement towards a more secure attachment status in relation to others. Only in the TFP condition did the patients show a significantly increased reflective function (mentalization), gaining more insight into themselves and their relations with others. These results are important since changes in the personality structure are associated with lasting changes in terms of coping better with self, others, and major life challenges such as love and work.

COMPARISON WITH OTHER THERAPEUTIC MODALITIES

TFP Compared with Other Kleinian Approaches

TFP draws on the contributions of the Kleinian school regarding primitive defences and object relations (Yeomans, Clarkin & Kernberg, 2015), the use of

countertransference, and avoiding supportive techniques. 'Analyst-centred interpretations' (Steiner, 1993), which focus on how the patient is perceiving the therapist, help link mental states normally kept separate from each other, especially early in therapy. TFP differs significantly from Kleinian psychotherapy described in the Tavistock Adult Depression Study (Fonagy *et al*., 2015). In addition to treatment-resistant depression, patients in the study had an average of two personality disorder diagnoses (Rost, 2018, personal communication). While TFP therapists, like the Tavistock psychotherapists, follow the patient's narrative (Tavistock study manual; Taylor, 2010), they also scan patients' functioning in the external world, and transference interpretations are closely linked to outside interactions. The TFP therapist may 'arbitrarily' bring in some aspect of life, and then focus on the transference developments that ensue. In contrast, the Tavistock depression treatment manual focuses on the psyche in the here-and-now of the consulting room, discouraging introducing topics or giving guidance on how to behave (Taylor, 2015). TFP also does not guide behaviour, except regarding departures from contractual obligations.

Limit Setting

Differences in client groups in domains such as symptom severity, educational attainments, unhealthy reliance on state benefits and drug or alcohol use all impact on TFP limit-setting regarding threats to patients' wellbeing and the goals of therapy. Of major outpatient therapies for personality disorders, TFP is very explicit and detailed in its approach to behavioural expectations and compliance with treatment (Yeomans, Delaney & Levy, 2017). There are significant differences from Kleinian psychotherapy. Both Kleinian and TFP therapists seek to understand the pressures and circumstances leading to acting-out, and make interpretations designed to lessen this pressure. If that does help, they will discuss the behaviour that seems out of control. However, Tavistock therapists act only in more extreme situations, if, for example, the patient breaks down and becomes dangerous or unable to cooperate. The TFP therapist, in contrast, sets explicit limits at the outset and manages breaches earlier.

DBT (Linehan, 1993) requires patients to agree to 'work towards' solving their problems without using self-harm or suicidal behaviour; to reduce 'therapy interfering behaviour', which is a broad category including drug use and lateness; to complete homework; and to attend both individual therapy and a skills training group. There are explicit expectations around the use of telephone consultations and skills training. Patients are usually discharged if they do not attend four consecutive appointments. If they produce challenging behaviour which exceeds the limit of what their therapist can tolerate, they may be given a 'therapy vacation', a change of therapist, or they may be discharged. Schema therapy (Young *et al*., 2003) approaches limit-setting by the therapist, introducing a rule the first time a patient violates it. Limits are explained using personal disclosure: 'for my peace of mind, I have to know you're safe', and 'empathic confrontation' addressing disruptive behaviour with reference, where relevant, to origins in developmental experiences. Consequences are added if limits are repeatedly breached and limits are enforced more as therapy progresses. Ultimately, therapy can be

terminated. Mentalization-based therapy (MBT; Bateman & Fonagy, 2016) views contracting as, at times, unenforceable, because patients who agree at the outset may not have access to the same mentalizing competency when they breach limits. Although MBT contracts are used to implement initial short-term goals, they are not linked to potential discharge. Goals may include addressing life-interfering results of therapy-interfering problems (Fonagy, 2018, personal communication). The use of drugs and alcohol is discouraged from the outset.

Early Interpretations: TFP versus MBT

There are common aspects of technique between TFP and MBT in the early stages of therapy, notably use of clarification by asking the patient what s/he is thinking and feeling, and comparing this with descriptions of interactions with the therapist or outside therapy. In TFP, interpretations are made early in therapy, whereas in MBT, these are considered unhelpful impositions of therapists' views. By rooting its model of interpretation in the shared experience of the 'here-and-now' (Caligor *et al*., 2009), TFP attempts to avoid interpretations being experienced as unhelpful impositions.

