A Psychodynamic Approach for the General Psychiatrist

Using Transference-Focused Psychotherapy Principles in Acute Care Settings

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KEYWORDS

• Personality disorders • Transference • Psychodynamic psychotherapy
• General psychiatry • Psychopharmacology

KEY POINTS

- Psychiatrists in acute care settings routinely see a significant number of patients with personality disorder pathology.
- Failure to recognize primary or co-occurring personality disorder pathology can be problematic and complicating.
- Central tenets of this evidence-based treatment (transference-focused psychotherapy [TFP]) for borderline personality disorder can be useful for clinicians in acute care settings, even when those clinicians are not acting as the primary psychotherapist.
- Utilization of fundamental principles of TFP can help improve outcomes and also serve as an effective risk management strategy.

INTRODUCTION

Transference-focused psychotherapy (TFP), one of the evidence-based treatments for patients with borderline personality disorder (BPD), was developed by clinicians steeped in psychoanalytically informed psychotherapy who recognized that their standard treatment approach required significant adjustment to be of use to patients with moderate to severe personality pathology.[1] Although TFP research has focused thus far exclusively on individual psychotherapy with those individuals meeting *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) criteria for BPD, its central principles may have utility for clinicians treating a broader group of patients and in a variety of settings including those in acute care psychiatry.[2,3] It might

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seem, on the surface, counterintuitive to suggest using psychoanalytically informed interventions in the world of contemporary acute care psychiatry, now dominated by pharmacotherapy and cognitive-behavioral interventions. That said, numerous studies have concluded that patients with personality disorder (PD) pathology, and in particular those with BPD, are significantly represented in psychiatric emergency departments, inpatient psychiatric settings, and general outpatient psychiatric clinics.[4,5] (Although this article refers to patients with moderate to severe PD generally, because the vast majority of PD research has been on patients with BPD, most of the references relate to findings on that particular subgroup of patients.) What is the general psychiatrist's likely present-day accommodation? Some clinicians might ignore PD symptoms completely, focusing exclusively on mood, anxiety, eating, or substance use disorders, which are comorbidities frequently seen in BPD.[6] (This conjecture is supported by research examining rates of PD diagnosis in outpatient clinics; when clinicians use semistructured interviews they are much more likely to make a PD diagnosis than when assessing the same patient without such prompts.[7]) Others may try to direct patients to specialized care, although such opportunities may be rare, or prohibitively expensive, or both.[8] Applications of TFP principles, although not a panacea, can provide clinicians with a way to assess PD pathology by category and by level of severity, and to help them manage common clinical situations.

As noted, TFP was originally developed as an individual psychotherapy for patients with BPD. Since its inception, academic leaders have proposed adapting TFP concepts and techniques for patients with higher-level personality pathology, with adolescents, and with a group treatment format.[9–11] More recently, psychiatry residencies have introduced TFP teaching as a tool to enhance trainees' introduction to conducting individual psychotherapy, and as a tool to help manage patients with PD pathology in the acute care settings where residents practice.[12,13] Psychiatry residents will generally see patients in situations marked by relatively high acuity, such as emergency departments, inpatient units, and tertiary-care outpatient clinics; this acuity is associated with high rates of patients with primary PD presentations or PD symptoms co-occurring with other disorders.[14,15] In general, psychiatry residents get relatively little training about working with patients with PDs and the exposure to treatments for patients with PDs tends to be focused on dialectical behavioral therapy (DBT).[16] Although learning about DBT will certainly have utility for psychiatric trainees and assist them in considering referral options, the pilot programs introducing TFP training to residents have a broader overarching goal of integrating TFP concepts into the trainees' daily work with patients in multiple spheres.

