Clinical Article

Conversion to Transference-Focused Psychotherapy from Other Treatments by the Same Therapist: Pitfalls and Benefits

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Abstract: Borderline personality disorder and broadly speaking, borderline personality organization, including narcissistic personality disorder, can be effectively treated by transference-focused psychotherapy (TFP), which is a modern object relations–based structured psychoanalytic psychotherapy. TFP can be taught successfully to therapists from a wide array of backgrounds, not only to psychoanalysts, provided they have a basic grasp of psychodynamic concepts, including object relations theory. We initially thought that starting with a new patient would always be easier than conversion to TFP from a different method. Our supervisory experience supported this only partially. To learn more, we distributed a survey among therapists who completed formal TFP training or participated in supervision for at least 1 year. Only four of the 36 respondents felt that starting with a new case was easier. Conversion was a lot more common than we had expected (in fact, it seemed to be an almost inevitable part of training), and it often took place without appropriate supervision of the process. Moving from supportive therapy to TFP was the most difficult for the therapist, and often for the patient. All respondents felt that they would treat all new patients with borderline personality organization with TFP from the outset or, if indicated or necessary, begin with a preliminary treatment using TFP elements. Our findings strongly suggest that conversion needs to be taught in training seminars, and should not be left to be dealt with entirely in supervision.

Keywords: transference-focused psychotherapy, supervision of conversion to TFP, learning TFP, difficulties converting to TFP, conversion to TFP during training, teaching TFP

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Transference-focused psychotherapy (TFP) is an evidence-based manualized psychoanalytic psychotherapy based on object relations theory, especially designed to treat patients with borderline personality organization (Caligor, Kernberg, & Clarkin, 2007; Clarkin, Levy, Lenzeweger, & Kernberg, 2007; Clarkin, Levy, & Schiavi, 2005; Diamond, Yeomans, & Levy, 2011; Doering et al., 2010), including narcissistic pathologies (Diamond, Yeomans, & Keefe, 2021; Stern, Yeomans, Diamond, & Kernberg, 2013). TFP was modified, importantly, to treatment of adolescents with personality disorders (Normandin, Weiner, & Ensink, 2021). All these have in common the use of primitive defenses (splitting, projective identification, denial) and identity diffusion, and they are not psychotic, although they can have transient psychotic episodes. These characteristics differentiate these patients from those with a neurotic personality organization and those with a psychotic personality organization. The goal of TFP is to help patients integrate all aspects of their internal world, rather than defensively split off conflicted, shameful, painful, traumatic, or otherwise intolerable thoughts, feelings, and motivations, and ultimately come to experience themselves and others in a more coherent and balanced way.

It may take longer to learn TFP than the other specific evidence-based treatments for borderline personality organization, such as dialectical behavioral therapy, mentalization-based therapy, and schema-based therapy (Cristea et al., 2017), but TFP's aims are more ambitious. Its goal is structural change by helping more mature defense mechanisms to develop, resulting in the establishment of an integrated personality. This leads to much better functioning in all areas of patients' lives—work, love, and an overall better quality of life. Symptomatic improvement will materialize sooner. Patients' affect tolerance and impulse control usually improve within a year. In a randomized clinical trial (Clarkin et al., 2007) between dialectical behavioral therapy, TFP, and supportive psychodynamic psychotherapy (Rockland, 1992), only TFP led to an increase of reflective functioning within a year and had the least attrition. As we describe below, certain elements of TFP are arguably easier to grasp for those who are psychoanalytically trained, but nonanalysts can also learn the method very well. Some analysts who are used to other frameworks sometimes may have more difficulty than nonanalysts.

A thorough introduction to TFP without full TFP training can be useful for the general psychiatric and psychotherapeutic communities, providing tools to deal more effectively with this very difficult patient population. Psychiatric residents can use some aspects of TFP in the emergency room, where patients with borderline personality disorder often present in a suicidal or other crisis (Hersh, 2015; Zerbo, Kohen,

Bielska, & Caligor, 2013). Fundamental understanding of the method can also help general medical practitioners when they encounter "difficult" patients, who commonly have a personality disorder (Hersh, 2018). Over the years elements of TFP have been applied in numerous settings, including with specific patient populations and public health initiatives (Hersh, 2021).