TFP and Aggression

TFP uses a Kleinian formulation of conflict caused by a difficulty integrating aggressive and libidinal drives within object relationships. Aggression is seen as an intrinsic drive, a normal, healthy aspect of human interactions. DBT and MBT tend to emphasize aggression, more commonly referred to as 'anger', as solely the result of being mistreated. Choi-Kane Albert and Gunderson (2016) compared DBT, MBT, TFP, and general psychiatric management. All treatments reduced symptoms; TFP and DBT also reduced suicidality, while TFP additionally reduced irritability, aggression and increased reflective function (see Levy *et al*., 2006), suggesting that the Kleinian understanding of aggression used in TFP is more effective than seeing anger as originating solely from being mistreated.

Economics of Delivering Therapy

In terms of time commitments, TFP and ST can be delivered by one clinician and so are suitable for both private and publicly funded therapy, as opposed to DBT, which involves groupwork and individual therapy, and requires at least two therapists. MBT has been delivered in a 'group plus individual' model in trials (Bateman & Fonagy, 2009), but is also now delivered in group-only format and in individual-only format, although these have not been evaluated. TFP is generally once or twice a week with a maximum of three times to reduce over-dependency, and therapy is conducted face-to-face, not using a couch. The two TFP research trials (Clarkin *et al*., 2007; Doering *et al*., 2010) were each based on 12 months of twice-weekly treatment. In a trial currently being conducted at the Weill Cornell Personality Disorders Institute, the research protocol is twice weekly over 18 months. In clinical practice, therapy often extends for

longer. TFP is carried out both in publicly funded institutions and by private practitioners, depending on risk considerations.

Other significant TFP divergences from alternative psychotherapies include explaining the diagnosis to the patient and agreeing aims for therapy, routinely meeting a relative, liaising with previous psychotherapists and with other professionals working with the patient. For further comparisons of models, including time commitments, training and qualifications, and matching patient characteristics to approach, see Choi Kane *et al*. (2016).

CASE EXAMPLE

In the following case example, we focus on contractual obligations to engage with the world, and how outside interactions activated disturbing object relationships which the patient normally avoided by staying at home. The patient's projections were explored in relation to these interactions and in the transference. The case illustrates split-off aggression, attacks on the self, somatization, passivity and helplessness, and a family member supporting the patient in her 'sick role' with associated secondary gains.

Frances, 45, was seen in a secondary-care NHS psychotherapy department by the first author. She was presenting with mood instability including depression, periodic rages, self-hatred, envy and sadness. The ending of her marriage several years earlier had led to the breakdown in her functioning from which she had not recovered. She had longstanding problems with social and sexual relationships, was doing little during the day, and had no contact with friends. She longed for a 'normal life', after a catalogue of failed relationships, physical and mental breakdowns. In childhood she suffered cruelty, neglect and violence at the hands of her mother, and was molested by a family member. She had several spells in children's homes. She was underweight, bulimic and a bowel condition necessitated constant access to a toilet. The sense was of an anxious person who was helpless and withdrawn. She had been on benefits most of her adult life, except in her 20s when she worked. She lived with her father and was materially comfortable.

Explaining the Diagnosis

After carrying out a TFP 'structural assessment' (Yeomans, Clarkin & Kernberg, 2015) to establish the nature of the personality organization, I (first author) discussed the meaning of 'personality' and 'personality disorder' with the patient to achieve a common understanding of her problems. I explained that personality disorders are severe, pervasive, and develop in childhood partly as a result of adverse experiences. I explained that BPD causes problems in four main areas: intensely varying mood; significant difficulties in relationships which tend to be stormy or non-existent; destructive acting-out; and a poorly developed sense of identity reflecting a lack of integration of different parts of the self, including a split between good and bad parts. I explained that this unstable sense of identity means that patients often feel terrible about themselves, causing emotional instability and problems relating to others. My description matched

Frances's perception of her difficulties and she was intensely relieved to feel it was not her fault and that there was a way forward. I explained that being bulimic and underweight would stop therapy working. She agreed to address her eating problems before starting TFP, and I arranged for her to have 18 sessions of CBT first. She agreed to maintain her body mass index above 18.

