TFP-G for Eating and Personality Disorders: A Clinical-Descriptive Report

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Eating disorders (EDs) are especially complex when they co-occur with personality disorders. Difficulties in identity integration, affect regulation, impulsivity, and interpersonal functioning often interact with ED symptoms, increasing clinical complexity (Paudex et al., 2025). Integrated approaches addressing both eating-related symptoms and underlying personality organization are therefore needed.

Group Transference-Focused Psychotherapy (TFP-G), derived from Kernberg's model of personality organization, may be particularly useful in this context, as it targets identity diffusion, affective instability, defensive functioning, and interpersonal dynamics within the group setting (Kernberg, 2009).

How does TFP-G work? Interpretive sequence

TFP-G follows the whole-group tradition of Bion (1961,1967) and Ezriel (1950), focusing on the group as a relational field in which individual personality dynamics become activated and observable. A central technical task is the identification of a **hierarchy of group process components**.

Stage 1 — Group-level interpretation

The therapist first addresses the group as a whole, identifying:

1. Dominant topic: the conscious theme the group is interested in working on.
2. Predominant affect: the main emotional tone emerging around the dominant topic.
3. Affectively dominant object relation: the central relational pattern enacted in the group, including roles, positions, and expectations.
4. Defensive operations: the main defenses organizing the group process, informed by countertransference.
5. Basic-assumption configuration: the regressive group mode protecting the working group from an unconscious catastrophic expectation.
6. Group tension: the oscillation between the working group and the basic-assumption group.
7. Unconscious feared scenario: the avoided scene or catastrophic expectation underlying the group's defensive organization.
8. Dominant group conflict: the conflict between the conscious dominant topic and the unconscious feared scenario.
9. Consequences: the therapist highlights the emotional, relational, and the consequences of maintaining the defensive organization.

Stage 2 — Individual interpretation

Once the group process has been named and the therapist considers that the group has understood the conflict, the therapist:

1. Comments on the extreme positions that emerge within the shared dynamic.
2. Links each extreme position to the member's individual relational patterns.
3. Shows how individual conflicts are activated within the collective group field.
4. Clarifies how each member participates in, avoids, or reinforces the dominant group conflict.

Sample & Setting

A semi-open TFP-G group was conducted in a private outpatient treatment service over one year, with weekly 75-minute sessions. The group included 8 female patients recovered from EDs and a comorbid borderline personality organization. ED diagnoses included AN, BED, and OSFED, with comorbid BPD and NPD features/diagnoses. Participants presented low to middle borderline personality organization. Treatment was delivered by a lead therapist and co-therapist, alternating the roles of conductor and observer throughout the sessions, with ongoing expert supervision. TFP-G was implemented as a specialized intervention for personality organization within an ED clinical context.

Clinical Vignette: Fear of Speaking Clearly in the Group

During a weekly TFP-G session therapists informed the group that several members were absent. The absence of one of the participants became rapidly affectively charged. Some members expressed irritation and disappointment about the patient's repeated non-attendance, whereas others felt that speaking about someone who was not present would be disloyal, unfair, or potentially harmful. The group polarized between the need to speak openly about the rupture of the group frame and the fear that doing so could damage the relationship.

Stage 1 — Group-level interpretation

Component	Clinical formulation
Dominant topic	Difficulty speaking openly about the absence of a group member and its impact on the group frame.
Predominant affects	Resentment, fear, guilt, discomfort, and anxiety about damaging the relationship.
Affectively dominant OR	Abandoned, resentful group members in relation to an absent, irresponsible, or rejecting object.
Defensive operations	Splitting, avoidance of direct conflict, moralization, displacement, and projective identification.
Basic-assumption configuration	Dependent basic-assumption group: the group implicitly relies on the therapists to manage the rupture and preserve the bond.
Group tension	Oscillation between the working group, which tries to address the absence and its impact on the frame, and the dependent basic-assumption group, which avoids direct speech due to frustrated dependency needs.
Unconscious feared scenario	If the group speaks clearly about disappointment, anger, or resentment, the relationship may break; the absent member may feel attacked, reject the group, or leave permanently.
Dominant group conflict	The conscious need to speak openly about the absence versus the unconscious fear that honest speech could destroy the relationship and lead to abandonment.
Consequence	Silence preserves the bond defensively, but inhibits more intimate and honest relationships within the group.

Possible group-level interpretation

"t seems that today the group began in contact with something painful and uncomfortable: the absence of a member and the feelings this absence produces. One part of the group seems angry or disappointed, while another part feels that speaking about her when she is not here would be unfair or dangerous. Perhaps the group is caught in the fear that speaking clearly about anger or disappointment could damage the relationship and lead to abandonment. The consequence is that the group is left without the possibility of developing deeper and more intimate relationships, where members can express honestly what they think and feel, even when conflict appears."

Stage 2 — Individual level formulation

Once the group conflict had been named and sufficiently understood, the therapist could move to each member's position within the shared dynamic:

- Patient A: represents the adult and responsible part of the group, attempting to uphold the therapeutic frame and the value of commitment.
- Patients B and C: represent the loyal and protective side of the group, fearing that open speech could be experienced as an attack, betrayal, or rejection.
- Patient D: carries the openly angry and disappointed side of the group, giving voice to resentment about non-attendance and lack of commitment.
- Patient E: occupies a guilty and self-referential position, wondering whether the absent member's withdrawal might have something to do with her.
- Other members: occupy a more childlike and dependent position, as if painful or conflictual issues should be handled by the therapists while the group remains silent.

Together, these positions represent different ways of managing the same shared conflict: the wish to speak clearly about what happens in the group and the fear that open speech could damage or destroy the bond.

Discussion

This vignette illustrates how TFP-G can help identify and address relational patterns by pinpointing dominant group tensions in patients with personality disorders within the context of a specialized center for the treatment of EDs. This approach may be especially useful in this population where difficulties with affect regulation, aggression, dependency, and relational rupture often maintain symptomatic and interpersonal dysfunction. Further research is needed to evaluate the clinical utility and outcomes of TFP-G for the treatment of personality disorders.

References