Using Transference-Focused Psychotherapy Principles in the Pharmacotherapy of Patients with Severe Personality Disorders

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Abstract: Transference-focused psychotherapy (TFP) is an evidence-based, manualized treatment for severe personality disorders. TFP provides clinicians with a comprehensive diagnostic approach, overarching theoretical orientation, and specific clinical techniques. While TFP was developed as a long-term psychodynamic psychotherapy for patients with personality disorders, the approach, orientation, and techniques used in psychotherapy treatment may be of use in pharmacotherapy with the same patients. Patients with borderline personality disorder, in particular, are high utilizers of all subtypes of psychotropic medication despite limited evidence for their effectiveness, creating multiple challenges for the prescribing clinician. The author suggests specific ways the TFP model can assist prescribers, including those who do not practice TFP psychotherapy.

Transference-focused psychotherapy (TFP) is an evidence-based, manualized treatment for severe personality disorders using a psychodynamic approach with a focus on object relations theory (Clarkin, Levy, Lenzenweger, & Kernberg, 2007, Clarkin, Yeomans, & Kernberg, 2010). TFP was developed initially as an individual psychotherapy intervention for patients with borderline personality disorder (BPD); its principles have since been used to treat a wider range of patients including those with primary narcissistic disorders (Stern, Yeomans, Diamond, & Kernberg, 2013) and higher level personality disorders (Caligor, Kernberg, & Clarkin, 2007). TFP has also been introduced in the treatment of personality disorders in a group treatment format (Kernberg, 2012). In addition, TFP has been introduced as a teaching

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tool in psychiatry residency training for use in acute settings such as inpatient general psychiatry, forensic psychiatry, and substance use disorder units (Zerbo, Cohen, Bielska, & Caligor, 2013).

TFP was developed as a twice-weekly psychotherapy lasting at least one year, often up to three years or more. TFP begins with an extended clinical assessment, or structural interview, as developed by Kernberg, followed by an extended contracting phase, before the twice-weekly psychotherapy actually begins (Kernberg, 1981, 1984; Clarkin et al., 2006; Caligor et al., 2007). TFP uses psychoanalytic principles and a psychodynamic orientation, but the psychotherapy in practice includes modifications informed by the specific psychopathology it is intended to treat. Key elements of the treatment are the establishment and maintenance of the treatment frame, reinforced by a detailed treatment contract, which is understood as essential in allowing the unfolding and examination of the patient's internal world as reflected in the relationship between the patient and the TFP therapist (Yeomans, Clarkin, & Kernberg, 2002).

The structural interview has two aims: first, to collect data to aid in making standard descriptive diagnoses (which would conform to standard *DSM-5* diagnostic categories; American Psychiatric Association, 2014) and, simultaneously, to assess the psychological structures which underlie functioning and may reflect personality disorder pathology. Most clinicians are familiar with the process of making descriptive diagnoses, for example, relying on patient's reports or parallel information sources in an effort to establish whether a patient meets criteria for specific psychiatric conditions, including personality disorders. This process often conforms to a "decision-tree" approach, as interviewers methodically acquire information which either supports or refutes the likelihood a patient will meet *DSM-5* criteria for a particular condition.

The structural interview includes investigation of standard *DSM-5* diagnostic categories but also introduces an approach to assessment focusing on a continuum of personality pathology. The interview is more loosely structured than a "decision-tree" approach, and stresses not just the content of what the patient says, but also how the patient behaves, and the clinician's reactions to the patient. The structural interview begins with a focus on the patient's presenting difficulties and next moves to exploration of the patient's personality. This exploration involves interviewer questioning about aspects of the patient's functioning in multiple spheres, as well as the patient's capacity for self-reflection and experience of important individuals in the patient's life.

Kernberg introduced the concept of the patient's level of organization, from the highest level or "neurotic" organization, to the "borderline" organization, which encompasses most of the *DSM-5* personality

disorders as well as certain other conditions, and the "psychotic" organization which includes patients with primary psychotic disorders as well as certain more impaired personality-disordered patients. The structural interview helps in determining patient's level of organization, as described above, as it attempts to characterize central elements of personality, particularly patient's reality testing, defensive operations, and degree of identity diffusion or consolidation.

At first glance it may not seem obvious how the principles of a long-term psychotherapy derived from psychoanalytic object relations theory would be of use in the pharmacotherapy of patients with personality disorders. While the relationship between a prescribing clinician and patient can be an established and predictable one, prescribers also at times find themselves evaluating and treating patients whom they hardly know. Zerbo et al. (2013) described the usefulness of TFP training for psychiatry residents in mastery of an organizing theoretical framework for both diagnosis and clinical process to be used in acute care settings with patients whom they may not know well, if at all. They note that TFP training may be of use to residents who do not pursue additional psychotherapy training after completing residency and suggest that TFP principles are helpful in settings like the psychiatric emergency room, inpatient psychiatric units, and medical units, where trainees often are required to manage difficult situations with patients with personality disorders.

