The Different Ways TFP Helps People with BPD

National Education Alliance for Borderline Personality Disorder
Webinar April 3, 2025, 12:00 noon

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We have not conflicts of interest to report

Outline of Today's Presentation

- An introduction to Transference-Focused Psychotherapy (TFP) as an individual treatment for patients with borderline personality disorder (15 minutes)
- An introduction to Applied TFP, or the use of TFP principles in clinical situations outside of the standard, individual psychotherapy modality (15 minutes)
- An introduction to a TFP-informed psychoeducation program (15 minutes)

Overview

TFP-A
for use with
Adolescent Patients

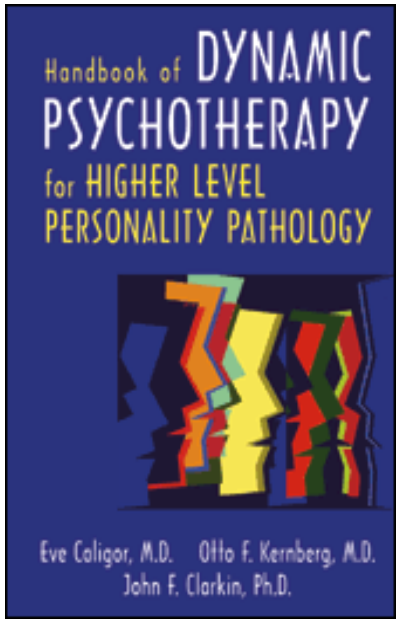
TFP-N
for use with patients
with Pathological
Narcissism

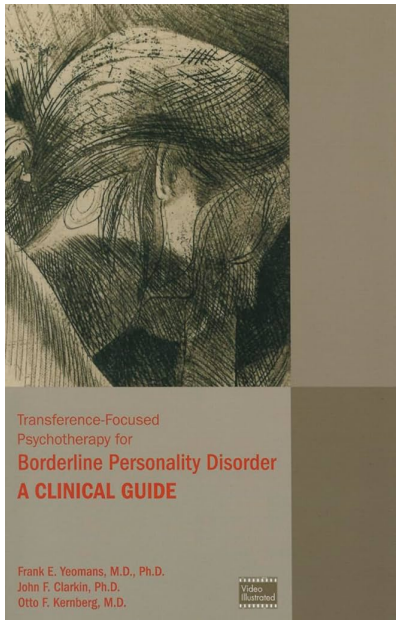
TFP-E
for Personality Disorder
Pathology Across the
Continuum

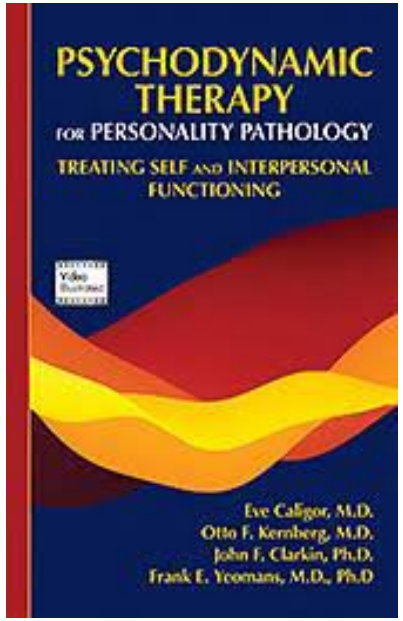
Applied TFP
use in General Settings

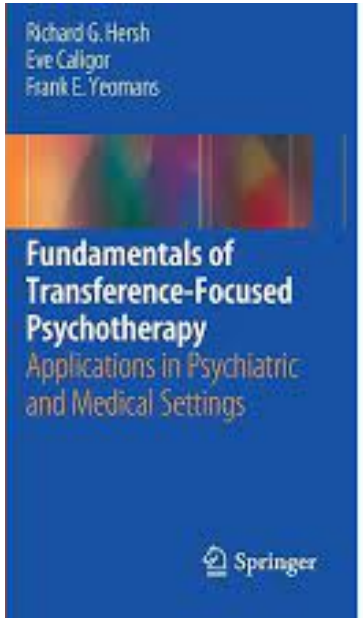
TFP
for Borderline Personality Disorder

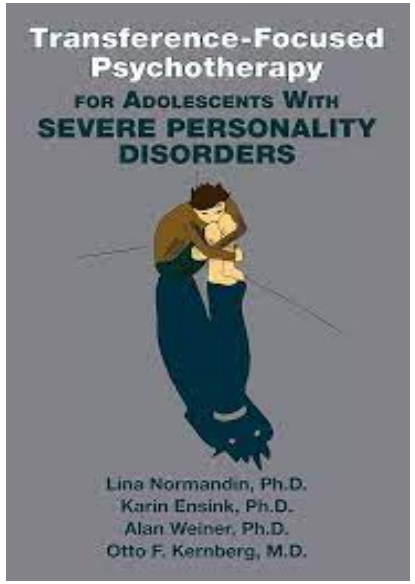
Key TFP Texts

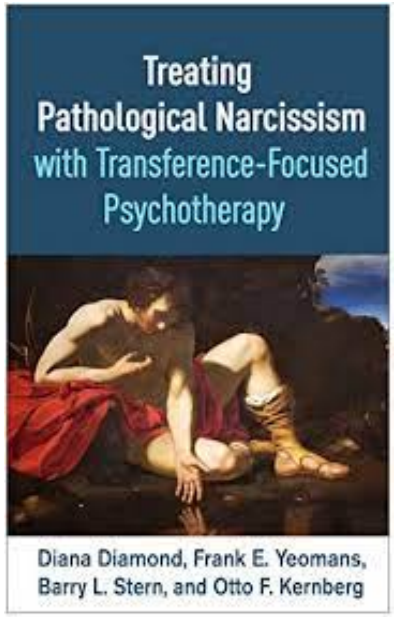


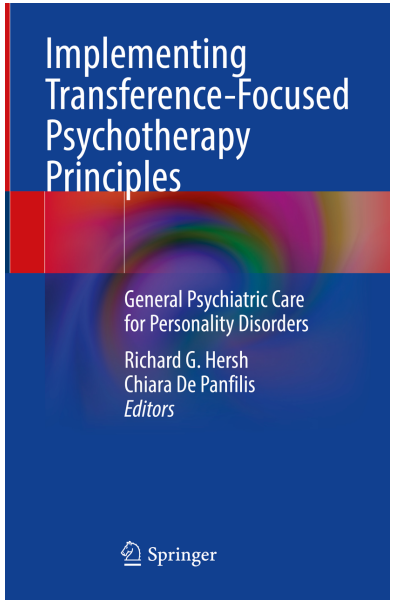












What Should Families Know About TFP as an Individual Treatment?