During our own teaching and supervision of groups just learning the method and through discussions with colleagues, we became aware that conversion of treatment-as-usual (by which we mean any non-TFP treatment to TFP by the same therapist/psychiatrist) often presents both patients and therapists with various problems and possibilities that merit attention and discussion. To gain deeper understanding, we conducted a survey of TFP therapists of varied experience with TFP in the United States and Europe, the results of which are presented here. We also wondered whether difficulties around conversion to TFP might be mainly a training issue. We asked participants what the likelihood was that they would convert a new patient to TFP, and whether they would start with TFP right away in the future.

We found that supervision alone did not provide enough time to deal with this issue sufficiently, and over the years our trainees echoed this view.

OVERVIEW OF TFP

TFP is described in detail in several publications (most recently, Yeomans, Clarkin, & Kernberg, 2015). We wish to highlight the main differences between TFP and general psychodynamic psychotherapy as it pertains to conversion to TFP. *Transference* signifies the enactment in the here-and-now of a specific affective relationship between patient and therapist that reflects one aspect, defensive or impulsive, of pathogenic dynamic unconscious conflict. This conceptualization of transference is one of the cornerstones of TFP.

ASSESSMENT

The structural interview is a specific diagnostic assessment whose primary aim is establishing the patient's level of personality organization (Caligor et al., 2007; Kernberg, 1984). This interview is not widely used outside of the TFP community and a few psychoanalytic institutes.

The structural interview has three fundamental goals. First, to determine the patient's personality structure and organization: the nature

of their defenses, the presence or absence of identity diffusion, and the soundness of their reality testing. Second, to identify specific problems that deserve attention as well as areas of ego strength. Third, to establish realistic treatment goals. The structural interview is a diagnostic tool that also enables differentiating primarily major affective/psychotic/anxiety disorders from personality disorders that present with many overlapping symptoms that may or not be the function of personality disorder. Three questions are asked all at once: (1) What brings you to treatment now? (2) Do you have any other difficulties/problems? (3) What do you expect from treatment? The reason for this opening is to immediately assess cognitive functioning and attitude rather than expecting sequential responses from the patient. In addition, questioning in this way probably mildly increases their anxiety, which provides a window into their defensive mechanisms.

The interviewer is more active than the typical psychodynamic therapist. We attend to contradictions common in borderline personality organization, and we inquire and tactfully confront these contradictions. We summarize what has emerged and ask, "If all of this were OK, would you be doing fine?" This often exposes more underlying problems. The patient's day-to-day life is explored with regard to life's four significant domains: work/studies, love/sexual functioning, social (friends, family, community), and play/hobbies/creative endeavors, asking about areas the patient did not mention.

An essential part of the structural interview is to determine the presence and extent of identity diffusion. Identity diffusion becomes apparent when self and an important other are described in vague, superficial, often contradictory ways, idealized, or with little distinction between descriptions of self and other, or only as the other relates to or gratifies the patient. A history of capricious, inconsistent schooling, work, and relationships is also highly suggestive of identity diffusion. During this interview a history, including family history, is gathered only insofar as it is relevant to the patient's current problems and life. On the other hand, we inquire about prior treatments in detail.

If it becomes apparent that the patient suffers from psychopathology such as severe major depression, bipolar, or psychotic disorder, the interview proceeds along the usual psychiatric diagnostic format, and further exploration of character pathology is left for another time, at which point conversion to TFP may be indicated.

Patients being considered for conversion to TFP who were not assessed using the structural interview may cause therapists to be unclear of their level of personality organization. While much information may already be known, therapists must explore and address areas and issues that would have come up during the structural interview, in

addition to modification of the contract, clarification of treatment goals, and the altered treatment frame, to name just a few points.

SHARING THE DIAGNOSTIC ASSESSMENT WITH THE PATIENT

Many therapists are surprised by this. Forthright and respectful discussion of the patient's difficulties, including the diagnosis, lays the foundation for collaborative work, and this should be done in cases of conversion as well. We explain the patient's personality disorder in an experience-near way, using the patients' own account of the specifics of their lives and difficulties. During the prior treatment, diagnosis seldom if ever was discussed with patients who were being converted to TFP, and we submit that it needs to be part of the process of conversion.

