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ARTICLE

Managing the clinical encounter with patients with borderline personality disorder in a general psychiatry setting: key contributions from transference-focused psychotherapy

Tennyson Lee & Richard G. Hersh

SUMMARY

This article describes how the core principles and techniques of transference-focused psychotherapy (TFP) can be used in general psychiatry to help in the management of patients with borderline personality disorder (or other moderate to severe personality disorders). It focuses on: knowledge – appreciating how an understanding of object relations assists the clinician in assessment and treatment; attitude – developing a stance to manage the confusing and negative feelings that may arise in both clinician and patient; and skills – describing how use of TFP techniques (technical neutrality, analysing the transference and countertransference, and judicious use of interpretation) helps the clinician to continue thinking in the fraught clinical encounter. The structural (including contemporary object relations) and structured approach in TFP are exemplified in clinical vignettes.

LEARNING OBJECTIVES

After reading this article you will be able to:

- Apply an understanding of object relations theory to interactions with patients with Borderline Personality Disorder (BPD)
- Describe the use of the treatment contract and technical neutrality
- Understand and better manage the countertransference in working with patients with BPD

DECLARATION OF INTEREST

None.

KEYWORDS

Transference-focused psychotherapy; personality disorders; general psychiatry; clinical management; countertransference.

There is an evidence base for the treatment of borderline personality disorder using specific forms of psychotherapy (Stoffers 2012). More important for psychiatrists, there is also evidence that structured clinical management of the disorder is effective in general psychiatry settings (Bateman 2013). This is encouraging, as 50% of patients in psychiatric out-patient settings meet criteria for personality disorders (Beckwith 2014). However, psychiatrists have negative feelings about working with patients with a personality disorder (Lewis 1988; Chartonas 2017). We believe that knowledge, attitudes and skills derived from the evidence-based psychotherapies will be useful to general psychiatrists working with patients with personality disorders.

Principles of transference-focused psychotherapy

Transference-focused psychotherapy (TFP) is one of the psychotherapies that has a treatment evidence base for patients with borderline personality disorder (Clarkin 2007; Doering 2010). Developed by the American psychoanalyst and psychiatrist Otto Kernberg, it is a psychodynamic therapy based on contemporary object relations theory offered for a minimum of 1 year. Sessions are typically twice a week, although the National Health Service (NHS) in the UK offers sessions once a week. Applied TFP principles can be used in general psychiatry (Zerbo 2013; Hersh 2015, 2017) and this is what we address in this article.

TFP may be considered to provide a structural understanding of personality and personality disorders based on object relations theory. It also provides a structured approach to the management of

Tennyson Lee, FFCH, FRCPsych, is a consultant psychiatrist in psychotherapy and a candidate in training at the Institute of Psychoanalysis, London. He is clinical lead in Deancross Personality Disorder Service in London and co-director of the Centre for Study of Personality Disorder (CUSP), linked to the Wolfson Institute of Preventive Medicine at Queen Mary University, London, UK. **Richard Hersh,** MD, is a special lecturer at Columbia University Medical Center, an adjunct faculty member at New York University School of Medicine and a faculty member at the Columbia University Center for Psychoanalytic Training and Research, New York, USA. Both authors are certified teachers and trainers in transference-focused psychotherapy.

Correspondence Dr Tennyson Lee, Deancross Personality Disorder Service, Mile End Hospital, 275 Bancroft Road, London E1 4DG, UK. Email: tennyson.lee1@nhs.net

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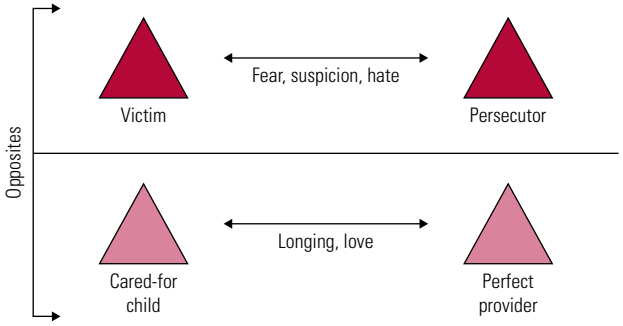

FIG 1 The predominant object relations interactions affecting Nina's behaviour in vignette 1 (both aggressive and libidinal dyads are shown). The 'surface' negative dyad (victim–persecutor) hides the defended-against, and longed for, positive dyad (cared-for child–perfect provider).

personality disorder through its emphasis on the therapeutic frame and treatment contract.