Overview of Transference-Focused Psychotherapy (TFP)

- Psychoanalytic psychotherapy informed by Object Relations theory
- Reworking of standard psychoanalytic psychotherapy to treat more impaired patients
- Evidence-based for the treatment of patients with borderline personality disorder (BPD)
- Manualized
- Twice-weekly, one to three years
- Anchored by the **structural interview** and the negotiation and maintenance of a **treatment contract**

TFP: What It's Not

- Psychoanalysis: doesn't use the couch, not more than twice weekly
- Unstructured psychodynamic psychotherapy: focuses on specific treatment goals, not just self-understanding
- Supportive therapy: doesn't involve specific advice, guidance unless there is a need to deviate from **technical neutrality**
- Cognitive behavioral therapy: aims for personality change, not only change in behaviors

Individual Psychotherapy for Patients with Borderline Personality Disorder

- Psychotherapies, most notably dialectical behavior therapy and psychodynamic approaches, are effective for borderline symptoms and related problems (Cristea et al., 2017)

Research

JAMA Psychiatry | Original Investigation | META-ANALYSIS

Efficacy of Psychotherapies for Borderline Personality Disorder
A Systematic Review and Meta-analysis

Ioana A. Cristea, PhD; Claudio Gentili, MD, PhD; Carmen D. Cotet, PhD; Daniela Palomba, MD; Corrado Barbui, MD; Pim Cuijpers, PhD

IMPORTANCE Borderline personality disorder (BPD) is a debilitating condition, but several psychotherapies are considered effective.

OBJECTIVE To conduct an updated systematic review and meta-analysis of randomized clinical trials to assess the efficacy of psychotherapies for BPD populations.

DATA SOURCES Search terms were combined for *borderline personality* and *randomized trials* in PubMed, PsycINFO, EMBASE, and the Cochrane Central Register of Controlled Trials (from database inception to November 2015), as well as the reference lists of earlier meta-analyses.

STUDY SELECTION Included were randomized clinical trials of adults with diagnosed BPD randomized to psychotherapy exclusively or to a control intervention. Study selection differentiated stand-alone designs (in which an independent psychotherapy was compared with control interventions) from add-on designs (in which an experimental intervention added to usual treatment was compared with usual treatment alone).

DATA EXTRACTION AND SYNTHESIS Data extraction coded characteristics of trials, participants, and interventions and assessed risk of bias using 4 domains of the Cochrane Collaboration Risk of Bias tool (independent extraction by 2 assessors). Outcomes were pooled using a random-effects model. Subgroup and meta-regression analyses were conducted.

MAIN OUTCOMES AND MEASURES Standardized mean differences (Hedges *g*) were calculated using all outcomes reported in the trials for borderline symptoms, self-harm, suicide, health service use, and general psychopathology at posttest and follow-up. Differential treatment retention at posttest was analyzed, reporting odds ratios.

RESULTS Thirty-three trials (2256 participants) were included. For borderline-relevant outcomes combined (symptoms, self-harm, and suicide) at posttest, the investigated psychotherapies were moderately more effective than control interventions in stand-alone designs (g = 0.32; 95% CI, 0.14-0.51) and add-on designs (g = 0.40; 95% CI, 0.15-0.65). Results were similar for other outcomes, including stand-alone designs: self-harm (g = 0.32; 95% CI, 0.09-0.54), suicide (g = 0.44; 95% CI, 0.15-0.74), health service use (g = 0.40; 95% CI, 0.22-0.58), and general psychopathology (g = 0.32; 95% CI, 0.09-0.55), with no differences between design types. There were no significant differences in the odds ratios for treatment retention (1.32; 95% CI, 0.87-2.00 for stand-alone designs and 1.01; 95% CI, 0.55-1.87 for add-on designs). Thirteen trials reported borderline-relevant outcomes at follow-up (g = 0.45; 95% CI, 0.15-0.75). Dialectical behavior therapy (g = 0.34; 95% CI, 0.15-0.53) and psychodynamic approaches (g = 0.41; 95% CI, 0.12-0.69) were the only types of psychotherapies more effective than control interventions. Risk of bias was a significant moderator in subgroup and meta-regression analyses (slope β = −0.16; 95% CI, −0.29 to −0.03; P = .02). Publication bias was persistent, particularly for follow-up.

CONCLUSIONS AND RELEVANCE Psychotherapies, most notably dialectical behavior therapy and psychodynamic approaches, are effective for borderline symptoms and related problems. Nonetheless, effects are small, inflated by risk of bias and publication bias, and particularly unstable at follow-up.

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Editorial
Supplemental content

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TFP Studies: 2006, 2007, and 2010

ORIGINAL ARTICLE

Outpatient Psychotherapy for Borderline Personality Disorder

Randomized Trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy

Josephine Giesen-Bloo, MSc; Richard van Dyck, MD, PhD; Philip Spinhoven, PhD; Willem van Tilburg, MD, PhD; Carmen Dirksen, PhD; Thea van Asselt, MSc; Ismay Kremers, PhD; Marjon Nadort, MSc; Arnoud Arntz, PhD

Context: Borderline personality disorder is a severe and chronic psychiatric condition, prevalent throughout health care settings. Only limited effects of current treatments have been documented.

Objective: To compare the effectiveness of schema-focused therapy (SFT) and psychodynamically based transference-focused psychotherapy (TFP) in patients with borderline personality disorder.

Design: A multicenter, randomized, 2-group design.

Setting: Four general community mental health centers.

Participants: Eighty-eight patients with a Borderline Personality Disorder Severity Index, fourth version, score greater than a predetermined cutoff score.

Intervention: Three years of either SFT or TFP with sessions twice a week.

Main Outcome Measures: Borderline Personality Disorder Severity Index, fourth version, score; quality of life; general psychopathologic dysfunction; and measures of SFT/TFP personality concepts. Patient assessments were made before randomization and then every 3 months for 3 years.

Results: Data on 44 SFT patients and 42 TFP patients were available. The sociodemographic and clinical characteristics of the groups were similar at baseline. Survival analyses revealed a higher dropout risk for TFP patients than for SFT patients ($P=.01$). Using an intention-to-treat approach, statistically and clinically significant improvements were found for both treatments on all measures after 1-, 2-, and 3-year treatment periods. After 3 years of treatment, survival analyses demonstrated that significantly more SFT patients recovered (relative risk = 2.18; $P=.04$) or showed reliable clinical improvement (relative risk = 2.33; $P=.009$) on the Borderline Personality Disorder Severity Index, fourth version. Robust analysis of covariance (ANCOVA) showed that they also improved more in general psychopathologic dysfunction and measures of SFT/TFP personality concepts ($P<.001$). Finally, SFT patients showed greater increases in quality of life than TFP patients (robust ANCOVAs, $P=.03$ and $P<.001$).

Conclusions: Three years of SFT or TFP proved to be effective in reducing borderline personality disorder–specific and general psychopathologic dysfunction and measures of SFT/TFP concepts and in improving quality of life; SFT is more effective than TFP for all measures.