OBTAIN OUTSIDE INFORMATION

Due to these patients' tendency for primitive denial, and the fact that they have often had several treatments, we ask permission to speak with prior therapists, which is usually unnecessary when working with patients with neurotic disorders. When converting returning cases, it is also necessary to explore what occurred and what led to the ending of the prior treatment. What was learned or missed?

Under some circumstances (such as severe suicidal behavior, chronically passive lifestyle with which the environment colludes, and patients whose treatment will be financed by someone else, such as adolescents and others) it is often appropriate to hold a session together with significant others, both to gather information and to clarify essential aspects about the proposed therapy.

CONTRACT SETTING

Once all this information has been gathered, and if it has emerged that the patient would best be treated with TFP, the final step is the establishment of a contract, an agreement upon the frame and conditions under which treatment would proceed, with an explanation of each party's responsibilities. Most of the time the contract in other psychotherapies was the same as that which is usually made with patients with neurotic disorders, clarifying only such standard things as schedule, fee, and cancellations. Contracting in TFP with patients

with borderline personality organization is a longer and more detailed process, often requiring several sessions. In returning or ongoing cases there is a need for a new contract. In every case, the contract addresses several essential issues. First, it includes certain conditions warranted by the patient's pathology and history, designed to protect the patient, treatment, and the therapist. If the health and safety of the patient and others is in question, there must be a very clear understanding and a mutual and firm agreement about how this will be dealt with. Typical examples include suicidal urges and behaviors, excessive risk-taking, weight monitoring for patients with anorexia, substance use, unprotected sex, and any other behavior that threatens the patient, others, the therapist, and the treatment. Many patients lead a passive lifestyle or perform below their capacities at work or in their studies. We address these areas in the contract: The patient needs to find a job or take training that could lead to gainful employment. These aspects of the contract may be nonnegotiable. In addition, since patients with borderline personality organization tend to mishear, misunderstand, forget, or discount much that has been agreed, every item of the contract must be discussed in sufficient detail to ensure the patient's full understanding and genuine agreement, and not simply lip-service. Part of the contract is the patient's commitment to free association. This requires psychoeducation and specific instructions beyond "just say whatever comes to mind."

Both parties should be clear from the outset that all that has transpired up until the point of signing the contract, is exclusively in the service of assessment. Only when this last step, agreement on the contract, has been satisfactorily concluded will treatment begin. The contract may be modified and renegotiated during treatment if warranted, for instance by the emergence of new self- or treatment-destructive material or behavior. Patients will invariably test the contract and the frame, which usually indicates activated object relations dyads that will be explored and interpreted. From all this it should be clear that the contract serves as a dynamic foundation of treatment of this patient population (Delaney & Yeomans, 2021).

WORKING WITH DYADS IN THE HERE-AND-NOW

Obviously working with the transference is central to TFP. While this is true for all psychoanalytic therapies, it takes a special, much more focused and immediate form in TFP (Kernberg, 2021); working with transference in TFP requires much more activity on the part of the therapist. According to object relations theory everyone has

internalized representations of themselves (self-representation) and of others (object-representation), and an affect linking the two. These three elements together constitute an object relations dyad. These dyads are based on real and fantasied object relations in the past, as well as defenses against them, and become variously activated in relationships between people. Transference is the reactivation of these past object relations in the immediate here-and-now. Patients with borderline personality organization have conflicting, variably distorted one-sided images of themselves and of others (split part-self and part-object representations, "all-good" and "all-bad"). Unable to tolerate intrapsychic conflict, one part-representation is split off, externalized, and projected onto the therapist together with the connecting affect. This affect indicates the activated intrapsychic dyads. Contrary to patients with neurotic disorders, these dyads are not stable, and are prone to reversal, often flip-flopping even within minutes during the hour. The therapist's task is to analyze—to identify, explore, and interpret—these dyads and their consequences as they manifest themselves in the ongoing present of the therapy hour. What part-object representation is projected onto the therapist, and what part-self representation is assumed by the patient? This interpretive tactic lies at the heart of TFP, described in detail and with vivid illustrations by Caligor, Diamond, Yeomans, and Kernberg (2009).

We refrain from genetic interpretations until later in the treatment. Such information, even if accurate, is not pertinent to the immediate situation; it tends to become "pseudo-insight," usually to justify why they are the way they are, not only alleviating responsibility for themselves, but also obviating any possibility for change. We attend to the patient's inner life while not losing sight of their functioning outside of the sessions.