A structural understanding

Use of the concept of internal objects, object relations dyads and how these contribute to personality organisation underlies the structural approach of TFP.

Object relations theory and dyads

The psychoanalytic use of the term 'object' is confusing. In normal discourse we usually expect an object to refer to a thing. However, in psychoanalysis 'object' usually refers to a person or to an aspect of a person. An 'internal object' is a mental representation that has acquired the significance of a person in the 'real' external world.

Object relations theory emphasises that the drives described by Freud – libido and aggression – are experienced in relation to a specific other (the 'object'). An implication of this is that any emotion we have is experienced in relation to another – be it a person or a thing.

Internalised object relations are the building blocks of psychological structures and they organise motivation and behaviour. These building blocks are units composed of a representation of the self and of the other, linked by an affect. These units of self, other and the affect linking them are the 'object relations dyads' (Fig. 1).

Personality organisation

Kernberg has developed a psychoanalytic categorisation of personality structure in which he describes different levels of personality organisation at the neurotic, borderline and psychotic levels. The term 'structural' captures the mixture of subtypes of defensive functioning, specifically the contribution of mature, repression-based defences (more at the neurotic and high-functioning borderline level) as opposed to splitting-based defences (more at the low-functioning borderline and psychotic level) (Caligor 2018).

The concept of borderline personality organisation as developed by Kernberg does not equate with the DSM-5 diagnosis of borderline personality disorder. Instead, borderline personality organisation includes a number of specific personality disorders, including borderline, narcissistic and antisocial personality disorder, among others. This conceptualisation is helpful to psychiatrists as it adds a dimensional aspect to identifying specific personality disorder presentations and also accounts for the overlap of symptoms in the different disorders (e.g. a psychiatrist may frequently think 'This patient has a predominantly borderline personality disorder presentation – but she also has narcissistic and antisocial features – how do I fit this together?').

In this article we focus our discussion on borderline personality disorder, the most comprehensively studied of the personality disorders, but we consider it to be a prototype for the moderate to severe personality disorder presentation that Yeoman *et al* (2002) describe as marked by:

- non-specific ego weakness: the ego is unable to fulfil its task of managing the demands of the id, superego and reality as described by Freud in his structural model of the mind (Freud 1923)
- disturbed interpersonal relations
- difficulty with commitment to love and work
- some degree of pathology in sexual relations
- superego pathology (this results in an excessively critical faculty that may be directed both internally and externally; it may manifest in significant superego lacunae marked by dishonesty or antisocial traits).

Box 1 outlines the key elements in personality organisation and how borderline personality organisation manifests (Yeomans 2015). These elements are most systematically identified using the Structured Interview of Personality Organization (STIPO-R; Clarkin 2016).

It follows that TFP addresses these specific aspects of personality organisation. The objective is to integrate the patient's contradictory representations, bringing together split-off aspects of personality. The focus of treatment is the therapy relationship – hence the name transference-focused psychotherapy. A difference with traditional psychoanalysis as it may have been practised in the past is that in TFP there is more explicit and thorough investigation of what is happening in the patient's life outside of treatment.

A structured approach

The structured approach relates to TFP's emphasis on operationalising its treatment (e.g. through its

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clinical guidelines manuals) and anchoring it within a clear treatment frame (Yeomans 2015; Caligor 2018). Much as a surgeon needs to establish a clear and clean field for operating, so a clinician working with a patient with a personality disorder diagnosis needs to establish a procedure that allows maximum chance of a therapeutic effect.

The treatment frame is established via the treatment contract (Yeomans 1992, 2017), which sets out the patient's and service's respective responsibilities. For example, the service may expect of patients that they attend their treatment sessions regularly and on time, and that they attempt to reduce their risk-taking behaviour. In turn, patients may expect of their service that the clinician provides a safe, containing environment. Once agreed on, any challenge to the frame (which is anticipated, given that the clinician is working with a patient with a personality disorder) is then an area for exploration. The treatment contract is a clinical document, not a legal one. This means that the clinician is keen to establish that the patient really understands the implications of what they are agreeing to (e.g. undertaking to reduce and stop a self-harming behaviour that has been a coping mechanism for many years is no light matter). The clinician will not feel pressed into offering a treatment if the treatment contract is not agreed to.