TFP as an individual psychotherapy has a distinct way of unfolding, marked by a specific order and critical essential elements required even before the therapy begins. Once the individual psychotherapy is started, the TFP therapist will use a defined set of interventions. In this respect, TFP is unlike many "free-form" supportive or expressive psychotherapies as they are widely practiced. The notion that TFP principles can be "applied" in settings other than an extended individual psychotherapy echoes the longstanding tradition of "applied psychoanalysis" or the use of psychoanalytic theory and technique in situations outside of the individual psychotherapy dyad.[17]

THE ESSENTIAL ELEMENTS OF TRANSFERENCE-FOCUSED PSYCHOTHERAPY AS AN INDIVIDUAL PSYCHOTHERAPY

Before discussion of applications of TFP principles in acute care settings, it is useful to review the essential elements of TFP as an extended individual psychotherapy. As noted, TFP was developed by clinicians working in a psychoanalytic mode,

specifically an object relations approach, who felt compelled to alter traditional psychoanalytic psychotherapy in the treatment of patients with BPD because they observed that a standard set of interventions did not seem to be effective. The overarching goal of TFP is the integration of thoughts, feelings, and actions that are “split off” or not within a patient’s awareness, in the context of persistent splitting, or experiencing self and others in caricatured “all good” or “all bad” ways. The major adjustments to the traditional psychoanalytic approach included the following:

- An extended, deliberate evaluation process anchored by the structural interview, which combines assessment of both standard DSM-5 diagnostic criteria and exploration of the patient’s level of organization. The short-hand term level of organization aims to capture the patient’s functioning in key areas using psychodynamic terminology and understanding.[18,19]
- Discussion with the patient about the clinician’s preliminary diagnostic impression, including frank discussion of PD pathology, as is the standard of care for all the evidence-based psychotherapies for BPD.[20]
- Explicit elucidation of the patient’s personal goals and treatment goals. This intervention has the goal of identifying specific markers for the effectiveness of the treatment, anticipating an alternating focus on what is happening in the treatment over time and what is happening in the patient’s life outside of treatment.
- A meeting held with the partner or family member in any situation in which the patient might have a significant dependence (financial, emotional) on another party. This intervention has the goal of helping the clinician (obtaining parallel information, sharing with the family member the risks associated with the disorder) and recognizing with the patient the reality of the patient’s dependence, something often minimized or denied. This meeting may have the benefit of enlisting family members who become informed about and supportive of the treatment.
- An extended contracting phase, often lasting over multiple appointments, outlining the respective responsibilities of both the patient and the therapist. This process also includes exploration in advance of likely pitfalls in the treatment that may occur. The contracting phase precedes the beginning of the therapy; it is considered essential in setting the stage for the exploration of critical transference elements that are expected to emerge with the therapist, often related to the clearly outlined responsibilities.

Only when the therapist and patient have traversed the steps described, does the actual “therapy” begin. Each of these steps has multiple elements, as would be expected given the complexity of PD pathology. The following are the key guiding principles of TFP:

1. To create a situation that feels safe for both the patient *and* the therapist, and
2. To have in place a frame that will allow the patient and therapist to explore together the emerging transference currents, with close attention paid to the patient’s challenges to the frame or permutations in the agreement that come from the therapist.

Once the therapy begins, the TFP clinician will follow a relatively well-defined set of interventions. These include the following:

- Monitoring the 3 channels of communication: what the patient says, how the patient behaves, and how the therapist feels.
- Tolerating the expectable confusion associated with significant PD pathology, without feeling moved to immediately organize or structure the material.

- Identifying the dominant affects that emerge in the content shared by the patient in response to the expectation that the patient speak freely about what is on his or her mind.
- Identifying the dominant object relations dyads as they emerge, or the patient's experience of self, the patient's experience of another (including the therapist), and the associated affect.
- "Naming the actors" or putting into words the therapist's initial impression of the dominant object relations dyad as it develops.
- Considering the possibility of an emerging role reversal, or evidence that the patient is behaving in a way he or she previously ascribed to others.
- Considering the way a surface dyad keeps at bay a concurrent, but less available dyad. For example, the patient experiencing himself or herself as victimized by the therapist, alternating with the patient's victimizing of the therapist, often outside of the patient's awareness. This dyad might keep at bay the patient's experience of longing for an idealized figure.
- Use of "therapist-centered interpretations" to manage episodes of patients' heightened affective reactions. Often a therapist will become defensive or argumentative in such situations. The therapist-centered interpretation invites the patient to express concern, mistrust, or even nonpsychotic paranoid thinking about the therapist.
- Repeated use of the following interventions:
  1. Clarification, or a request for more information about anything offered by the patient that is unclear or sketchy,
  2. Confrontation, or bringing to the patient's attention any conflicting or disparate data points observed in what the patient says or how the patient behaves, or
  3. Interpretation, or a preliminary hypothesis about motivations and defenses offered by the therapist to the patient for consideration.