COUNTERTRANSFERENCE AND METACOMMUNICATION

We pay attention to all three channels of communication: verbal, nonverbal (metacommunication), and countertransference. Metacommunication and countertransference often provide much more reliable clues about the patient's immediate intrapsychic state than the spoken words do. Therapists working with borderline personality organization often have a difficult task recognizing, containing, and analyzing countertransference that is typically more intense than with patients with neurotic disorders (Carsky, 2021). Videotaped sessions showing both therapist and patient are instrumental in detecting metacommunication, including that of the therapist, revealing unconscious

countertransference. Trainees often recognize these elements when viewing their own sessions prior to supervision.

SOME DIFFERENCES IN THE USE OF FREE ASSOCIATION

Free association in TFP might more correctly be termed "qualified" free association. We stress its importance, but we also instruct patients to report any self-destructive behavior, impulse, or thought that occurred between the sessions—suicidal ideation, impulses, or behavior. These are often minimized: "I always think of killing myself—doesn't everybody?" or "What's the big deal, I didn't even bleed," and so forth.

Chronic silence breaks the contractual agreement to make every effort to free associate. We call attention to such behavior, as we might not do with patients with neurotic disorders. We consistently pay attention to whether patients' productions are relevant to agreed-upon treatment goals.

We have found that especially nonanalytically trained therapists have only a vague concept of free association, with the result that they unwittingly impede rather than further it. For instance, they often begin sessions with social chit-chat, "making the patient feel comfortable," or asking "What did you bring today?" rather than waiting for the patient to begin with whatever is uppermost in their mind. Conversely, we have also found that therapists neglect exploration of some unclear or apparently glossed-over material, because they don't want to interrupt what they feel is the patient's free association, which in fact is often a defense.

DIFFERENCES BETWEEN TFP AND SUPPORTIVE THERAPY

What may perhaps already be clear needs to be explicitly stated: TFP is an explorative, not a supportive psychodynamic psychotherapy method. Supportive therapy uses tactics that are not used in TFP. It is important to recognize that our capacity to contain and gradually interpret intense, unpleasant affect states and their effect on the transference, as well as our insistence on the importance of the contract itself, provides much implicit support. TFP therapists do not engage in supportive measures in the usual sense, such as suggestions, admonishments, advice, direct help with structuring time and money, role playing, praising adaptive behavior, or flexible treatment frame outside of therapy hours.

A common misconception of TFP is that we traumatize patients by addressing their aggression, including the recognition that self-directed aggression is an aggressive act against the self and object. By not avoiding it, we contain, metabolize, and interpret it in order to help patients better tolerate and come to understand their aggressive impulses. Therapists often view confrontation as an act of aggression, and indeed, it can be that if rudely phrased or countertransference is given free reign. In TFP confrontation simply means neutrally and realistically bringing patients' attention to contradictory, vague, or evasive material, and contradictions between their verbal and nonverbal communication—in other words, simply pointing out that which is not conscious or is avoided.

AUDIO-VISUAL RECORDING

Video recording is not commonly used in psychotherapy practice. TFP was developed with the systematic use of videotaped sessions. Video recording was adopted in treatment and teaching of TFP because of the singular importance of metacommunication and countertransference when working with patients with borderline personality organization (Clarkin et al., 2005). Patients and therapists both produce unconscious metacommunication. It requires training and practice to register these often fleeting phenomena, and even then, much may go unnoticed by even the most experienced practitioner. Recollection of sessions, notes of various kinds, even audio recordings fail to capture these phenomena fully. Thus, both parties must be visible and audible in the film. Filming is also very useful for identifying situations in which the therapist has unknowingly succumbed to the patient's projective identification. In group supervision other members often discover clues to the patient's and therapist's state of mind of which the therapist remained unaware even when viewing the video themselves. Therefore, trainees are required to use video recording, and it is strongly recommended that its use continue in peer group supervision after certification.

It is important to explain to the patient that video helps with their treatment by enabling consultation with a group of peers, who are bound to the same confidentiality as the therapist. Patients generally have less objection to video recording than might be expected. Therapists, on the other hand, are often uncomfortable when they first begin, which may be rationalized as, for example, ethical objections or insufficient technical knowhow. At times patients' refusal is the product of the therapist's own reluctance. After a short time both parties usually get used to it—if not, the difficulty needs to be explored and interpreted.