Arch Gen Psychiatry. 2006;63:649-658

BORDERLINE PERSONALITY DISORDER (BPD) is marked by chronic instability in multiple areas (ie, emotional dysregulation, self-harm, impulsivity, and identity disturbance). The prevalence of BPD is estimated to be 1% to 2.5% in the general population and 10% to 50% in psychiatric outpatient and inpatient settings.[1] The medical and other societal costs of BPD are substantial[2] (also T.V.A., C.D., A.A., and Johannis Severens, PhD, unpublished data, September 2005). Suicide risk is estimated to be up to 10%.[3] A few treatments—outpatient dialectical behavior therapy[4-8] and psychoanalytically oriented treatments[9-11]—have demonstrated some effectiveness in randomized clinical trials of patients with BPD, as manifested by good treatment retention and reduced suicide attempts, acts of self-harm, and hospitalizations. However, no pharmacologic or psychosocial treatment has demonstrated efficacy for all aspects of BPD, such as affective, identity, and interpersonal disturbances.[12]

We compared the effectiveness of 2 prolonged outpatient treatments that aim at achieving full recovery from BPD: schema-focused therapy (SFT)[13-15] and transference-focused psychotherapy (TFP).[16,17] Schema-focused therapy is an integrative cognitive therapy, and TFP is a psychodynamically based psychotherapy. Both treatments intend to bring about a struc-

Author Affiliations are listed at the end of this article.

Article

Evaluating Three Treatments for Borderline Personality Disorder: A Multiwave Study

John F. Clarkin, Ph.D.

Kenneth N. Levy, Ph.D.

Mark F. Lenzenweger, Ph.D.

Otto F. Kernberg, M.D.

Objective: The authors examined three yearlong outpatient treatments for borderline personality disorder: dialectical behavior therapy, transference-focused psychotherapy, and a dynamic supportive treatment.

Method: Ninety patients who were diagnosed with borderline personality disorder were randomly assigned to transference-focused psychotherapy, dialectical behavior therapy, or supportive treatment and received medication when indicated. Prior to treatment and at 4-month intervals during a 1-year period, blind raters assessed the domains of suicidal behavior, aggression, impulsivity, anxiety, depression, and social adjustment in a multiwave study design.

Results: Individual growth curve analysis revealed that patients in all three treatment groups showed significant positive change in depression, anxiety, global functioning, and social adjustment across 1 year of treatment. Both transference-focused psychotherapy and dialectical behavior therapy were significantly associated with improvement in suicidality. Only transference-focused psychotherapy and supportive treatment were associated with improvement in anger. Transference-focused psychotherapy and supportive treatment were each associated with improvement in facets of impulsivity. Only transference-focused psychotherapy was significantly predictive of change in irritability and verbal and direct assault.

Conclusions: Patients with borderline personality disorder respond to structured treatments in an outpatient setting with change in multiple domains of outcome. A structured dynamic treatment, transference-focused psychotherapy was associated with change in multiple constructs across six domains; dialectical behavior therapy and supportive treatment were associated with fewer changes. Future research is needed to examine the specific mechanisms of change in these treatments beyond common structures.

(Am J Psychiatry 2007; 164:922–928)

Impulsivity, diminished nonaffective constraint, negative affectivity, and emotional dysregulation are core characteristics of borderline personality disorder (1–3). The prevalence of borderline personality disorder in the community is approximately 1.3% to 1.4% (4, 5). This chronic and debilitating syndrome is associated with high rates of medical and psychiatric utilization of services (6, 7). Psychopharmacology notwithstanding, psychotherapy represents the recommended primary technique for treating borderline personality disorder (8). Dialectical behavior therapy (9) has demonstrated superiority over treatment as usual (10) and therapy by community experts (11).

Other therapeutic approaches, such as psychodynamic treatments, continue to be prominent in the treatment of borderline personality disorder, as supported by the APA Practice Guideline (8) and prior research (12). A promising psychodynamic treatment approach is an object relations approach called transference-focused psychotherapy (13). Transference-focused psychotherapy is an effective treatment using patients as their own comparisons (14) and has demonstrated superiority over treatment as usual (unpublished data by KN Levy et al. available from the authors).

A necessary and first step in illuminating effective treatments for borderline personality disorder is to show that a given treatment is associated with significant improvement in the disorder—improvement in relevant dimensions of pathology beyond self-damaging behaviors. Empirical evidence should show that candidate treatments, such as dialectical behavior therapy and psychodynamic approaches, are systematically related to change in a number of substantive domains of clinical significance. A recent influential review reported that existing therapies for borderline personality disorder remain experimental, and more "real-world" studies are necessary (15).

We examined patients who were taken from the community and reliably diagnosed with borderline personality disorder. Patients were randomly assigned to transference-focused psychotherapy, dialectical behavior therapy, or supportive treatment for 1 year. Our study has characteris-

This article is featured in this month's AJP Audio, is the subject of a CME course, and is discussed in an editorial by Dr. Gabbard on p. 853.

BJPsych The British Journal of Psychiatry (2010) 196, 389–395. doi: 10.1192/bjp.bp.109.070177

Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomised controlled trial

Stephan Doering, Susanne Hörz, Michael Rentrop, Melitta Fischer-Kern, Peter Schuster, Cord Benecke, Anna Buchheim, Philipp Martius and Peter Buchheim

Background
Transference-focused psychotherapy is a manualised treatment for borderline personality disorder.

Aims
To compare transference-focused psychotherapy with treatment by experienced community psychotherapists.

Method
In a randomised controlled trial (NCT00714311) 104 female out-patients were treated for 1 year with either transference-focused psychotherapy or by an experienced community psychotherapist.

Results
Significantly fewer participants dropped out of the transference-focused psychotherapy group (38.5% *v.* 67.3%) and also significantly fewer attempted suicide ($d=0.8$, $P=0.009$). Transference-focused psychotherapy was significantly superior in the domains of borderline symptomatology ($d=1.6$, $P=0.001$), psychosocial functioning ($d=1.0$, $P=0.002$), personality organisation ($d=1.0$, $P=0.001$) and psychiatric in-patient admissions ($d=0.5$, $P=0.001$). Both groups improved significantly in the domains of depression and anxiety and the transference-focused psychotherapy group in general psychopathology, all without significant group differences ($d=0.3$–0.5). Self-harming behaviour did not change in either group.

Conclusions
Transference-focused psychotherapy is more efficacious than treatment by experienced community psychotherapists in the domains of borderline symptomatology, psychosocial functioning, and personality organisation. Moreover, there is preliminary evidence for a superiority in the reduction of suicidality and need for psychiatric in-patient treatment.

Declaration of interest
None.