Family Meeting

Prior to starting therapy, or at an early stage, TFP therapists routinely meet a relative or partner, with the patient present, as part of the assessment. Collateral information helps the therapist understand the patient and their context more quickly. Second, it is an opportunity to explain the therapy and its aims to the relative, facilitating their support of the patient's engagement with therapy. Third, it allows a discussion about whether relatives are unwittingly reinforcing the patient remaining in a sick, helpless position. A large secondary gain from illness reduces motivation for change, hence addressing this with the relative during contracting.

Frances was initially reluctant to involve her father, but agreed after I explained the advantages. Her reluctance became more understandable when we met, and her father launched into an extensive account of his own childhood and achievements, maintaining a flow of talk that was difficult to interrupt. Patients' descriptions of their relatives are often partial and distorted by projective processes. Frances had previously held back from fully describing her father so it was especially useful to meet him. Secondary gain was also relevant. He explained that she could never do paid work because of her bowel dysfunction, and he could provide for her as he was wealthy. He said voluntary work was a noble calling. I sensed that he enjoyed her companionship. In response, I put the case for Frances regaining financial independence, pointing out that there are many advantages of paid work in addition to the money. Although he disagreed, he softened his position. It was useful for Frances to observe a discussion of both sides of the argument to help decide what was in her own best interests.

Contracting

Following this meeting, Frances and I discussed in detail the aims of therapy and the contract obligations necessary for success. TFP has ambitious aims relating to three arenas of life: work and career, social and creative life outside work, and love and sex, with the exact aims tailored to each patient. TFP does not impose goals if the patient does not express interest in them, in which case the therapist may offer a less ambitious, more supportive type of therapy. Frances's aims were to be less isolated and to have what other people have; friends and a romantic partner. She wanted to be able to do paid work if her bowel would allow this.

As the contract is a two-way agreement, I committed to the standard contractual obligations of being reliably present, listening closely and making comments aimed at helping Frances gain a deeper understanding of herself. I could see her for 18 months of once-weekly therapy. This was less than the twice-weekly TFP

research trial protocols (Levy *et al*., 2006; Clarkin *et al*., 2007; Doering *et al*., 2010) but it was the standard offer in the psychotherapy service.

From her side, Frances agreed to prioritize the therapy over other activities, to attend every session on time, and to try to say whatever came into her mind without censoring or editing. This is the standard psychoanalytic instruction to patients, namely to free associate. A limitation of free association is that patients may seem to be free-associating while consciously or unconsciously avoiding difficult subjects, including after this has been pointed out. Standard free association contains only the obligation to say whatever comes into the mind. TFP therefore adds an additional obligation to actively participate by bringing important, albeit uncomfortable, aspects of life to therapy. Insisting on regular weighing was not needed, but I would have added this if I became concerned that she was becoming under-weight.

The agreement for contractual obligations should not be superficial. Our negotiations included a discussion of how and when Frances would engage more in the world, and she agreed to make immediate efforts to make new friends and engage in voluntary work, and later to look for paid work and start dating. Frances had previously worked as a volunteer in a carers' organization for two hours a week and been in a community theatre group. She agreed to return to these and increase her hours of voluntary work.

For the purposes of this paper we will focus on the use of the contractual commitments to engage in the world and the projective processes these stirred up:

1. voluntary work, later followed by paid work;
2. social engagement in a structured setting followed by establishing friendships outside the setting;
3. later, dating, with the goal of having a loving, sexual relationship.

The Therapeutic Process

The first phase involves the therapist observing and commenting on internalized representations of self and others in the world and in the transference relationship. As mentioned, TFP emphasizes the relatedness of the patient's internal objects. The therapist describes the characteristics of the representations of self and other present in the patient's descriptions, asking the patient to clarify their perceptions of the other person's thoughts, feelings and intentions, and their own, as well as their feelings towards the other person. The therapist starts with feelings closest to the surface. In Frances's case a dyad emerged of an aggressive figure dominating a weaker one. This hostility-infused object relationship dominated much of Frances's world, causing great anguish, and this explained why she had withdrawn from the world. She described her experience of volunteering at a garden project in the third session:[2]

> On her first day, an older woman, who Frances perceived as intimidating, criticized her. Frances said this made her want to leave and not go back. Frances had offered this woman an unusual coloured carrot and the woman said

angrily, 'I know what a carrot tastes like!' In our session, Frances wept, saying that she had been stupid. I asked how she felt towards the woman. She said angry, although she did not look it. Instead, she criticized herself for being useless, before saying, helplessly, 'What shall I do when I go back?' When I asked what she thought she should do, she said her inclination was to ignore this woman. I said that sounded like giving her the cold shoulder because she was angry. She admitted that was possible.