Once consent has been given, every session should be recorded, and the camera should be turned on before patients enter the room and switched off only after they leave. This is for two reasons: It makes recording feel less intrusive, and much important material often transpires in the first and last few minutes of sessions, which otherwise might go unnoticed.

Written informed consent for recording is essential, and local laws regarding protection of patient privacy must be obeyed. The consent needs to state that videos will only be viewed by a small group of colleagues who are bound to the same rules of confidentiality. Patients have the right to revoke consent at any time. However, such refusal needs to be explored, rather than simply accepted. The TFP community is not unaware of various professional objections to video, nor do we contend that these are without merit. Nevertheless, we feel that the benefits of its use in training and practice far outweigh the potential drawbacks.

SUPERVISION

Video constitutes the basis of supervision, which in our case is conducted in groups of four to six members meeting biweekly for 90 minutes online. We typically watch the first and last few minutes in addition to what the therapist wants to present. A productive group dynamic generally emerges rather quickly—supportive but not uncritical, in a mutually trusting atmosphere, where most members lose their trepidation and are able to profit from their colleagues' input. Further, work with patients with borderline personality organization is often taxing, and the help and support of a peer group is almost irreplaceable. At times we notice a parallel process that usually represents patients' split representation of self and other, and attention to the group process—including the supervisors' participation in it—can be very helpful.

TECHNIQUE OF CONVERSION

In principle, conversion should be done whenever a therapist has determined that a first treatment approach is not suitable, or not as effective as another, so a switch should be made. Because of the significant differences between the earlier therapeutic method and TFP, conversion is a complex issue; therefore, ideally the entire process, from the time the therapist first considers the move, should be supervised.

First and foremost, the reasons for the conversion and differences from the treatment up until that point need to be addressed with the

patient. These typically have to do with a change of focus, a change of contract, video, and how the therapist will work differently.

In more detail: The reason for conversion from other psychotherapies is that the therapist feels that TFP would be more useful. There might be several reasons for this: The first diagnosis is found to have been mistaken, for instance, because identity diffusion and splitting were not so obviously present, as is often the case with higher-level borderline personality organization and many narcissistic personalities. Further, a student in TFP training realizes that their patient with borderline personality can be treated more effectively with this newly learned method. Yet again, TFP may have been indicated from the beginning but, due to either realistic obstacles or inadvisability (such as patient's financial situation, or addiction), it was postponed. A further factor is occasionally a therapist's reluctance to use TFP due to countertransference, often couched as, "the patient is too fragile for such a confrontational method," thus unstructured psychodynamic therapy was started. These therapies at times fail to sufficiently address the transference and countertransference and have various degrees and kinds of supportive elements, for instance, tolerating excessive extra-session communication and various forms of acting out. Therapists then often feel overburdened. Converting to TFP brings with it the setting of limits on such behavior, a move which leads to the activation, exploration, and analysis of transference and countertransference, which was side-stepped before, and treatment becomes more effective—albeit for a while less "easy" or pleasant. Unfortunately, some cases are brought to supervision after too long a time, and only because the therapist feels stuck and useless by then. Yet another scenario is when TFP elements are gradually and informally introduced into other psychotherapies, trying to gingerly slide into TFP without the patient noticing. (As we later found in supervision, one of the reasons is ambivalence about certain elements of TFP.) When conversion is instituted, it should be a clearly demarcated move, formally discussed with the patient, including an explanation of the reason for the change, and some of the ways in which TFP will be different from the earlier work and explicit invitation of the patients' sharing their reactions to the changes.

We found that therapists often "overexplain" the conversion, possibly as a defense against a sense of guilt and embarrassment over not having begun correctly. This is ill-advised and may evoke a loss of confidence in the therapist, or a feeling that this new way of working is somehow dangerous or overly complicated, and therefore must be introduced and handled very gingerly. Finally, at least some conversions result from the artifact created by being in training, with its conditions and inherent insecurities. (As our survey showed, conversion

is very common during training). Trainees would like to start treating patients as soon as possible, not only because it is required, but also because they are eager to begin using TFP, and it is fastest and easiest to enlist patients whom they are already treating instead of waiting for a new case. All this ought to be processed internally and during supervision, which too often doesn't happen. This is one of the many reasons why we argue for including conversion in the formal course work before trainees begin to treat patients.

