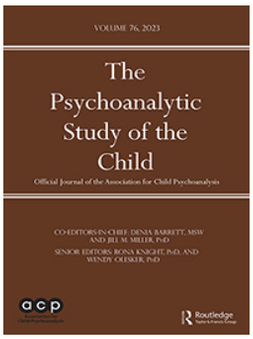

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Reflections on the Treatment of Youth During Simultaneous Training in Transference-Focused Psychotherapy and Psychoanalysis

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ABSTRACT
The author recounts his experience training simultaneously in transference-focused psychotherapy and psychoanalysis while treating youth with personality disorders. He discusses their similarities and differences, and considers the dilemma of selecting the appropriate treatment modality when both may be helpful. He then illustrates his handling of this dilemma with case material from the treatment of a 12-year-old girl with borderline personality disorder.

KEYWORDS
Transference focused psychotherapy; psychoanalysis; personality disorders; adolescents

During my psychiatry clerkship in medical school, I was most fascinated by patients with personality pathology. Everyone seemed to dislike, disparage, and avoid them, even the most skilled and compassionate doctors, while at the same time these patients were suffering tremendously. It struck me as a major and inviting challenge to learn to help them. Mentors pointed me in the direction of psychoanalysis, a comprehensive way of thinking about patients with personality difficulties. In my independent reading I stumbled upon works by Otto Kernberg and his conceptualization and treatment of severe personality disorders via transference-focused psychotherapy (TFP) (Kernberg et al. 2008). I learned that he was on faculty at Weill Cornell Medicine as head of the Personality Studies Institute. Mentors advised me that Cornell had a rich tradition of valuing and prioritizing psychoanalytic ideas in its training of residents. This combination of transference-focused psychotherapy and psychoanalysis drew me there.

At Cornell, transference-focused psychotherapy and psychoanalysis were introduced simultaneously (Bernstein, Zimmerman, and Auchincloss 2015). We had TFP lectures, case presentations, and supervision from Otto Kernberg, Frank Yeomans, Jill Delaney, and others. TFP is an evidence-based, manualized, twice-weekly individual psychodynamic psychotherapy rooted in psychoanalytic object relations theory, designed for patients suffering from personality disorders (Yeomans, Clarkin, and Kernberg 2015). At the same time, psychoanalysts affiliated with several different institutes taught us about psychoanalytic concepts, illustrated the concepts with case material, and listened to cases longitudinally. My interest gravitated toward treating adolescents and young adults between 13 and 25. I enjoyed the sense of "getting in on the ground floor" and assisting with personality development at this critical and lively stage of identity formation. I found myself most engaged when my adolescent patients struggling with suicidality and self-harm would

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become puzzled and wonder aloud with me about the meanings of their behaviors. They were often able to recognize they were feeling a particular way because of unexamined beliefs about themselves and others. As I completed child psychiatry fellowship training, I signed up for simultaneous training in psychoanalysis and transference-focused psychotherapy at the Columbia Center for Psychoanalytic Training and Research. I soon began treating two adolescents in transference-focused psychotherapy and two college-aged young men in psychoanalysis.

It got complicated. As beginners do, I expected there would be categorical simplicity and clear rules when choosing between psychoanalysis and transference-focused psychotherapy for any given patient. While there is a clear mutual respect and collaborative dialogue between TFP therapists and psychoanalysts, there is also a lot of good-natured elbowing based on real differences and disagreements on the assumptions, techniques, and applications of each approach (Kernberg 2022). Whenever I raised the prospect of doing TFP to a psychoanalyst, or of doing psychoanalysis to a TFP therapist, this was often met with a raised eyebrow and twinkle in the eye, an eagerness to argue for the value of that person's preferred approach, and with a wink a dismissal of the obvious flaws in the "other method." Sometimes these disagreements were quite serious. Psychoanalysts sometimes feel TFP therapists revile reverie, dismiss dreams, force a focus on "outside life" at the expense of fantasy, and relentlessly railroad the patient into confronting their defenses. TFP therapists sometimes feel psychoanalysts contemplate crisis as the world burns, listen listlessly, and allow splitting as a soporific in a never-ending, goalless treatment.