APPLICATIONS OF TRANSFERENCE-FOCUSED PSYCHOTHERAPY PRINCIPLES IN ACUTE CARE PSYCHIATRY

The idea that TFP principles could be of use to clinicians in settings outside of an individual extended psychotherapy developed organically. Psychiatry residents learning TFP as one of a number of individual psychotherapy interventions were also fulfilling their duties in the standard tertiary-care training sites, often settings with high acuity and high rates of patients with primary or co-occurring PD pathology. These residents were thus armed with a "toolbox" of interventions to use in these settings. The "tool box" included the following:

1. Active monitoring of countertransference elements
2. Attentiveness to how the patient behaves, at least as much as to what the patient says
3. Openness to consideration of a PD diagnosis, even with incomplete information
4. Appreciation of the dominant affect expressed with words or with actions
5. Speculation about an emerging dominant object relations dyad and the possibility of role reversal

Along with these elements, TFP training gave residents some possible "scripts" to use, borrowed from TFP as an extended psychotherapy, including the following:

1. "Naming the actors"
2. Delineation of a recurrent object relations dyad and its reversal

3. The “therapist-centered interpretation” to be used in periods of heightened affect. Psychiatry trainees used these TFP principles in their work in consultation-liaison psychiatry, inpatient psychiatry treatment, and forensic psychiatry settings. Again, the goal was not to introduce a half-baked or diluted version of the individual psychotherapy, but rather to use core elements of the treatment (assessment processes, contracting, identification of patterns as reflected in dominant object relations dyads and their reversals, and maintenance of a treatment frame) in acute care settings.

It is not within the scope of this article to explore all the possible uses of TFP principles in acute care psychiatry; as noted, the literature on applied TFP thus far has introduced its use in inpatient settings (general psychiatry and forensic services), outpatient pharmacotherapy, consultation-liaison psychiatry, and crisis settings (that could include psychiatric emergency departments). This article’s focus is on the use of TFP principles in prescribing for patients with primary or co-occurring moderate to severe PD pathology in a “step-down” setting, such as an intensive outpatient program. Given the shifting employment patterns among psychiatrists in the United States and Canada, and the aforementioned high rates of psychiatric comorbidity associated with serious PD diagnoses, such challenges are not rare.[21,22] What is the extent of useful training for clinicians facing such thorny challenges in contemporary practice? The situation is a murky one; there are no medications approved by the Food and Drug Administration for PD pathology. Despite this, patients with BPD, for example, are unusually high users of all subtypes of psychiatric medication.[23] Risk management education tends to be generic and does not routinely address the particular complications associated with prescribing medication to patients with PD symptoms, particularly those with subsyndromal presentations. Authoritative research groups have concluded in definitive analyses that the effectiveness of pharmacotherapy for PD symptoms is, at best, very limited.[24,25] The body governing decision-making about prescribing within the United Kingdom’s National Health Service, to add to this complicated picture, has recommended use of no medications in the treatment of BPD.[26] Good Psychiatric Management for Borderline Personality Disorder (GPM), another empirically validated treatment, has specific recommendations for prescribing medications to patients with BPD, but TFP principles would extend these recommendations by (1) offering a way to think about the range of moderate to severe PD presentations, beyond those patients meeting DSM-5 criteria for BPD, and (2) providing a detailed way for the prescriber to approach treatment of the patient with PD symptoms, including attention to the level of illness severity, introduction and maintenance of a treatment frame, and introduction to a “script” when identifying and describing patterns (in TFP short-hand, the dominant object relations dyads and their reversal) and for managing episodes of heightened affective states.[27]

The following is a sample clinical vignette that aims to capture the usefulness of TFP principles for the general psychiatrist as prescriber:

Dr A is a recent psychiatry residency graduate. She takes a job with a large multi-hospital system (in current terms, an accountable care organization) that operates with a model of capitation, not fee-for-service. Her employers expect that psychiatrists in the system will prescribe medication only and refer to other professionals, mostly social workers, to provide psychotherapy in individual and group formats. Dr A is assigned to work in the intensive outpatient program, where she sees recently hospitalized patients or those outpatients seeking “crisis” appointments; she is expected to see a number of new patients per week and to see 3 patients per hour in follow-up “medication management” visits.