An important issue, seldom discussed in the TFP literature, is the therapeutic alliance and its vicissitudes as this is related to conversion. This is especially relevant to returning patients: The return itself indicates alliance, but at the same time it might have been fragile in cases when the patient left treatment. The differences between TFP and other psychotherapies are such that the patient will be treated by a therapist who behaves quite differently from the person they had become accustomed to. This "new" therapist will be less supportive, and possibly be initially experienced as unhelpful or intrusive. Troublesome aspects of the patient's pathology that had been insufficiently addressed or avoided altogether will begin to emerge, and the patient becomes uncomfortable and feels threatened and abandoned: "What has happened to my friendly therapist, with whom I had felt so comfortable? I don't like it one bit!" As a result, the therapeutic alliance is often strained. However, it is precisely the exploration and interpretation of these shifts and the attendant defenses that are so useful.

The other side of that same coin is the therapist, who has often been trained to make the patient comfortable, not interrupting, not analyzing resistance, not discussing uncomfortable material nor directly addressing negative transference. We often hear, "Can I really say *this*—isn't it too blunt?" Breaking such habits is not easy but can usually be accomplished successfully once the therapist understands its necessity. Finally, we initially assumed that if psychotherapy had been very long and supportive, conversion would be difficult, perhaps even impossible. That is not always true. Rather, the alliance formed during the prior experience seems able to contain the rawer winds stirred up by TFP. In fact, the length of prior supportive treatment is far less relevant than the therapist's aptitude.

SURVEY OF TFP THERAPISTS

We conducted a survey of TFP therapists and trainees to better understand and examine context and challenges to conversion to TFP from other therapy modalities. We distributed a survey to trainees in TFP

who had been under supervision for at least 1 year and to fully trained TFP therapists. The response rate was 36/43 (84%). Fourteen participants were from the United States, eight of them graduated psychoanalysts, 21 from Hungary, only one of whom was a psychoanalyst, and one psychiatrist from Spain. Altogether, 17 respondents had completed TFP training, and 19 were still in training, and had been in supervision for at least 1 year, several for much longer. There were far fewer psychiatrists in the European group than the United States group (3 vs. 10, respectively). The level of clinical experience and training varied greatly. Fourteen of the participants (39%) were our own supervisees, raising the possibility of selection bias.

We were interested in knowing how common conversion was, as well as from what type of therapy, what kinds of difficulties were encountered, and what kind of dyads were activated. Was TFP easier if begun with a new patient compared to conversion of an ongoing or past treatment to TFP? Which elements of TFP did they struggle with the most, what was most helpful, least helpful, and did they use, or did they anticipate using in the future, methods other than TFP for patients with borderline personality organization?

Twenty-eight therapists (78%) had done conversions, eight (22%) had not. Of those that had, 14 had one or more returning cases, and 21 converted from ongoing treatments. The length of these treatments varied from 2 months to 10 years. Most, but not all, nonanalysts had used supportive-dynamic therapy, while three analysts converted cases to TFP from 1–5 years of psychoanalysis, and two from supportive-dynamic therapy. Thus, conversion was quite common. The difficulties encountered varied greatly, but as expected, moving from supportive therapy to TFP was the most difficult for the therapist, and often for the patient, as well. Six (17%) reported resistance to video, including their own.

Four therapists out of the 28 who had experience with using TFP from the outset as well as converting cases reported that *de novo* is easier. Five felt it was easier to convert, and for 19 it varied, depending on the case, or they stated that there was no difference. Psychoanalysts found no difference between the two situations, suggesting the role of expertise with techniques common to psychoanalysis and TFP—including working with transference and countertransference and eschewing supportive methods.

The dyads activated by conversion to TFP were the expected ones: predominantly paranoid (14); passive/exploitative (3); victim/rescuer (1); abandoned/neglected/deprived (4); passive, helpless/protected, idealized (6); and voyeuristic/exhibitionistic (1).

Nearly all therapists reported that the features of TFP that were the most difficult to learn were exactly those that make it the most effective,

such as working with dyads, the interpretive process at the core of TFP. Psychoanalysts and nonanalysts alike reported struggling with tolerating intense affect, neutrality, and working with dyads.