She began the next session by confessing to not having gone back so as not to have to face 'that woman'. She said she felt terrible that she was so immature compared to the others there, especially younger ones. I said perhaps she had not developed as she could have done, because of her life experiences. Frances became emotional, expressing shame and resentment at her immaturity. When I said this must be difficult she became tearful and started looking away. I felt she was removing herself from our relationship in that moment, so asked 'how are you feeling towards me right now?' She said that I thought she was no good and probably wanted her to leave because she was so useless. When pressed on the feeling towards me, she said she would like to shake me, knitting her hands together and clenching her fists. Later, I reminded her that sticking with the voluntary work was in the contract.

In the initial stages of TFP the patient is helped to develop an observing ego and tolerate her feelings so she can reintegrate split-off feelings. In this vignette she projected a pre-existing aggressive, internal object onto the older woman, first fearing her, then becoming angry. It is likely that, after being initially touched by my empathy, a projective process took place in which Frances projected the attacking parts of herself onto me and internally transformed my empathy into the type of criticism and dismissal that characterized her internal world. I brought to her awareness something that she habitually split off and preferred not to think about. It probably also had to do with the patient's paranoid transference which would include the assumption that I would not sympathize with her lack of development but would look down on her because of it. She quickly moved to attacking herself, a safe, well established displacement, reflecting harsh superego precursors attacking the self. Not going back to the garden project was the defence of avoidance. In the subsequent session she projected a critical object onto her therapist. The TFP therapist draws the patient's attention to fluctuations between subject and object roles, in this case in a persecutory relationship between victim and aggressor. Frances primarily took the victim position but briefly became the aggressor when she wanted to shake me. Noticing fluctuations in identification with each pole of the dyad prepares the way for later integration of persecutory and idealized relationships. Repetitions and reversals are linked to the projection of different parts of the patient. Early in therapy patients may not tolerate a focus on what is going on inside them, as opposed to how they perceive the therapist, but Frances was able to tolerate some of this.

The same hostility-infused dyad was repeated at a community theatre group, where Frances was continually preoccupied with assertive older women. Her

characterizations of these women fitted earlier descriptions of a hateful, domineering mother. Helping her elaborate her internal representations in relation to people outside therapy, to myself and to past figures, gradually enabled her to perceive the exaggerated and narrow nature of the representations, and this served to tame the harshness of her aggressive attacks on herself and others.

Reversals of Dyad Poles and Using the Transference

Engaging more with the world stirred up persecutory interactions that could be discussed in therapy. Noticing repetitions and considering her perception of others in the context of her factual descriptions of interactions helped give Frances insight into her projections. Patients who have been avoidant for many years often withdraw from situations when problems arise. The TFP therapist will then remind them what they agreed in the contract and why they agreed to it. When they stop cloistering themselves off, in time, patients learn that the external world is not as harsh as their internal world.

The reversal of the two poles of aggressive controller and his/her victim was evident in the seventh and eighth sessions:

> Frances described telling another patient in the doctor's waiting room to stop using her mobile phone as it was not allowed, and the other patient had responded angrily. I pointed out that lately she had felt reprimanded by me for being avoidant and now she was behaving like a police officer herself. After this session, she had a migraine for three days, and on her return to therapy she could not at first remember anything of what we discussed. She then recalled feeling angry I had apparently told her that she got what she deserved. I said perhaps her anger with me combined with a wish to please me had caused the migraine. She smiled. When I went on to comment on the powerful effect of being criticized, she wept. She said she could never please her mother, who she then started angrily criticizing. I pointed out that talking about her mother took us away from the strong feelings towards me from a moment earlier.