Transference-focused psychotherapy was developed by Otto F. Kernberg and is based on his model of borderline personality disorder.[1,2] The efficacy of transference-focused psychotherapy has been evaluated in two randomised controlled trials (RCTs) to date. A 1-year RCT[3] with 90 participants with borderline personality disorder compared transference-focused psychotherapy with dialectical behaviour therapy[4] and psychodynamic supportive therapy. All three groups showed significant positive change in depression, anxiety, global functioning and social adjustment in a multiwave design. Transference-focused psychotherapy and dialectical behaviour therapy were associated with a significant improvement in suicidality, transference-focused psychotherapy and supportive therapy improved facets of impulsivity and only the former yielded a significant improvement in anger, irritability and verbal and direct assault. Moreover, only those individuals in the transference-focused psychotherapy group improved significantly in their reflective function and their attachment style.[5] Giesen-Bloo *et al*[6,7] compared transference-focused psychotherapy to schema-focused therapy[8] in a 3-year RCT with 88 participants with borderline personality disorder. The transference-focused psychotherapy revealed a significantly higher drop-out rate (51.2% *v.* 26.7%) and – despite improvements in all domains of outcome – significantly smaller treatment effects. The American Psychological Association (Division 12) evaluated transference-focused psychotherapy as having controversial research support. Thus, more research is needed before transference-focused psychotherapy can be considered to have modest or strong research support.[9] The present study aims to bring clarity to the field and to determine whether transference-focused psychotherapy can be regarded as empirically supported treatment according to the American Psychological Association (Division 12) criteria.[10] This investigation examines the efficacy of transference-focused psychotherapy for borderline personality disorder in an RCT comparing those randomised to transference-focused psychotherapy with those randomised to a group treated by experienced psychotherapists in the community.

Method

Study design

The study was approved by the ethics commission of the Medical University Innsbruck, Austria, on 24 March 2004 (ID: UN1950) and was registered at Clinicaltrials.gov (NCT00714311). Participants were recruited at the out-patient units of the Departments of Psychiatry and Psychotherapy, Technical University of Munich, Germany, and the Psychoanalysis and Psychotherapy Department, Medical University Vienna, Austria. People who fulfilled the inclusion criteria were given a complete description of the study. Those who gave written informed consent were assessed by trained local research assistants. The results of the first assessments were sent to a researcher outside the two study centres who performed the randomisation. Participants were randomly assigned to either transference-focused psychotherapy or experienced community psychotherapists. After randomisation participants were referred to a therapist; medication was registered continuously by the local administrators. Medication treatment was not standardised, its type and amount were decided on an individual basis by the individuals' psychiatrists in the community in both groups. One year after treatment started, outcome was assessed by the local research

What is the evidence for this evidence-based treatment?

- (Giesen-Bloo et al. 2006) TFP vs. Schema-focused therapy (SFT)
- Both interventions in this 3-year study showed reduction in all BPD symptoms, increases in quality of life, associated changes in personality features
- SFT had lower attrition rate, superior to TFP in certain spheres, but not in improved quality of life

What is the evidence for this evidence-based treatment?

- (Clarkin et al. 2007) TFP vs. DBT vs. manualized supportive treatment
- All three interventions showed significant positive change in the patients' depression, anxiety, global functioning and social adjustment over 1 year of treatment; only TFP was predictive of decrease in irritability
- TFP and DBT were associated with a decrease in suicidality; TFP and supportive treatment were associated with reduced anger and impulsivity
- Only TFP showed significant improvement in reflective functioning

What is the evidence for this evidence-based treatment?

- (Doering et al. 2010) TFP vs. local expert therapists
- Patients improved in both groups, but TFP patients had a lower drop-out rate, significantly fewer suicide attempts, inpatient admissions, and BPD symptoms, and greater improvement in personality organization and psychosocial functioning

The Benefits of Sequenced Treatments

- This article will evaluate four major evidence-based treatments for BPD- dialectical behavioral therapy, mentalization-based treatment, transference-focused psychotherapy, and General Psychiatric Management
- A proposal for providing stepwise care through assessment of clinical severity will be presented as a means of achieving system-wide changes and greater access to care (Choi-Kain, Albert and Gunderson, 2017)

PERSPECTIVES

Evidence-Based Treatments for Borderline Personality Disorder: Implementation, Integration, and Stepped Care

Lois W. Choi-Kain, MD, Elizabeth B. Albert, BA, and John G. Gunderson, MD

Learning Objective: After participating in this activity, learners should be better able to:
- Evaluate evidence-based therapies for borderline personality disorder

Abstract: Several manualized psychotherapies for treating borderline personality disorder (BPD) have been validated in randomized, controlled trials. Most of these approaches are highly specialized, offering different formulation of BPD and different mechanisms by which recovery is made possible. Mental health clinicians are challenged by the degree of specialization and clinical resources that these approaches require in their empirically validated adherent forms. While these effective treatments have renewed optimism for the treatment of BPD, clinicians may feel limited in their ability to offer any of them or may integrate an eclectic assortment of features from the different treatments. This article will evaluate four major evidence-based treatments for BPD—dialectical behavioral therapy, mentalization-based treatment, transference-focused psychotherapy, and General Psychiatric Management—and possible modes of implementation in adherent and integrative forms. Models of implementing these diverse treatment approaches will be evaluated, and the potential advantages of combining evidence-based treatments will be discussed, along with some cautionary notes. A proposal for providing stepwise care through assessment of clinical severity will be presented as a means of achieving system-wide changes and greater access to care.

Keywords: borderline personality disorder, dialectical behavioral therapy, General Psychiatric Management, mentalization-based treatment, transference-focused psychotherapy

When the term *borderline* first emerged in the psychiatric literature, it was used to refer to a distinctive group of patients who were neither chronically psychotic nor stably neurotic.[1] The patients on the borderline of these two well-defined groups were notably prone to "negative therapeutic reactions." For much of our field's history, we characterized them as "treatment resistant"—when in truth, our existing treatments were inadequate at best and harmful at worst. The stigmatization of these patients in our field began with this distinction of treatment resistance, causing most clinicians to give up hope for these individuals, rather than scrutinize the treatments that we offered them.

The good news is that researchers over the last two decades have elucidated the diagnosis afflicting these patients at the borderline, now known as borderline personality disorder (BPD). Research has shown that BPD is a prevalent,[2,3] disabling,[4,5] sometimes fatal[6] disorder; it therefore carries significant public health relevance. Longitudinal studies initiated before the proliferation of evidence-based treatments (EBTs) for BPD show that even without intensive or specific treatment, these patients experience high rates of remission in ten years[4,7] (Figure 1). While psychopharmacologic interventions have dominated as the gold standard of treatment for most major mental illnesses, research on the efficacy of medications in managing BPD has yielded mixed and inconsistent results. Related to this lack of robust and definitive data favoring medication, few trials on psychopharmacologic strategies in BPD have been undertaken. To date, there are more articles published out of the CATIE trial[8] (for schizophrenia) and three times as many reports from STAR-D[9] (for depression) than on medications for the treatment of BPD (with ClinicalTrials.gov listing 91 trials as of January 2016).[10,11] While no psychopharmacologic intervention has been shown to have more than moderate efficacy for BPD,[12] over half a

From Harvard Medical School (Drs. Choi-Kain and Gunderson) and McLean Hospital, Belmont, MA (Drs. Choi-Kain and Gunderson, and Ms. Albert).