As in any good competition, each side argues their merits, and I am caught in between, drawn to both, and feeling a pressure to "choose a side" to form my primary therapeutic identity. The rubber meets the road when I have a patient whom I feel could benefit from both but might be inefficiently or ineffectively treated by the "wrong choice." This is often a patient at a high level of borderline personality organization or a patient on the border between borderline and neurotic personality organization. Both camps claim these patients, with TFP therapists saying their approach is more efficient, and psychoanalysts saying their approach is more patient and in-depth. For a given patient with amenable personality pathology, what is the best way of treating them? I will illustrate my grappling with this dilemma in the case of Lindsay,[1] a 12-year-old girl I treated with transference-focused psychotherapy for adolescents.

Lindsay is a 12-year-old girl with divorced parents, a younger brother, and three older sisters. She attends a mainstream middle school. Her difficulties began in late grade school when she began to experience significant rejection from her peers because of her bossy and controlling attitude. That was emotionally devastating for her and led her to question her own value. When her parents decided they wanted to sell her childhood home and move to a different state across the country, she started lashing out at them and refused to attend school, despite what struck me as genuine attempts from her family to effectively engage and understand her. Lindsay's troubles culminated in a suicide attempt using a box cutter for which she was psychiatrically hospitalized. We later came to understand this suicide attempt as her way of communicating a feeling of helpless distress to her family, as well as angrily controlling and punishing them for moving her from her childhood home. It was also a way of sadistically punishing herself for her perceived worthlessness and badness. She felt comforted and safe in the hospital where she could safely regress into "being cared for like a baby" and avoid the more grownup demands of moving to a new home, participating

in school and social life, and contending with growing from a thin child into a developed woman with nascent sexual interests. After her discharge she attended a few months of outpatient dialectical behavior therapy, but she did not like the group component and was interested in individual psychotherapy, prompting her family to consult with me.

When I first met Lindsay, she struck me as both childlike and exceptionally mature for her age. She attended sessions remotely from a laptop in her bedroom, with stuffed animals and dolls populating her bed and shelves, and she wore pajamas. She was notably thin. At the same time, she engaged with me with a sophisticated vocabulary and spoke with the tone and humor of someone in their twenties or thirties, with a jaded world-weariness and dismissiveness of the "obvious immaturity" of her peers. Lindsay's presenting difficulties included a predominantly bossy and rude attitude, an oscillation between very low self-esteem and fantasied superiority to peers, and significant anxiety that "no one liked her" resulting in school refusal and social isolation such that she spent most of her free time playing video games alone at home. At home, she oscillated among angrily yelling at her parents, silently rejecting their attempts to engage her, and complaining about various nonspecific physical complaints like headaches and stomachaches which prompted her parents to soothe and care for her. At other times she was loving and caring toward family, acquaintances, and pets.

Lindsay described her relationship with her parents as generally good. She felt they loved her although they were sometimes very angry at her, unfairly blamed her, were disappointed in her and saw her as fragile, or paid more attention to her siblings who were "smarter and more attractive." She saw her parents worry about her and privately wondered if she "had what it takes to be an adult," a prospect with terrifying responsibilities, and felt it would be easier to "be a kid forever." She said, with humor but also visible anxiety, "How can anyone possibly figure out how to get a mortgage?" At the same time, she had strong ambitions to attend a good college and become a successful lawyer. At the time of evaluation, she was not suicidal and not engaging in self-harm, substance use, or eating-disordered behavior. She was clearly intelligent, psychologically minded, and motivated for treatment, with insight that her current approach to life was not as sustainable, enjoyable, or meaningful as it could be. I diagnosed her with borderline personality disorder and discussed treatment options with Lindsay and her family.