During her first year of practice, Dr A finds that she can manage the work load expected and she believes is able to provide quality care to her patients, with a few exceptions. Dr A notices that a relatively small number of patients in her practice, fewer than 10%, occupy a disproportionate amount of time and cause her unusual worry and uncharacteristic conflict with the other medical specialists in the hospital system and the therapists with whom she works. Dr A's residency training program had little didactic focus on PDs, just a few hours, mostly focused on DBT, taught by a psychologist. Her familiarity with the diagnosis and management of PDs, including pharmacotherapy, was limited to anecdotal information conveyed by supervisors, and the preparation she did for her psychiatry boards examination, which had few questions related to PD pathology.

Dr A learns from a friend from residency, Dr B, about the latter's experience with TFP training. Dr B has a practice that involves both psychotherapy and pharmacotherapy, and he encourages Dr A to take a 1-day TFP course, as he had done. Dr B describes his improved confidence when assessing and treating patients with complex presentations that include PD elements and reports that he uses TFP principles in multiple clinical situations other than an extended individual psychotherapy.

Dr A takes the TFP course and begins to integrate into her work elements of the treatment she has learned.

POINT 1: ASSESSMENT

The TFP assessment process is based on the structural interview. This process, first described decades ago, presaged the current hybrid categorical-dimensional approach of the DSM-5 appendix.[28] The structural interview aims to capture not just the diagnostic category (borderline PD, narcissistic PD), but also how impaired or functional the patient is. The structural interview has the goal of investigating the following elements, easily remembered using the mnemonic RADIOS:

- Reality testing
- Aggression
- Defenses (specifically the admixture of mature, repression-based, or splitting based defenses)
- Identity diffusion versus consolidation
- Object relations (the nature and quality of the patient's connections with others)
- Superego functioning (or moral values)

The TFP assessment process also attempts to identify elements that might suggest a particularly concerning prognosis, specifically a "secondary gain" of the patient's illness, or some elements of prominent aggression, nonpsychotic paranoia, or antisocial traits. The term secondary gain of illness captures those patients whose symptoms and condition confer some kind of gratification, which can be in the patient's awareness, or sometimes not. Such situations could include the exploitative patient who gets financial support from family or the state based on his or her psychiatric symptoms. Another example would be the patient who derives gratification from the sympathy derived from or control over family members who "walk on eggshells" because of the patient's condition. The patient with elements of ego-syntonic aggression, nonpsychotic paranoia, and antisocial traits may have a subtype of severe narcissistic PD pathology that would alert the clinician about likely challenges going forward with the treatment.

Dr A begins to incorporate certain TFP assessment elements in her initial evaluation of patients. She moves from a "decision-tree" approach to one informed by the

structural interview. She spends more time on elements of the patient's social history, at times, and pays particular attention to issues of finances and legal difficulties, when indicated. Dr A begins to use the RADIOS mnemonic in her thinking, aiming to gage how functional or impaired each patient might be, often using her countertransference to consider a patient's aggression or aspects of the patient's defensive operations as they emerge in their budding relationship.

POINT 2: SHARING THE PERSONALITY DISORDER DIAGNOSIS

Dr A had learned during her residency that it was not appropriate to make a PD diagnosis when other co-occurring disorders were active. During her first year in practice, this policy seemed to Dr A impractical; a number of her most challenging patients had both PD symptoms and co-occurring mood, anxiety, substance use, or eating disorders that often showed no signs of remitting any time soon. Dr A learned in her TFP training that ignoring PD symptoms and/or withholding PD diagnoses from patients and families might not be in anyone's best interest.