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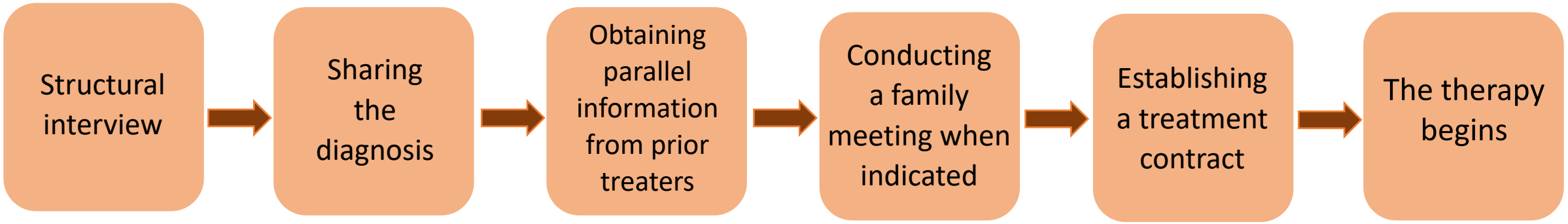
How TFP Unfolds



Details of the Treatment Contract

- **Meaningful activity requirement (paid work, volunteer work, studies)**
- Scheduling process
- Starting and stopping sessions on time
- Patient hygiene
- Fee and payment schedule
- Cancelation policy
- Intersession contact
- Permission to contact family members
- Permission to contact other treaters.
- Adherence with medical care
- Adherence with laboratory testing
- Adherence with medication
- A requirement for abstinence from substance abuse, if indicated
- A plan for managing eating disorder symptoms, if indicated
- Participation in adjunctive treatments
- The patient's obligation to be honest
- Management of suicidal behavior
- Involvement of psychiatric emergency services
- Involvement of psychiatric inpatient services

Conducting a Family Meeting When Indicated

- In TFP we arrange for a family meeting at the outset of treatment in any situation where the patient is fundamentally (financially, emotionally) dependent
- This obviously captures many, maybe even most, patients with these diagnoses

Goals of the Family Meeting

- Obtain parallel information
- Provide psychoeducation about the disorder
- Explain the treatment including counterintuitive elements (limits on intersession contact; deferring to emergency department and inpatient psychiatry staff about certain clinical decisions)
- Address in advance expectable splitting
- Describe the range of family interventions (psychoeducation, coaching, family therapy)
- Determine in advance the frequency of family contacts

Once the Treatment Begins

- Patients are instructed to speak freely, with particular focus on material that relates to their goals
- The TFP therapist will not organize the session, as is often the case in supportive psychotherapy or cognitive-behavioral therapy.
- This change in format may present a challenge for some patients requiring the therapist to acknowledge the difficulty in “free association” and to explore with the patient the specific barriers that emerge

What Happens During the Course of Treatment

- *What the patient says*
- *What the patient does*
- *Countertransference*

- *Resist the urgency to act*

- *Naming the actors*
- *Role reversal*

- *Clinician-centered interventions*

- *Clarification*
- *Confrontation*
- *(Interpretation)*

Hersh RG, Psychodynamic Psychiatry, 2015, 2021; Lee & Hersh, BJPsych Advances, 2018

What Families Should Know About Applied Transference-Focused Psychotherapy

Why use **TFP Principles** in **General Psychiatry?**

- High rates of personality disorder (PD) diagnoses and co-morbidity in most psychiatric settings (Widiger 1991)
- Limited training in most residency programs in the assessment and management of patients with PDs (Sansone 2013)
- Effects of PD pathology on the success of treatment of other diagnostic categories (Biskin 2012)
- Expectable risk management concerns

Why use **TFP Principles** in **General Psychiatry?**

- Worldwide, the number of certified clinicians in empirically-supported therapies (EST) for BPD is insufficient to meet the demand posed by BPD treatment seekers *(Iliakis, Sonley, Ilagan & Choi-Kain, 2019)*
- Mental health systems lack the necessary resources to provide formal EST; therefore, most PD patients still receive unstructured, unspecific, inconsistent treatment as usual *(NIMH in England, 2003; Hutsebaut, Willemsen, Bachrach & Van, 2020; Gunderson, 2016; Bateman & Tyrer, 2004)*
- In clinical practice, the most severe mentally ill PD patients do not receive EST *(Hutsebaut et al, 2020)*
- 48% of BPD patients are not responding to psychotherapy *(Woodbridge, Townsend, Reis , Singh & Grenyer, 2022, ANZJP)*

Key Points

- Clinicians in acute care and shorter-term settings (psychiatric *and* medical) routinely see a significant number of patients with personality disorder pathology (Zimmerman 2005, Sansone 2015)
- Failure to recognize primary or co-occurring personality disorder pathology can be problematic and complicating (Paris 2007)
- TFP provides an overarching theoretical approach *even when the clinician is not offering and extended individual psychotherapy*
- TFP principles can help improve outcomes and serve as an effective risk management strategy

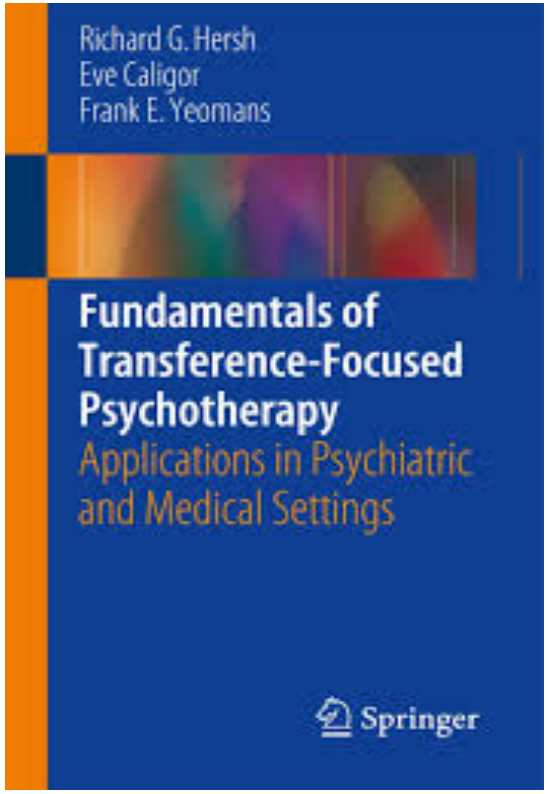
Applied TFP vs. TFP as an Extended Psychotherapy

- **Not the same goals;** don't expect sustained integration of the patient's split internal world with **"Applied TFP"**
- Assessment process helps clinicians recognize pathology (often minimized or ignored) in situations where doing so is not usually a priority
- Clinicians can **"borrow"** TFP elements for use on an *ad hoc* basis when they are helpful, *in any clinical setting*

What is special about **TFP Principles**?