I felt Lindsay's intelligence, psychological mindedness, and motivation might allow her to make use of a more intensive and in-depth treatment like psychoanalysis. She wanted to understand and work through her difficulties. She was also able to reflect on how early experiences and relationships with caregivers were in part the genesis of the way she engages with herself and others in the present. But her acting out via suicidality and self-harm (previously) and school avoidance (currently) posed a great and immediate risk to her. Transference-focused psychotherapy for adolescents (TFP-A), via the contract, would provide a containing structure and focus on understanding and interpreting these behaviors intensively, and might lead to rapid improvement (Normandin et al. 2021). On the other hand, the demands of the contract might lead her, a girl who defensively relies on avoidance of powerful affect, to prematurely quit treatment or even refuse it altogether. Psychoanalysis might also allow us to explore these dynamics at a more gradual and tolerable pace, but her problematic behavior could cause great damage in the meantime. I consulted with two supervisors, one who primarily does TFP and one who is primarily a psychoanalyst, and each advocated for the appropriateness and effectiveness of their preferred treatment

modality. In the end, I decided to proceed with TFP-A, to engage first in the contracting process with Lindsay which would rapidly address the most concerning behaviors, and if I found that Lindsay could effectively participate, I would consider offering psychoanalysis later.

The primary advantage of the transference-focused psychotherapy approach came in the form of the contract as a constant mutual frame of reference. During the contracting phase, Lindsay earnestly agreed to attend school daily and on time, which she tied to her goals of getting into a good college and becoming a lawyer. Early in the treatment phase, Lindsay predictably began arriving late to school, and on some days missed school altogether. When she did attend sessions, she was often bossy, rude, and contemptuous. I took an active approach and inquired about her angry facial expressions and silences, clarifying her defenses. The following was our exchange, condensed for clarity:

Me: I notice that you're silent.

Lindsay: (Remains silent, angry expression.)

Me: Judging from your facial expression, I think you are actually very angry with me.

Lindsay: (Remains silent.)

Me: I don't really know, but it could be that you're angry with me because you feel I've been forcing you to go to school. (I inferred this from feeling silently controlled by her in the countertransference. I imagined she must be feeling controlled by the demands of the contract, which she was perceiving as a controlling demand made by me rather than an agreement we'd made together to help her.)

Lindsay: Yes, I'm furious that you're forcing me to go to school on time. Sometimes I just want to sleep in. You don't care about me at all, you're just rigid and controlling. So I'm not talking with you.

Me: You feel I'm uncaring and controlling, and I'm forcing you to do what I want, and you're really mad about that. You're silent to protect yourself from me.

Lindsay: (Expression softens, appears uncertain.)

Me: There's something that's confusing to me – you're saying it's my desire that you go to school and I'm forcing you to do that. But I'm only saying you should go to school because *you* said you wanted to do that, at the beginning, to achieve your goals of getting into a good college.

Lindsay: (Expression softens.) I guess I did say that. Maybe you aren't really controlling me. I know that you want me to go to school because it would help me. It's just really hard sometimes. I don't like the people there and it's hard to deal with them, especially on days when I don't feel great about myself. It's hard to trust them. I guess I'd rather fight with you than fight with myself about going to school.

Me: You often see me, and others, as mean and controlling toward you, and to cope with that, you turn the tables. You try to control them – you're dismissive toward peers, and with me, you're silent. That protects you, but this thinking can also turn people into something they aren't and get in the way of their helping you. We've seen that with me.

As you said, you'd rather fight others than deal with anxieties in you. I think underneath, you're really worried no one really likes you, that you can't ever depend on people, even though you really want affection and to show others affection. That sounds really tough.

Lindsay: (Begins to cry.)