Dr A slowly began to introduce to certain patients her understanding of the contribution of PD symptoms or diagnoses to their difficulties. In some cases, she used standard DSM-5 terminology; in other cases, Dr A used more euphemistic language, as when describing to a patient with a "thin-skinned" narcissistic disorder profile the likelihood that his mood reactivity might be best understood as related to fluctuations in his self-esteem. Making a PD diagnosis and then sharing her impressions with patients and families allowed Dr A to qualify her endorsement of certain medication trials and even recommend stopping certain medications. Dr A also found making and sharing PD disorder diagnoses allowed her to engage in a more honest informed consent process and limited the situations in which patients were disappointed with the results of medication trials, a familiar pattern she had noticed during her first year of practice.

POINT 3: FAMILY INVOLVEMENT

The standard TFP approach to beginning an individual psychotherapy will strongly encourage a family meeting in situations in which patients are dependent on partners or parents in some significant way. Given TFP's development as a treatment for BPD, these situations were not rare; such patients often function poorly and require significant emotional or financial support, or have destructive enmeshed relationships, often a source of confusion for the treaters involved. In addition, because many patients with BPD are actively suicidal, treaters often experience understandable anxiety about these patients, made worse when treaters feel isolated or "in the dark" because patients forbid contact with family members. The family meeting in TFP has multiple goals: to help the therapist as he or she gathers parallel information; to address risk management elements, as family members are given an opportunity to raise their concerns; and to address an often-unspoken aspect of the patient's denial, that his or her disorder has led to a state of dependence.

Dr A begins a treatment with Mr C who presents in a "crisis appointment." He comes with a diagnosis of "treatment-resistant depression" and has failed numerous medication trials and psychotherapies. Mr C comes to Dr A on an unusually complex regimen that includes a monoamine oxidase inhibitor (MAOI) antidepressant and a relatively high benzodiazepine dose. Mr C has not worked for a number of years; he recently moved back in with his parents who are paying toward his health insurance. Dr A's initial assessment suggested Mr C had significant PD pathology in the narcissistic category, along with his purported depressive disorder. Dr A was aware of her own

countertransference, both irritated by Mr C's entitlement and fearful about his adherence to the MAOI diet, given his history of 2 recent emergency room visits following his impulsive decision to try eating pizza.

Dr A feels strongly she would need to have a meeting with Mr C and his family if she were to feel comfortable enough to continue their treatment. Mr C was somewhat reluctant to have the meeting, but eventually agreed. During the meeting, Dr A was able to learn more about Mr C, which confirmed her initial impression about co-occurring narcissistic PD traits, and she was able to explain to Mr C's parents her goals for the treatment and the risks associated with his current regimen. Following the meeting, Dr C felt more comfortable going forward treating Mr C, as she had clearly reviewed the risks associated with his underlying disorder and the medications he had been prescribed begun by prior clinicians.

POINT 4: NEGOTIATING THE TREATMENT CONTRACT

The TFP contract anchors the extended psychotherapy; this contract is more than "boiler plate" office policies, it outlines the patient's and the therapist's responsibilities and initiates a discussion of likely challenges to the treatment frame, as would be expected with patients with moderate to severe PD symptoms. The contract should include all the details necessary so that the clinician can feel secure in his or her treatment; the goal is for the clinician to be able to think clearly and not feel clouded by undue anxiety. The contracting phase follows the evaluation process; the general rule of thumb is that the more impaired the patient is (in TFP parlance, the lower the level of organization), the more rigorous the treatment frame. Many clinicians, including prescribers, will take a one-size-fits-all approach. Unfortunately, what might work when prescribing medication for a patient with a generally higher level of organization (operating without a treatment contract) can lead to confusion, surprise, or even outright panic for the psychiatrist or nurse practitioner responsible for treating patients with more significant PD pathology. The act of establishing a treatment contract will proactively address a well-described phenomenon among patients with PD: a belief, conscious or unconscious, that a prescriber and the medications he or she recommends will be enough on their own to address a chronic PD condition. A patient may express surprise that he or she has *any* responsibility in his or her treatment; a detailed treatment contract will introduce this reality from the beginning.