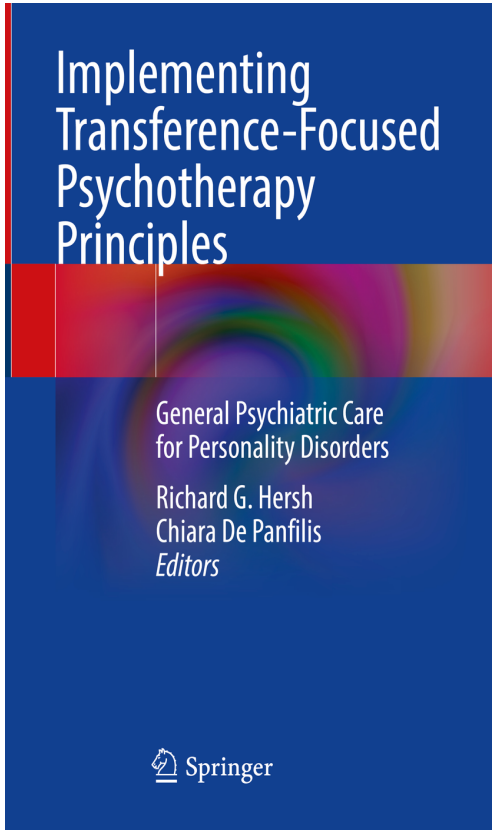
1. Coherent and organizing **overarching approach**
2. Flows naturally from a **psychiatric orientation** (sensitivity to medical co-morbidities, focus on diagnosis)
3. Allows psychiatrists to **address PD pathology** and avoid reflexive referrals to costly or unavailable adjunctive treatments
4. Confers skills to **manage "difficult" patients**
5. Can help to **avoid familiar pitfalls** of treating patients with PD pathology (polypharmacy, unnecessary hospitalizations, unfocused/aimless psychotherapy)
6. Takes into account the thesis of the **AMPD** (DSM-5, Section III)

Fundamentals of Transference-Focused Psychotherapy (Hersh, Caligor and Yeomans, 2016)



- TFP Principles in:
- Crisis management
- Family engagement
- Inpatient psychiatry
- Pharmacotherapy
- The interface of medical and psychiatric treatment
- Psychiatry residency training

Implementing Transference-Focused Psychotherapy (Hersh and De Panfilis (Eds), 2024)



TFP principles applied to:

- Emergency psychiatric care
- Inpatient treatment
- Day Hospital
- Consultation-liaison psychiatry
- Group therapy
- Group psychoeducation
- Forensic settings
- Outpatient, community-based psychiatric services

Summary: **Applied TFP**

- Offers a coherent package of knowledge, attitude, and skills
- Knowledge: a working application of contemporary object relations theory
- Helps the clinician identify extreme positions and rapid state-shifting of patients with BPD and other moderate to severe personality disorder presentations
- Attitudes: acceptance of the expectable confusion seen with PD patients
- Comfort with conveying what the patient can realistically expect from the treatment via establishment of the treatment frame

Summary: **Applied TFP**

- Skills: Monitoring the 3 channels of communication
- Identifying dominant object relations dyads as they emerge
- Identifying expectable reversals in those dyads
- Managing periods of heightened affect with containing "therapist-centered" interpretations

Example of Applied-TFP: TFP-informed group psychoeducation (PE)

Outline

- Why is it important? Goals of PE in (B)PD
- Structure of the PE program
- Topics of the Meetings – Meeting example

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Goals of TFP-informed group PE

1) Improving knowledge about (B)PD
   - Diagnostic difficulties (symptom heterogeneity, diagnostic overlap with other disorders)
   - The importance of a timely diagnosis *vs* the fear of stigma

2) Bolstering hope for change
   - Focus on findings from longitudinal studies – remission *vs* recovery
   - Change is not only possible, but EXPECTED

3) Empowering the patient in shared treatment decision making with mental health providers
   - The importance of an agreed-on treatment plan
   - Treatment goals, crisis management, modalities of others' involvement in the therapeutic process

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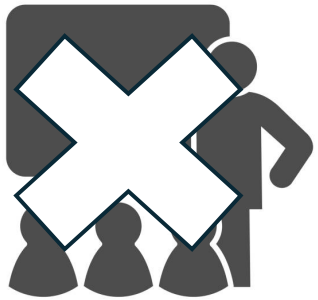
Structure of TFP-informed group PE

1) For whom?
   - BPD AND other Cluster B PD («Borderline Personality Organization» – BPO – excluding Antisocial PD)
   - The program can be adapted to family members as well

2) How?
   - 9 weekly group sessions, 60-75 minutes each; 8-10 px
   - 2 experienced coordinators
   - Informal, collaborative climate
   - Modality: collect information from group members, and then summarize/organize/clarify it
   - Flip-chart – no slides



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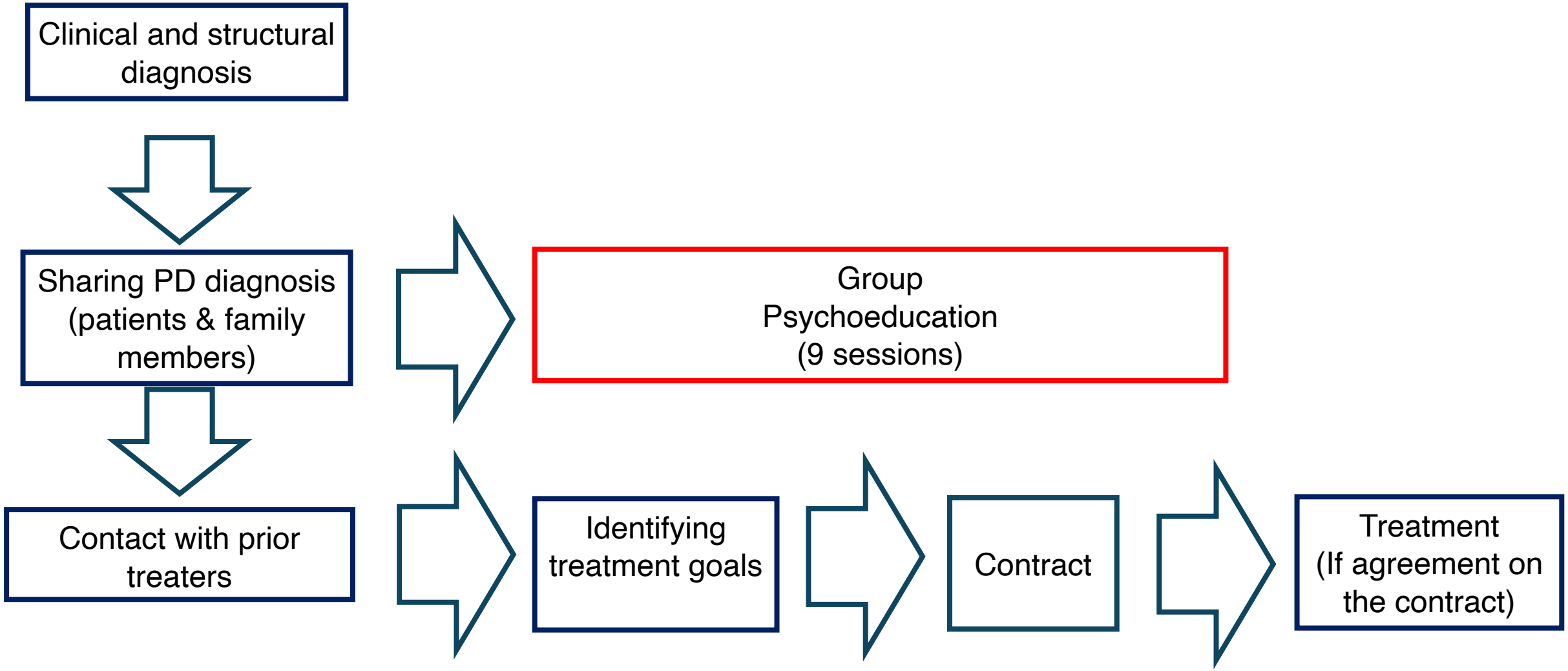
Structure of TFP-informed group PE: When? (I)