Securing Lindsay's genuine agreement to attend school and therapy to further her specific goals in the contracting phase served as a useful point of reference when she refused to attend school and, in her silence, refused to engage with me. We had already clearly established together that there was a part of her that wanted to attend school and engage in treatment ("adult-like"), which she then disavowed, split off, and externalized onto me, instead demonstrating to me only the part of her that does not want to attend school and wants to remain safely exactly as she is ("child-like"). We would have come to this internal conflict if we had not engaged in contracting and instead proceeded with psychoanalysis, but transference-focused psychotherapy very likely speeds this process up because of the availability of a clear mutual point of reference in the contract. Under the emotional pressure of her splitting and projection being confronted early and directly, there was a risk that Lindsay would defensively retreat further into a position of enraged denial, stating that she never agreed to go to school or that she lied and "didn't mean it," or she might find it affectively intolerable and quit treatment altogether. A less directive and less confrontational psychoanalytic approach might have allowed Lindsay to move at the pace she chose, allowing breathing room for elaborated internal fantasy without consistent redirection to external reality (Goldblatt et al. 2015). It might also have left her feeling more autonomous and in control of the process, a feeling of paramount importance to adolescents.

In the following eighteen months of transference-focused psychotherapy, Lindsay's most problematic behaviors steadily improved. Suicidality retreated, and she began attending school regularly and on-time. In the transference, she began to experience me less as a punitive, controlling, and uncaring authority, and more as an invested, imperfect but helpful guide. She shifted from saying, "You just want me to talk more with friends because it'll make you feel better as a therapist," to, "I wish you understood how hard this is and gave me more time, but I know you're trying to help, and I do want to work on these things." This was accompanied by shifts in my countertransference from frustrated, helpless anger to deepening concern, appreciation, and caring. She began to understand her earlier suicidal action as "acting rather than feeling," and began to better verbalize and tolerate anxieties associated with her primary conflicts around trust versus isolation, autonomy versus dependency, and remaining a child versus developing into an adult. She began to tolerate her feelings of aggression without fearing her basic goodness would be overwhelmed, took ownership of aggression and experienced guilt for her sometimes bossy and demeaning actions, sought repair with her parents and ex-friends, and better tolerated the shortcomings of others: "My dad gets really angry, just like me, and I wish he didn't because it hurts me sometimes, but I still love him." As Lindsay's family prepared to move to a different state across the country, I pursued licensure there to continue teletherapy. When I told Lindsay of my new licensure, we shared a deeply emotional moment in which she first looked surprised, then said, "I'm really, really happy to hear that," and I said, "I'm happy, too." We both teared up, although she tried to partially shield her eyes from me.

With time and development, transferences and themes shifted further. Lindsay started wearing more age-appropriate and revealing clothing. I commented on her change in dress; she appeared pleased that I had noticed, then paused and expressed curiosity about what kind of clothing my wife wears. In following sessions, she reverted to wearing pajamas for some time, before again experimenting with more seductive clothing, and more freely discussed with me her new romantic interest in a boy at school, in whom a competitive female friend of hers was also interested. This shift from paranoid and sadomasochistic transferences accompanied by dangerous behavior to erotic and oedipal transferences accompanied by verbalized anxieties demonstrated clearly to me how transference-focused psychotherapy and psychoanalysis work similarly, with different strengths and weaknesses for different patients and phases of treatment (Kenny 2021).

I continue to struggle with my therapeutic identity as I treat youth with personality pathology. I am only beginning to work with young patients analytically, and I anticipate growing to further appreciate the utility of a depth approach with less structure and increased frequency. This is a good kind of struggle, because these questions are at the forefront of our discipline. Psychoanalysts must contend with the rise, popularity, and efficiency of manualized treatments, and those who practice manualized treatments must contend with the depth of theory and unparalleled comprehensiveness offered by psychoanalysis. Learning and practicing both transference-focused psychotherapy and psychoanalysis has shown me very clearly that despite their very real differences, they can through competition and dialogue inform and enhance each other.

Note

1. All patient names have been changed and identifying information has been disguised.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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