TFP has been operationalised in a manual (Yeomans 2015) that emphasises strategies, tactics and techniques:

- strategies support the overall objective of therapy, namely integration of 'split-off' negative and positive experiences of self and others
- tactics refers to the setting of secure conditions of therapy, by establishing a clear treatment frame in the treatment contract
- techniques are the minute-by-minute interventions and include the clinician's 'technical neutrality'. ('technical neutrality' does not mean that the clinician is distant and passive; instead, the clinician refrains from taking any particular side in the patient's internal conflict; this distinguishes the TFP approach generally from a more supportive or case-management approach). Other core elements of the therapist's techniques include use of the transference, the countertransference and interpretation. Importantly, in its technical application, TFP encourages the clinician to monitor all three channels of possible communication – verbal, nonverbal and the countertransference. This is important as patients with borderline personality disorder may communicate particularly in nonverbal ways and through the countertransference. Indeed, what is *not* verbalised may be more important clinically.

BOX 1 Elements of borderline personality organisation

Identity

In borderline personality organisation the individual lacks identity consolidation, i.e. lacks a coherent sense of self and/or of others. This results in non-reflective, contradictory or chaotic experiences of the self and others.

Defences

These are at a primitive level. There is predominant use of splitting – with a radical separation of good and bad feelings, of good and bad objects. (This is opposed to the use of repression by individuals with a higher level of personality organisation.) This excessive use of splitting leads to the lack of integration and sense of identity of the individual.

Reality

Reality testing is usually intact but is subject to fluctuation: particularly under stress, thinking becomes paranoid and confused.

Object relations

Lack of integration results in rapid alternation between loving and depriving objects. This confuses both the individual and those around them – others are perceived as alternately idealised or devalued. Relationships can be highly unstable.

Aggression

There is a moderate to high level of aggression directed at the self and others. This can manifest in irritability, anger, rage, envy and hatred.

Morality

The lower the level of personality organisation, marked by antisocial traits with more extreme ego-syntonic aggression, the more guarded the prognosis.

Some practical examples

The terms introduced thus far are rather abstract, and in the following fictitious clinical vignettes, which are based on our clinical experience, we give examples of what we mean. The vignettes also show how key clinical contributions from TFP – the clinician's knowledge, attitude and skills – help in the management of patients with borderline personality disorder (or other moderate to severe personality disorders):

- knowledge – appreciating how an understanding of object relations assists the clinician in assessment and treatment
- attitude – developing a stance to manage the confusing and negative feelings that may arise in both clinician and patient
- skills – describing how use of the techniques in TFP (technical neutrality, analysing the transference and countertransference, and judicious use of interpretation) helps the clinician to continue thinking in the fraught clinical encounter.

Vignette 1: risk management

Nina is a 34-year-old unemployed White British woman. She has a partner, Eddy, with whom she has an intense, unstable relationship – alternately seeing him as the best and then the worst of partners. She has recently moved into the area and is being seen for the first time in out-patients by a psychiatrist. She has a queried diagnosis of borderline personality disorder, and has in the past attracted numerous diagnoses, including depression, post-traumatic stress disorder, complex post-traumatic

stress disorder and bipolar affective disorder. She is presently being treated with high doses of two antidepressants, an antipsychotic and a mood stabiliser.

She starts the interview very tearful and eager to please. However, in the course of the appointment she becomes increasingly angry and demanding and then suddenly says 'You don't know anything and you're a waste of time. I'm leaving now and I've got lots of tablets at home and I'll just take them and save everyone's time'. She makes ready to leave.

Managing the encounter

Tolerate the confusion and affect

When the patient says 'You don't know anything and you're a waste of time', the clinician may well be thinking 'She's right – I don't have a clue what to do. And whatever I do will just make things worse'.

The use of TFP principles in general psychiatry would suggest that a clinician should be open to considering the contribution of possible personality disorder pathology, even with limited information, as is suggested in this vignette about Nina. The clinician's initial goal in a situation like this would be to tolerate the expectable confusion and not feel moved to organise the patient's often contradictory or inchoate material. The clinician who can tolerate the expectable confusion seen with patients with moderate to severe personality disorder pathology will therefore have a chance to think clearly first, rather than act reflexively.