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Structure of TFP-informed group PE: When? (II)

Group
Psychoeducation
(9 sessions)

Stand alone first step in treatment

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Topics of TFP-informed group psychoeducation (PE)

9 Meetings:

1. Rules of the Group/Treatment frame
2. Personality Disorder diagnosis
3. Developmental issues
4. Comorbidities
5. Pharmachotherapy
6. Introduction to Psychotherapy
7. Introduction to TFP principles
8. Crisis management
9. Conclusion /Evaluation

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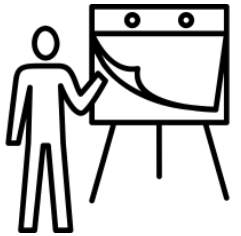
The warm-up exercise of the meetings

What was the best thing happening to me since the last meeting…?

positive

Example: Meeting on Personality Disorder Diagnosis (I)



1) Gather information from the participants about the PD /comorbid diagnoses they might have received
   - Clinicians are reluctant to share a PD diagnosis! → need for clarification / definition

2) What is personality?
   - The automatic instinctive way that we think, feel and act, that comes naturally to us
   - We became who we are because over time, based on repeated interactions with others, we incorporate a series of images of ourselves in relation to others
   - Personality = internalized images of self and others → sense of self and others that may or may not be accurate

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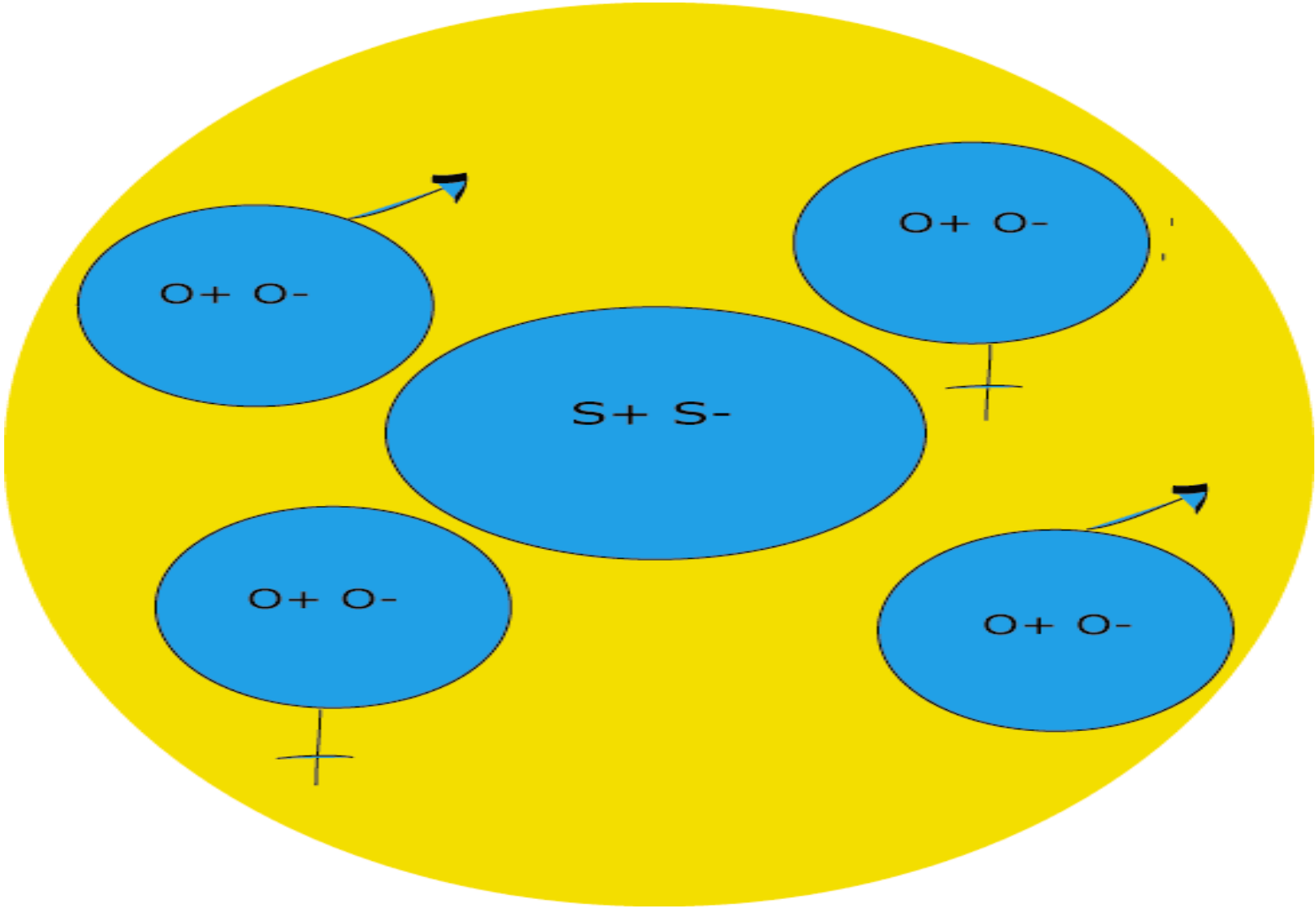
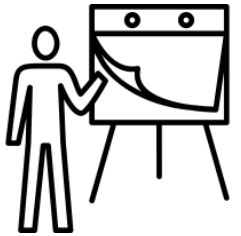
Healthy Personality Organization:
Awareness of Complexity, accurate sense of self and others



Stable knowledge about strenghts and weaknesses of oneself and important others (relatives / friends)

Example: Meeting on Personality Disorder Diagnosis (II)



What is personality pathology?