Over time, Frances became more able to cope with the voluntary work and theatre group but avoided trying to make friends outside these safe settings. I reminded her that making friends was part of the contract, and we discussed how she might go about it. Her initial attempts were unsuccessful, making her feel that she was doomed to fail. However, each attempt provided an opportunity to disentangle the reality of what may have happened from her projections, and to think about whether she was unconsciously repeating experiences of rejection rather than risk a warm relationship developing. These discussions led her to persevere, and eventually she formed a strong friendship.

When a TFP therapist points out that a patient is not sticking to an agreement, the therapist often feels cruel. Supervision is useful to help therapists 'keep their bearings', reducing the likelihood of unhelpful enactments. The contract represents

engaging with the world and its realities, and this challenges patients' defensive systems. When we make someone anxious, we often feel we are aggressive. Ultimately it is up to the patient whether they stick with the contract, but the therapist needs to explain that the consequence of action or non-action may require the therapist to stop or suspend therapy.

Work and Career

Frances described a difficult experience at her voluntary job at the carers' centre. She said her manager had abandoned her in the busy reception and she needed the toilet. Eventually when she rushed there she had an explosive expulsion, which she described in graphic detail. We explored her representation of self and other, why her manager left her in this situation and how she felt towards her. I said perhaps she was also telling me that in recent discussions about her getting paid work, she had been experiencing me as trying to push her into unmanageable situations. I said that the explosion of shitty rage showed the strength of her feelings at the potentially humiliating situation I was pushing her into. I said while she felt I was ignoring the physical issue of her bowel dysfunction, if I did not help her overcome these problems, I would be neglecting her emotional needs.

The TFP therapist will often liaise with other professionals. Frances eventually agreed to me speaking to her bowel doctor. Her doctor said she was optimistic about Frances regaining bowel functioning, but Frances kept pushing her for more drastic operations. We discussed Frances's personality disorder which she had not known about. Consequently, she arranged for a specialist nurse to carry out 'bowel-training'. Frances was initially resistant to this, both because of anxiety, and I felt also because she was attached to her condition which kept her helpless but allowed her to avoid frightening situations. Early on, the bowel training created a physical difficulty, which was not serious but which terrified Frances, and it was investigated in hospital as an emergency. Frances managed to make her nurse so anxious that she stopped the training. When I contacted her doctor we were able to work out what had happened, and to restart the training. With perseverance and discussions in therapy, Frances gradually started regaining more control of her bowel, a vital step towards greater independence. However, she continued to resist looking for paid work. Eventually I suggested that she was using her bowel as a 'get-out'. This shocked her, but I pointed out that she recently managed a coach holiday with her father with no toilet on the bus. She said this was true, but countered that she did not need money anyway as her father would leave her an inheritance. I said this would not last forever, and work would not only give her greater independence but could also be more satisfying. Not getting paid work would restrict her life, and also, paid work was one of her original goals for therapy. This departure from a neutral position was justifiable given that paid work was in the contract.

Frances then accused me of believing her bowel condition was in her mind. I pointed out that I again had become a harsh and neglectful figure who believed she

was making excuses for not working and did not really care about her. I asked if she could imagine me believing that both physical and mental aspects were interacting? She responded with a graphic description of the bowel training, in disgusting detail. I interpreted that she was pushing repulsive images into my mind because she was annoyed with me. Her laughing response suggested some pleasure at aggression coming into the open. I pointed out that she usually responds respectfully, but here we could see anger and aggression, normally under the surface, being expressed more directly, which was healthier.

There was also a parallel between her bowel function and her mental capacity to contain her feelings and anxieties. Her doctor had earlier explained that her bowel was either flaccid or went into spasm due to years of lack of use, but it could be gradually strengthened. We discussed the parallel with the gradual strengthening of her mental muscle (ego strength) to cope with the anxieties caused by her feelings after years of under-use.