Group supervision, better assessment (structural interview), recognition of passivity and related passive aggression, lack of patient motivation, and recognizing/tolerating/using countertransference were all mentioned as helpful. Many (66%) listed no unhelpful elements.

Surprisingly, given the reputation of TFP among the general therapeutic and psychoanalytic community for being "too aggressive for frail patients," only one therapist felt that TFP overemphasized aggression. TFP seminars help trainees to understand the role of aggression in severe personality disorders and the importance of attending to it. One therapist felt that reminding the patient of the contract was infantilizing. Eight therapists felt that the twice-a-week treatment could be a potential obstacle.

Only eight respondents reported difficulty working with dyads. We question this answer, because in supervision we find that there is a gap between understanding dyads and working with them, and the latter takes the longest time for most to grasp—though they themselves often don't realize it. For some it comes naturally, regardless of their background, and for some it is very, very difficult.

All respondents reported that they would use TFP from the beginning, or a preparatory phase might be indicated during which they would use TFP elements, including therapeutic neutrality and an exploratory stance.

DISCUSSION

TFP is an object relations–based psychoanalytic psychotherapy utilizing basic analytic techniques modified to address the primitive defenses and identity diffusion that are the core of borderline personality organization and borderline personality disorder. TFP aims at resolution of both, resulting in reduction of splitting-based defenses, thus leading to integration of split-off parts of personality and ultimately the development of a consolidated identity. While symptomatic improvement and improvement of reflective function may occur within 12 months (Clarkin et al., 2007), it takes longer to achieve deeper psychological changes. Consequently, learning this method takes longer than other evidence-based methods (mentalization-based therapy; dialectical behavioral therapy; schema-based therapy). Because we start treatment with the structural interview, followed by a phase of contract setting that addresses self-destructive behaviors, treatment interfering

behaviors, and passive lifestyle, among others, it seems logical that it is easier to begin learning the method with new cases.

Since we encourage supervision to begin sometime during the theoretical coursework, many trainees convert currently ongoing cases rather than waiting for a new referral. In our supervisory experience the process of converting cases to TFP stretches the time limits of twice-a-month 90-minute group supervision with four to six participants, which is one of the reasons trainees often convert cases without adequate supervision.

Our survey of already trained TFP therapists and supervisees with a minimum of 1 year of training found that during training, conversion was very common. We inquired about their difficulties and were also interested in finding out how often they would use other methods rather than TFP for their patients with borderline personality organization. Therapists had various kinds and levels of training and mostly practiced supportive-dynamic therapies. Some of the difficulties were similar: tolerating intense affect, neutrality, and working with dyads.

Not surprisingly, conversion was most difficult from a long supportive therapy. On the other hand, in many cases therapeutic alliance, frail as it may be because of splitting mechanisms, helped to withstand the initial storms of the more intensive treatment. In our own experience, supervisees often bring converted cases when they have problems, especially in the earlier phase of supervision, but later many can generalize the knowledge they gained and do not encounter severe problems. A lot depends on the therapist's aptitude.

Based on the results of our survey, we propose that supervision alone is not sufficient to address the intricacies of the process, and teaching conversion in formal seminars, before trainees start to treat patients, would provide a better foundation.

CONCLUSION

TFP can be taught to the level of competence in a minimum of 3 years of group supervision in addition to formal seminars. Peer supervision thereafter remains essential when working with borderline disorders. The seminars, which include learning the structural interview, sharpen trainees' diagnostic skills, which often leads to a recognition of current or recurring cases' borderline level of personality organization. This, in addition to the requirements of training, leads to many conversions from other treatments to TFP that are inadequately supervised. The process itself is rarely brought to supervision, and, while some more advanced therapists present converted cases when there is progress,

more of these cases come to our attention only when there are various difficulties because the foundations of treatment—clear structural diagnosis, proper contract, and managing inevitable breaches of contract—are missing.

Our survey revealed that—trained or in advanced training—would begin all new patients with borderline personality organization with TFP. In rare cases—for instance, inadequate motivation, significant harmful use of substances—they begin with a TFP-informed preparatory therapy. We conclude that conversion is first of all a training issue: It should be taught during formal coursework, before trainees begin to treat patients with TFP, and should not be left to be dealt with in supervision alone. Finally, while psychoanalysts have an easier time working with the transference, utilizing countertransference, and therapeutic neutrality, nonanalysts can learn the method well within a reasonable amount of time.

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