What am I thinking and feeling? Use of the countertransference

As noted above, the clinician who has considered the possibility of an element of moderate to severe personality disorder pathology will be attuned to a patient's use of splitting-based defences such as projection, projective identification, splitting, idealisation, devaluation and omnipotent control. In such a case, the patient may have 'projected' feelings that are intolerable, such as aggression or hatefulness, and then identified those feelings in the therapist. At the same time, the therapist may be aware of countertransference feelings of uncharacteristic aggression. The clinician who is alert to the possibility of emerging countertransference patterns in the treatment of a patient like Nina will be less likely to act out ('Don't talk to me that way!' or 'I'll find you another doctor') and may be better able to explore those intolerable feelings with the patient.

The aggression a patient projects into the clinician can be of such intensity that the term 'countertransference hate' is appropriate (Winnicott 1949). It is critical that a therapist working with severely disturbed patients such as Nina learn to tolerate these challenging feelings, rather than discharge these feelings through actions that might be described as countertransference enactments. By tolerating these feelings, the therapist will have a strong sense of what a patient like Nina might be experiencing (Maltsberger 1974).

Naming the actors or identifying the dyads: use of the object relations model and exploration of the transference

The psychiatrist in general practice can use the TFP technique of 'naming the actors' in situations marked by heightened affect or confusion. 'Naming the actors' is the therapist's first bid at putting into words what they are observing. The therapist aims to describe the dominant observed affect, how the patient might be experiencing him- or herself and an important other, including the therapist. The goals of 'naming the actors' include a general containment of affects, an attempt to give the patient an experience of feeling understood, and the opening of a dialogue between the patient and therapist about the dominant object relations dyad in play. The therapist does not aim to get it 100% correct, but rather invites the patient to correct any aspect of 'naming the actors' that feels inaccurate. This process is the opening gambit in a series of interventions that can include identifying the dominant object relations dyad in evidence and its reversal, and eventually speculation about what dyad may be defended against.

In Nina's case, there is a perceptible change: at the beginning of the appointment she is anxious and sees herself as needy and vulnerable, possibly fearful of an uncaring other. There is a rapid reversal with the threat of self-harm; the clinician becomes the anxious one, with the patient in the more powerful role. Over time the therapist might begin to speculate that this reversal of the dyad of victim/victimiser might serve to obscure Nina's covert longing to be properly treated and cared for by a benevolent parental figure. (See the response by the clinician below, where there is identification of the defensive dyad, for an amplification of possible reasons for this reversal.)

De-escalation with understanding

An example of a clinician's acting out response might be: 'I have been trying to help, but it seems you are just getting very frustrated and raising your voice at me. Maybe you need to see another doctor'. Such a response is likely to indicate that the clinician is failing to identify, explore or manage their own (understandable) negative feelings, but is instead letting these feelings direct their behaviour.

A more helpful response might be: 'I think having doctor after doctor who doesn't really seem to want to help, who doesn't seem interested, who may think

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things are your fault, would be frustrating – maybe even enraging'. This response conveys to the patient an appreciation of how they may be experiencing the psychiatrist and is an example of a therapist-centred interpretation (Steiner 1993: pp. 131–46).

The use of clarification, confrontation, judicious interpretation and identification of the dominant object relations dyad and role reversals are illustrated in the following potential response by Nina's clinician:

> 'You started this meeting saying you were feeling anxious and nervous and that I wouldn't listen to you. Now you are saying that you think this is all a waste of time and you want to end this all and kill yourself. Is that correct? **[clarification]** By threatening to self-harm and saying you don't care what you do, things seem reversed – so that I'm now the anxious one and you're in control of taking your life **[identifying the reversal of the dyad]**.
>
> This sudden switch in how you feel about yourself and those around you is in fact a problem you have described that also affects your relationship with your husband. [Fig. 1 – there has been a reversal, with the patient switching from being the victim to being the persecutor in the negative dyad.]
>
> You started off the meeting telling me how long you had waited for this appointment – that after years, you hoped I would be able to help you – because the most important thing for you is to be a good mother **[clarification]**. You may now be so scared that such an important thing will not happen that it seems safer to walk out on this **[interpretation, identification of defensive dyad]**. [Fig. 1 – this is the positive dyad which has been defended against by the more surface negative dyad.]
>
> Rather than ending this meeting, I think what has just happened here is what you describe happening with your loved ones, and this worries you. I think your meeting with me is an opportunity for us to understand what leads to these switches in you and what you can do about it. There is something very important that we need to work out.'