In time, Frances got a job as a dinner-time supervisor at a tough local school, where her tendency to split between good and bad could again be seen. Frances quickly formed a view that the black boys were aggressive bullies in contrast to the nice white boys. Her response was to attempt omnipotent control of the 'bullies' and one of the black boys reported her for telling him to 'shut it', prompting a surge of self-criticism and anxiety. Racism can be seen as defensive, paranoid schizoid thinking (Davids, 2002; Rasmussen, 2013; Tan, 1993; Young, 2001). I interpreted that the division of white and black boys reflected the split between her 'bad', aggressive parts and the morally upstanding but mistreated victim part, seen earlier in relation to persecutory older women. We had seen earlier reversals when she became aggressive. Once we had made the link with earlier understandings, she was able to reflect on her perceptions and behaviour, and to continue to work through her projected aggression in this new situation. She observed the boys more closely and realized she was interpreting normal boisterousness as maliciousness at a time when she was anxious about her own goodness. TFP considers aggression a normal constituent of the psyche; people get in trouble when they deny and project it, rather than integrating and mastering it. In time, Frances became friendlier to the black boys, proudly telling me that she organized food for them when the canteen was closed, gratified by their friendly responsiveness to her. As her projection and acting-out reduced, she was able to use her aggression constructively by wading in and breaking up fights when necessary. The black and white boys became more accurately experienced as a mixture of good and bad, avoiding split relations and the concomitant split in the self.

Love and Sex

During the first 12 months of therapy Frances had shown no interest in a romantic relationship, despite this being one of her aims of therapy. A common pattern is for patients to want a warm, close relationship with their therapist, a safe haven where they can discuss bad relationships in the world, reflecting a split in relationships. Being in contact with an idealized therapist means the patient has less need for

outside relationships, and other relationships may not match up. Frances emphasized how important therapy was, how she had spoken of things here for the first time, and she only slept well for a day or two after her weekly sessions. I reminded her of her aim of getting a boyfriend and asked what might be holding her back? Her belief was that any man would inevitably reject her after discovering how inadequate and damaged she was. I pointed out the repetition of a critical, attacking object attacking the inadequate, vulnerable one, and said that the remaining six months were an opportunity to overcome these anxieties while she was in therapy. She responded with the slip that she had 'six months to live'. I pointed out the idealized version of a therapy that was essential to life, set against the reality that if she did not get a boyfriend now, she would be more alone when therapy ended.

Frances started online dating and came to sessions wearing a T-shirt with 'Je t'aime' written on it and a picture of a heart, showing the presence of libidinal wishes previously hidden beneath paranoid anxieties. She quickly met Colin, triggering feelings of intense vulnerability. She defended herself against these by being stand-offish, minimizing her investment in the relationship which I interpreted. Over time, she began to risk relating to him more warmly. On early dates, she veered between submissively going along with him but resenting it, and at other times bossily directing what they should do. Later she moved towards being assertive but negotiating their dating activities on equal terms.

After a while, I pointed out her avoidance of discussing sex, and she revealed intense performance anxieties, including a fear of her bowel leaking. After a time she took courage:

> Wringing her hands, she said she and Colin were planning sex for the first time. Her association was to being touched and mocked by her mother's boyfriend. Her first husband was older. She met him as a teenager wishing to escape from her parents, and she felt like a child with him, then later he was unfaithful. Her next boyfriend was more sexually compatible but like a little boy. Then she had a boyfriend who she tried to please but was unfaithful and cruel, which was when she became bulimic. Her second husband was narcissistic and neglectful, used her for sex, and took her on extreme cycling holidays twice a year. The strain of cycling in mountains, day after day was the original cause of her bowel problems.

She and Colin were able to gradually establish successful sexual relations.

In the early treatment phases, the therapist avoids links with the past, focusing on current relations outside therapy and linking these to the transference. The last TFP phase involves links with the past to produce a narrative. Frances reviewed her past relationships in the context of the possibility of a new sexual relationship in a way that helped her understand and avoid repeating earlier mistakes.

At her 12-month follow-up appointment, she reported that work had continued to go well, as had her relationship. Having not wanted another therapist upon ending our work, she now asked for a recommendation for a private psychotherapist to help further address her problems.

DISCUSSION

The above case shows how a short treatment of 44 sessions over 18 months, combining contractual obligations to engage in the world with an exploration of the patient's experience of interactions outside therapy and in the transference, led to an intensification of normally warded off dyadic projections. Social, work and romantic interactions stirred up intrapsychic conflicts and primitive defences which were interpreted and understood. The focus was on improving functioning, and the borderline personality organization was treated by addressing identity diffusion, primitive defences, and distorted perception of reality.