- The internal images of self and others do not necessarily correspond to external reality → the sense of self and others is often not accurate
- Individuals live more in response to their internal images than to what is really going on around them
- The severity of personality pathology relates to how large the gap is between an individual's internal representations of self and other and the external reality

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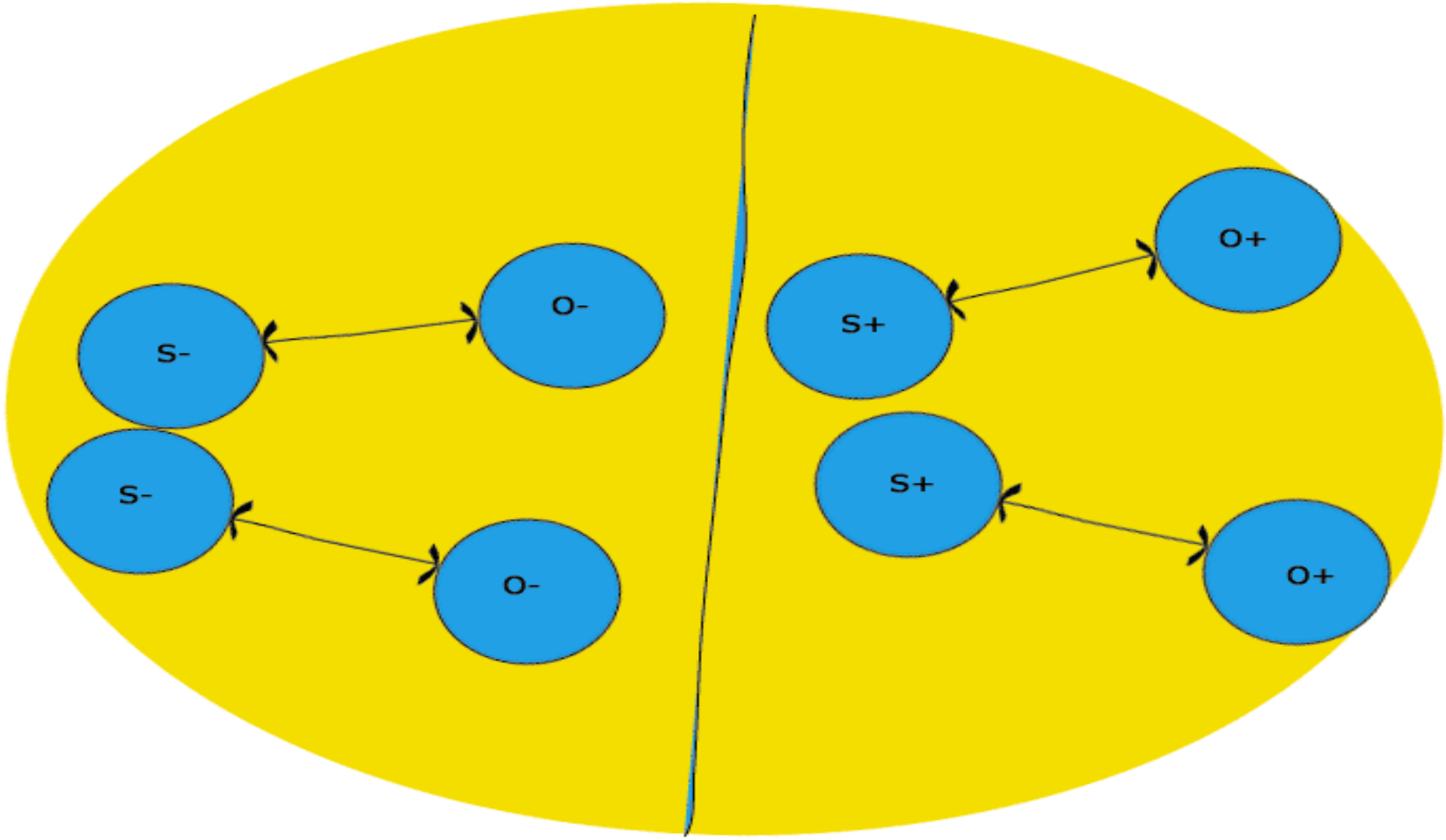
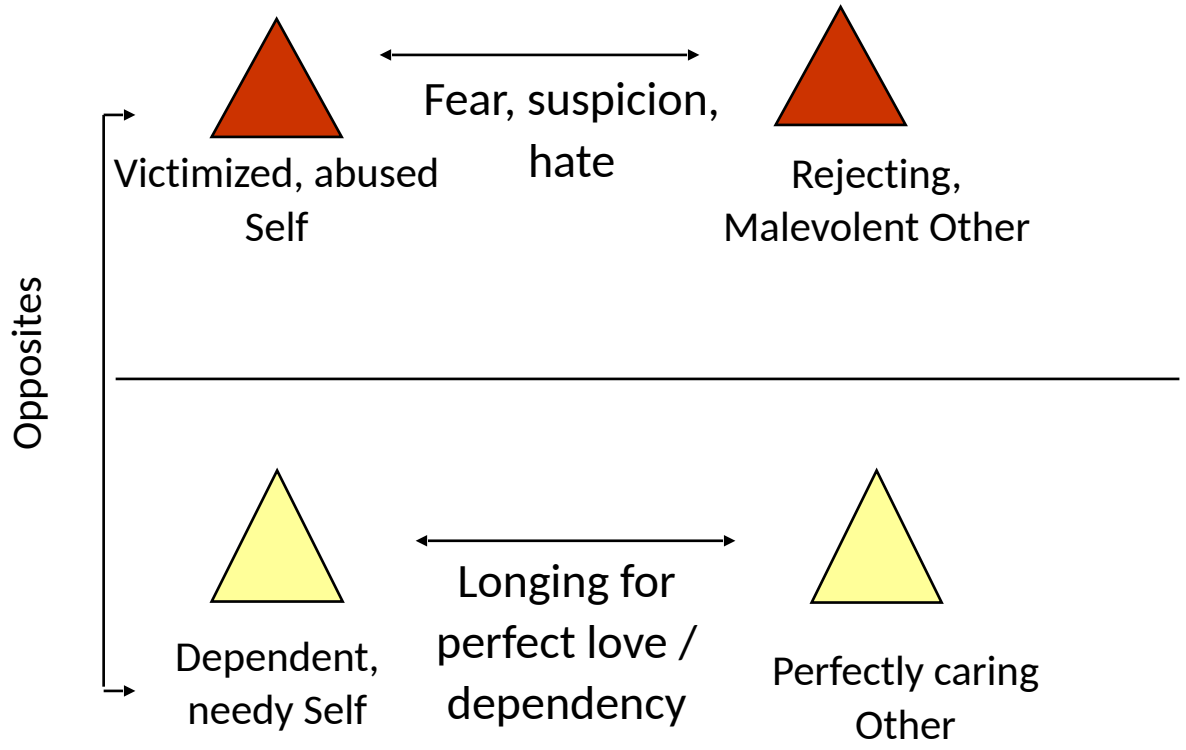
Borderline Personality Organization/Identity Diffusion:
Awareness of “all good/all bad”, inaccurate sense of self and others



The perception of oneself and important others is distorted and changes from moment to moment

BPO patients' current subjective experience…



…and the reason why they seek help – and the others

TFP-informed group psychoeducation: Conclusions

- TFP principles can be used to convey to patients (& family members) comprehensive and structured information about PD pathology, etiology, course, comorbidities & available treatments

- The program aims to increase PD patients' motivation for treatment
  - A guide for «new» patients
  - A way back to treatment for those with a drop-out history

- Solid knowledge, active responsability for treatment & realistic hope and expectation for change

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Thanks for your attention!

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