An illustration of the importance of picking up all three of the channels of communication is that a few minutes before her outburst, when she said 'You don't know anything and you're a waste of time,' Nina had become less engaged and had started looking out of the window and at her watch. If the clinician had picked up on this non-verbal behaviour earlier, he may have been able to identify Nina's frustration before it crescendoed to an unmanageable level, and intervened earlier.

Notes on the above scenario

1 Nina's story and presentation illustrate the nature of borderline personality organisation in terms of her lack of a sense of identity, primitive defence mechanisms (of a splitting nature, e.g. projective identification), tenuous grip on reality when highly aroused, an object relations dyad of a typically persecutory nature, and level of aggression. Nina does, however, have a genuine caring for her daughter and partner – her level of morality indicates that she is not at the most severe end of low-functioning borderline personality organisation. This is a positive factor in her prognosis.

2 It may not always be possible to name the defended-against dyad. It is not infrequently – as in this case – a longed-for scenario of ideal care. In the heat of a clinical interaction, it may easily be missed. It also may not be appropriate timing to raise this subject if there is a risk of humiliating the patient. Nevertheless, it can be helpful for the clinician in managing a negative countertransference to keep in mind the defended-against dyad (e.g. the wish for a 'perfect' carer) when exploring with the patient the negative dyad on the surface. Note that technical neutrality does not mean a disengaged impassive approach. Instead, the clinician is active and shows empathy for the internal conflicts the patient is experiencing.

3 A therapist-centred interpretation can offer a greater chance for the patient to feel that they are understood. It is less challenging for the patient than a patient-centred interpretation such as 'You are feeling lost and frustrated, as though you are in a situation you have no control over'.

Vignette 2: TFP-informed prescribing

> Mr B is a 25-year-old unemployed man. He has recently moved back home to live with his parents after failing his final year of university. Mr B has been recently evaluated and given diagnoses of major depression and social anxiety disorders. He is being treated with venlafaxine (having failed to respond to a number of other antidepressant medications) and olanzapine (used by his previous psychiatrist as an adjunct to antidepressant treatment). When he first meets with his new psychiatrist (Dr C), Mr B insists he needs a higher dose of olanzapine (even though he complains at times of excessive sedation) as well as a second antidepressant medication. He describes marked and persistent affective instability and mood reactivity, almost all interpersonally mediated, often in the context of routine requests for accountability by teachers and family members.

Dr C uses an applied TFP approach in his work, even when he is not planning to act as a patient's psychotherapist. This approach has a number of deliberate steps, as shown in Box 2.

Step 1

Dr C begins by 'tolerating the confusion' associated with the urgency conveyed by Mr B in their initial appointment. Dr C is aware of his countertransference

BOX 2 A transference-focused psychotherapy approach to the clinical encounter

The following steps structure and manage the first clinical encounter with a patient with borderline personality disorder in a general psychiatry setting.

1 An extended evaluation process that includes a focus on both diagnostic criteria (using ICD-10 or DSM-5) and a series of questions informed by the Structured Interview of Personality Organization (STIPO-R; Clarkin 2016). The aim of the evaluation is to clarify the patient's relative functioning or impairment in multiple spheres (work, relationships, self-care).
2 A straightforward sharing with the patient of the clinician's tentative diagnostic impression. This might include a discussion of clinical disorders such as depression and anxiety, as well as either a technical or layman's discussion of personality disorder pathology, if it is in evidence.
3 A deliberate discussion of the patient's personal goals, treatment goals and target symptoms for medication.
4 Contact with the patient's prior treater(s).
5 A family meeting, if the clinician thinks that the patient is dependent on the family in some fundamental way (living with family, financially supported by family) and if a family meeting is required so that the clinician can feel he or she can safely treat the patient.
6 A treatment contract outlining the respective responsibilities of both parties. This process automatically addresses a patient's unconscious wish or expectation that medication alone will resolve their problems (a common feature in borderline personality disorder).

of annoyance and some fear related to Mr B's history of having 'emergencies' because of non-adherence to medications as prescribed. Dr C proceeds with the steps outlined in Box 2; he goes forward with his own evaluation, even though Mr B protests, saying 'I have depression! Why do you have to ask me all these questions?'. Dr C completes his evaluation, which combines questions related to standard ICD-10 or DSM-5 criteria and also explores at length other aspects of Mr B's behaviour and functioning.