The case description has focused on the use of contractual agreements to address avoidance, although these also commonly address destructive acting-out. Could therapy have worked without behavioural injunctions? It is possible that a good therapist could have got results purely using interpretation. However, it seems unlikely that Frances would have started voluntary work as quickly and persevered with it without this leverage. Similarly, she strongly resisted making friends, getting paid work, and finding a boyfriend. Contractual obligations were used in each case. TFP emphasizes explaining why these requirements are important rather than being authoritarian, but naturally these injunctions stir up object relations and associated affects, which need to be explored. For example, the patient may resent the therapist for 'making' them do something, despite behaviours and goals being agreed at the start. Working through such reactions is central to the exploration of the patient's inner world and necessary to avoid defensive acting-out. For instance, Frances may have reacted self-destructively as an under-cover attack on the therapist for insisting on these behavioural changes.

Is it ethical to require patients to behave in a certain way to receive therapy? In TFP we believe that therapy is only likely to be successful if the right conditions are in place, and so what appears to be coercion is, in fact, seeing through an agreement based on how best to help the patient. The nature of defences may mean that patients act against their own best interests. We respect the patient but not their defences, and it is necessary to recruit their will to work towards greater health, which is made easier when patients have had previous unsuccessful therapies.

At times, a therapist may become coercive, or conversely, avoid addressing significant breaches to the contract, due to being caught up in countertransference enactments. The TFP manual is a useful reference point to help therapists keep their bearings, as is supervision. In common with the other major treatments for severe personality disorder, it is highly recommended that therapists regularly engage in supervision or consultation with a colleague or colleagues, to discuss potential enactments of strong countertransference reactions, including those which have not been recognized by the therapist.

What about a situation where a patient agrees at the outset but later refuses to find work or engage in social activities, or repeatedly returns to drinking? The broad principle is that therapy may be ended or suspended if a significant contractual obligation is not adhered to, although only after much work to try to help them

overcome their resistance. This raises the ethical dilemma of what to do if a patient does not agree to treatment requirements in a public healthcare system where there is an expectation to treat highly resistant patients. In this situation, the TFP assessor may direct a patient to a less challenging type of psychotherapy, to drug and alcohol services, to vocational services, or s/he may offer to see the patient less frequently for supportive psychotherapy.

TFP continues to be developed with regard to patient presentations (Caligor *et al*., 2018) and aspects of its methods applied in medical and psychiatric settings (Hersh *et al*., 2017). As Kernberg and his colleagues refine increasingly specific approaches for patients with narcissistic personality disorder, they have found that the initial rigidity of these patients' psychic structures requires greater flexibility in the initial approaches to psychotherapy, including a longer negotiation of the patient starting to function more productively outside their home, while addressing grandiose aspects of the self that interfere with them doing this, such as perfectionism (Diamond *et al*., 2013).

CONCLUSION

TFP is a distinctive adaptation of psychoanalytic psychotherapy for patients with personality disorders with good evidence of effectiveness. With its emphasis on the treatment contract, TFP may give the impression of being a behavioural treatment, and indeed the authors of the model acknowledge that it involves elements of contingency contracting that might be found in a behavioural treatment. Many in the psychoanalytic community are wary of introducing as much structure to the therapy as in TFP, owing to concerns that these detract from free associative processes. In our experience, the methods of TFP do not inhibit access to essential unconscious material. Another common concern is that manualization interferes with the therapist's receptivity and freedom to think creatively. In our view, the TFP manual and methods do not restrict these aspects; rather, the TFP frame facilitates therapists' capacity to think, freed from the worst excesses of anxiety caused by behaviours inimical to the therapeutic process. Being clearer about boundaries and how to manage infringements helps keep the therapy on track. The case study illustrates how the structure of TFP sets the stage for exploratory psychodynamic work which we believe goes further in resolving intrapsychic conflicts than the other main therapeutic models for treating BPD.

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NOTES

1. TFP is well established in the US and is becoming better known elsewhere. It is less widely known in the UK. A UK training group has been formed with assistance from the Weill Cornell Personalities Disorders Institute in New York. The growth of TFP in the UK provided the impetus for this paper.
2. We have chosen vignettes from different points in therapy to illustrate the techniques and overall shape of the treatment, which has reduced the level of detail that would allow the reader to assess the accuracy of the interpretations.

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