The following is a list of TFP contracting elements that will have salience for the prescriber who may *not* be engaged in psychotherapy:

- Scheduling process
- Starting and stopping sessions on time
- Patient hygiene
- Fee and payment schedule
- Cancellation 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

Ms D is discharged from the inpatient psychiatric unit to Dr A's care. Ms D was hospitalized briefly following an episode that was initially understood as a suicide gesture; she had taken 4 times the recommended dose of her sleeping medication, apparently in the context of an argument with her boyfriend. (She later denied any intent to harm herself.) Dr A notes that the chart from the inpatient hospitalization lists diagnoses including primary insomnia, unspecified anxiety disorder, and unspecified PD. Dr A also reads about Ms D's most recent treatment, which was marked by nonadherence to her medication regimen, missed appointments, and premature calls for medication refills.

Dr A's initial evaluation of Ms D suggested some prominent BPD symptoms associated with the hospitalization, specifically affective instability, unstable interpersonal relationships, and a preoccupation with abandonment. Dr A was aware of her immediate countertransference, feeling anxiety (Would Ms D misuse her medications again?) and irritation (Would she be subject to complaints from Ms D if she did not comply with premature requests for refills? Would Ms D lodge a complaint with the accountable care organization, something taken seriously by administrators?) Dr A felt strongly that her best hope for treating Ms D would rest on a wide-ranging and detailed contract. Dr A spent a significant portion of her initial sessions with Ms D putting this contract together. She expected push-back from Ms D, which she got, but remained clear that an agreement in place would be necessary. As the treatment progressed, Dr A referred back to the contract repeatedly, and monitored her own urges to depart from the contract as they came up.

POINT 5: IDENTIFYING DOMINANT OBJECT RELATIONS DYADS AND THEIR REVERSAL

TFP as a psychotherapy provides clinicians with certain explicit "scripts" that are used to explore recurrent object relations dyads as they emerge in the course of treatment. The TFP therapist first attempts to "name the actors" or put into words the most prominent object relations dyad in evidence, often a challenge when obscured by the chaos so often prominent with a severe PD disorder. The therapist then continues to refine this object relations dyad, often highlighting the patient's experience of the therapist, while observing for a role reversal, or the way the patient might behave in a way he or she previously ascribed to others. Sometime in periods of heightened affective states, or "affect storms," the therapist will simply put into words the particular stark experience of the therapist the patient is having at the time. The affect storm is often marked by the patient's mistrustful or devaluing sentiments about the therapist. These "scripts" may be of use to the prescriber in ongoing treatment, given the likelihood that medications will have powerful and complicated meaning for the patient with PD.

Dr A meets weekly with Ms D in the period following her hospitalization. Ms D continues to have difficulty sleeping, despite Dr A's review of sleep hygiene guidelines and a referral for cognitive-behavioral therapy specific for insomnia. Ms D presents to her next appointment looking angry, sitting with her arms crossed and scowling. She is sarcastic with Dr A, stating "Those new pills you gave me for sleep are pretty worthless. You took away the narcotic–the one thing that helped me sleep. I didn't sleep a wink last night and now I have to go to work feeling terrible!" Dr A attempts to "name the actors" in this exchange, guessing at what Ms D is going through. She responds: "It sounds like you're feeling pretty vulnerable, seeing me as not very competent or maybe just uncaring, and you're pretty upset about it." This comment was

momentarily containing. Later in their meeting, Ms D is more aggressive, raising her voice and threatening Dr A that if she can't get a good night sleep, she may need to take an excessive dose of medication as she had before, risking rehospitalization. Dr A avoids an excessively active response to this comment, instead describing the dominant object relations she observes, and its reversal, by saying: "You've made it clear you see yourself as neglected and powerless, suspecting that I'm acting in a punishing way; I'm also aware that right now your threats about adherence to your medication regimen and a risk of rehospitalization are punishing to me, likely to concern me or even frighten me." Dr A considered that putting her observation into words did not immediately lead Ms D to have an increased insight into her behavior, but it did diffuse the threat in the air, thereby reducing Dr A's anxiety.

SUMMARY

TFP principles applied outside of an individual psychotherapy modality have a practical utility for psychiatrists working in acute care settings. Psychiatric education about work with patients with PD diagnoses is limited, at best. Psychiatrists will work with patients with PD diagnoses in almost all the settings where they practice, and such work is bound to be fraught and labor-intensive. TFP principles offer a commonsensical and organizing blueprint for psychiatrists. Its systematic approach, deliberate and considered, can help psychiatrists in practice manage some of their most challenging clinical situations.

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