Dr C learns in his interview with Mr B about the patient's relative lack of identity consolidation (i.e., a limited and inconsistent sense of his interests, values, friends), use of more primitive lower-level splitting-based defences (particularly splitting between prior treaters and omnipotent control of his parents through his vague threats of suicide) and relatively impoverished object relations (few friends, no meaningful romantic experiences). Dr C is comfortable describing his diagnostic impression to Mr B, including layman's language of borderline personality disorder (Box 3).

Step 2

Dr C explains that there is an overlap of feelings of distress in both borderline personality disorder and what psychiatrists diagnose as recurrent major depressive disorder. Dr C explains that his assessment indicates that Mr B's experience of low mood is more suggestive of borderline personality disorder than a recurrent depressive disorder. Mr B does not accept Dr C's suggestion that recurrent major depressive disorder alone is not the problem; again, consistent with TFP training, Dr C does not 'insist' that Mr B accept his diagnosis, but plans to revisit the topic at some point in the future. (TFP stresses that, although the clinician should be clear and forthcoming about their diagnostic impressions, including those of personality traits or disorders, the patient's agreement about the diagnosis is not required to move forward with the treatment.)

Steps 3 and 4

Dr C also reviews at length Mr B's goals for treatment and obtains permission to speak to Mr B's prior treaters. Mr B is initially uncooperative with the process of determining treatment goals, responding 'My goal is to feel better! Isn't that enough!'. Dr C nevertheless goes into detail about the realistic goals for antidepressant medication and recommends that Mr B stop the atypical antipsychotic. (Dr C's recommendation to stop the antipsychotic would be consistent with National Institute for Health and Care Excellence (NICE) guidelines as well (NICE 2009).)

Step 5

Dr C insists on a family meeting, as he feels he needs to review with the family the risks that Mr B's current medication regimen and periods of non-adherence and impulsive drinking present to his safety. Mr B is initially adamant that he would not agree to a family meeting. Dr C is also aware of his own need to feel comfortable proceeding with the treatment: he feels that a family meeting is essential if he is going to be able to think clearly in his treatment of Mr B and not feel overwhelmed by anxiety about the family's disapproval of his decision-making. Dr C is polite but firm: if Mr B would like him to take over responsibility for prescribing, then they will have to arrange a time to meet together with Mr B's family.

Step 6

When Dr C describes to Mr B his expectation that the two formulate a contract that sets out their respective responsibilities, Mr B is taken aback and shares his confusion, as he had always considered his prescriber as someone whose job it was to make him better. Dr C describes his goal of a collaborative process that would include, for example, Mr B avoiding binge alcohol use, which had previously complicated his response to treatment. Mr B is dismissive of Dr C's suggestions, countering: 'Don't you think I would avoid alcohol if I could? Don't you understand how depression can lead to drink sometimes?'. Dr C acknowledges that Mr B is

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BOX 3 Disclosure of diagnosis and discussion of medication: a typical dialogue

Dr C We've had a chance to review your history and the current difficulties you are seeking help for. Do you think I've asked you most of the important questions related to your history and goals for treatment?

Mr B Yes, I suppose so.

Dr C I wanted to talk with you about my impression, which would include discussion of your diagnosis. Is that something you'd like to hear?

Mr B Well sure, but isn't it clear that I have depression? I've been told that many times.

Dr C Well, I think you may have elements of a mood disorder, but I am also wondering if you have a pattern of personality rigidity that is marked by reflexive feelings about yourself and about other people.

Mr B Are you talking about a personality disorder? I've been told that in the past but I think it's wrong. Like borderline personality disorder?

Dr C Some of what you've described does make me think of borderline personality symptoms, like your impulsivity and your threats of suicide. Would you agree that those fit a pattern of poor coping strategies?

Mr B Maybe. But isn't borderline untreatable? That's what I've heard.

Dr C Actually, borderline personality disorder is a condition with a favourable prognosis. Unfortunately, medications don't work very well for most of the symptoms.

Mr B Is that why I've had so many different medications with so little response?

Dr C That could be. One goal for our work together could be to look together at the fluctuations in mood you often experience and review whether medications are at all helpful with this. But to do so productively we would need to have an agreement, what we call a treatment frame that outlines our responsibilities.

MCQ answers
1 d 2 d 3 b 4 c 5 c

likely to struggle with this, but reaffirms the need for them to have some basic agreement about their responsibilities from the start.

Mr B grudgingly agrees to both the family meeting and the details of their treatment contract. Dr C feels more confident that he can safely proceed with the treatment, while continuing to refine the goals of their work together.

Summary

TFP provides a structural understanding and a structured approach for clinicians faced with the chaotic world of patients with personality disorders. It does this by providing:

- a coherent package of knowledge, attitudes and skills:
  - knowledge: a working application of contemporary object relations theory, helping the clinician to identify the extreme positions and rapid state-shifting of patients with borderline personality disorder or other moderate to severe personality disorder presentations
  - attitudes: a greater acceptance of the confusion that inevitably occurs in the clinical encounter; this tolerance is fused with firmness – the clinician has expectations of the patient and in turn sets realistic limits for what the patient can expect, through clarity of the treatment contract and treatment frame
  - skills: listening to the three channels of communication, recognising dyads, and knowing how and when to clarify, confront or interpret (e.g. interpretation is appropriate only when the patient is in a more reflective state of mind, which may not happen frequently in an acute psychiatric setting)
- a set of guidelines that provides an overall structure (a map) with appropriate specificity (e.g. how to track the speed of change of the patient's mental state by recognising dyads and their reversal); these guidelines are sufficiently practical to allow application to other settings, not just psychotherapy.

Most important, TFP principles can help clinicians manage challenging patients in real time. The goal is to help the clinician to think before acting, and to use countertransference cues to better manage difficult situations rather than act on them.

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MCQs

Select the single best option for each question stem

1 As regards using principles of transference-focused psychotherapy (TFP) in prescribing for patients with personality disorders:

a evaluating a patient's defences is not likely to be important, as all patients taking medications will use predominantly mature defences

b prescribers should not use psychodynamic concepts in decision-making, as strategies for managing medications require research data only

c patients with borderline personality disorder will do best with pharmacological treatment for their symptoms, as there are no evidence-based psychotherapeutic treatments for the disorder

d TFP principles can help clinicians avoid the polypharmacy often associated with treating patients with borderline personality disorder

e a patient with borderline personality disorder and a pattern of rapid shifts between idealisation and devaluation will always have a positive response to psychiatric medications.

2 TFP principles should be of use to clinicians in general psychiatry for all of the following reasons *except:*

a structured treatments of borderline personality disorder have been shown to be more effective than unstructured ones

b patients with borderline personality disorder are likely to present particular challenges in clinical practice marked by their use of splitting-based defences

c assessment of superego pathology or moral values can help clinicians avoid situations complicated by a patient's pattern of lying, cheating or stealing

d psychodynamic concepts have no place in contemporary treatment of psychiatric disorders

e the use of a treatment contract underscoring the respective responsibilities of the patient and clinician can address, from the outset, a borderline personality disorder patient's expectation that the treater and/or prescribed medications alone will address their difficulties.

3 As regards the application of technical neutrality in general psychiatry:

a in applying technical neutrality it is important that the clinician is able to remain unmoved

b technical neutrality means keeping equidistant from the patient's conflicting forces

c an example of technical neutrality in the encounter with an angry patient is to encourage the patient to collect and calm himself

d an example of technical neutrality is saying to the patient 'You are feeling very persecuted by me at the moment and I need to see what I can do to improve this'

e technical neutrality needs to be put 'on pause' when the patient is in a high state of arousal.

4 As regards the use of the TFP concept of a treatment contract in general psychiatry:

a if the patient breaks the treatment frame, the clinician discharges them immediately, using the principle 'one strike and you're out'

b if the patient breaks the treatment frame, the clinician will always be willing to renegotiate, given an understanding of how difficult it is for patients with borderline personality disorder to keep within the frame

c the treatment contract sets out the treatment frame, i.e. the agreement on how patient and clinician will proceed in treatment

d the treatment contract sets out responsibilities for the patient but not necessarily for the clinician

e the treatment contract ensures that the patient complies with the treatment plan.

5 In general psychiatry, in the acute encounter with a patient with borderline personality disorder, which of the following TFP principles is not correct:

a use of a structural approach, as in an understanding of which internal representations may be dominant at any particular time

b use of a structured approach, for example being able to fall back on what has been agreed in the treatment contract

c the clinician can respond immediately because TFP is an operationalised approach

d identifying what dyads may be operating at the time

e considering what defensive function the negative dyad may serve.