The goal of this article is to extend the concept of applied TFP to yet another set of clinical situations. Clinicians practicing psychiatry in a "medical model" might reflexively think of TFP principles as overly difficult to understand or impractical in settings other than long-term psychotherapy. On the other hand, it is clear that the field of pharmacotherapy for patients with personality disorders at present is marked by confusion and uncertainty; one expert has made a plea for a collective "nuts and bolts" discussion of the process (Silk, 2011). TFP principles as outlined in the TFP treatment manual may be one useful intervention in this "nuts and bolt" approach, among others, helping clinicians to manage these thorny clinical situations.

The term "severe personality disorders" in this article will refer to patients described in the structural assessment as having a mid- to low-borderline organization, which encompasses many patients with BPD (the best studied of the personality disorders), among others. Research on the pharmacotherapy of personality disorders has focused almost exclusively on the study of patients with BPD. The following discussion will refer largely to the research findings on BPD but the findings are likely generally applicable to other conditions including hypochondriacal, narcissistic, sadomasochistic, and histrionic personality types,

identifiable by identity diffusion, generally intact but at times tenuous reality testing, and predominantly primitive or splitting-based defenses.

THE PHARMACOTHERAPY OF SEVERE PERSONALITY DISORDERS

The pharmacotherapy of severe personality disorders is universally described as challenging for psychiatrists and other prescribers for a variety of reasons. Patients with severe personality disorders are often in great psychic pain and may convey this to clinicians as an emergent request for medications. Some patients with symptoms consistent with severe personality disorders are not aware they may have these disorders, in part because many clinicians may be reluctant to make or document a personality disorder diagnosis or may be reluctant to share with patients a diagnosis of personality disorder even if they are confident the patient meets criteria for the disorder (LeQuesne & Hersh, 2004; Paris, 2007; Zimmerman & Mattia, 1999). In this setting as a result there is an associated tendency for prescribers to prefer to focus on a putative mood, anxiety, substance use, eating or attention disorder while largely neglecting co-occurring personality disorder symptoms. This can be true even if the clinician recognizes the important contribution of personality disorder symptoms. Therefore in many clinical settings patients with severe personality disorders are prescribed multiple medications with associated risks which are not particularly effective for the personality disorder symptoms or may be less effective than expected for treatment of co-occurring conditions (Reich & Green, 1991). This phenomenon is not unusual; patients with personality disorders are disproportionately represented in most outpatient and inpatient psychiatric treatment settings and some, specifically patients with BPD, are unusually high utilizers of medications in all psychotropic categories (Bender et al., 2001; Zanarini, Frankenburg, Hennen, & Silk, 2004; Zimmerman, Rothschild, & Chelminski, 2005).

The high rates of pharmacotherapy in BPD are notable because there are still no medications approved by the F.D.A. to treat personality disorder symptoms and results from placebo-controlled randomized clinical trials for BPD and other personality disorders have been consistently modest, at best (Lieb, Volm, Rucker, Timmer, & Stoffers, 2010; Stoffers et al., 2010). While patients with BPD, for example, appear to take multiple medications for extended periods, almost all the medication studies are short-term.

TABLE 1. Challenges of Pharmacotherapy with Patients with Severe Personality Disorder

1. Patients may not be aware of their personality disorder diagnosis
2. Clinicians may be reluctant to make a personality disorder diagnosis
3. Clinicians may be reluctant to share a personality disorder diagnosis
4. Patients with severe personality disorders may take multiple medications even though evidence does not suggest this will be effective
5. Patients with severe personality disorders may not respond robustly to pharmacotherapy for co-occurring conditions
6. Patients with severe personality disorder may engender splitting between prescribers and other members of the treatment team
7. Patients with severe personality disorders may present for adjustment of medications in crisis leading to frequent changes in medications or in polypharmacy
8. Threats of suicidal behavior may compromise the prescriber's steadiness and consistency in pharmacotherapeutic practice

Further complicating the picture, certain guidelines for the treatment of BPD continue to endorse use of medication, although qualifying that endorsement with the reminder that medications are at best ancillary to the psychotherapies which have the central role in treatment, while other guidelines have encouraged clinicians to avoid any use of medications in treating BPD if possible (American Psychiatric Associaton, 2001; National Institute for Health and Clinical Excellence, 2009).

For the prescriber, clinical experience suggests that patients with severe personality disorders are often in crisis, leading to crisis-driven prescribing and eventually polypharmacy (Silk, 2011). In addition, patients with severe personality disorders often engender splitting among treaters including between primary psychotherapists and prescribers (Busch & Sandberg, 2007). Clinical experience suggests that patients with severe personality disorders can have unusually powerful placebo responses to medications. These powerful placebo responses, when combined with impulsivity, may lead patients to start and stop medications on their own, risking higher frequency of adverse reactions related to medication withdrawal phenomena.

The practice of medicating patients with BPD is further complicated by the high rates of suicide attempts, threats, or non-suicidal self-injurious behavior, in this population along with the lifetime rate of completed suicide of 5–10% (Goodman, Roiff, Oakes, & Paris, 2012). The pattern of suicidal behavior and high rates of completed suicide understandably adds a degree of complexity to the process of prescribing medication and associated heightened anxiety for the prescriber.

Clinicians prescribing medication for patients with personality disorder symptoms may sometimes have an established relationship with the patient, but in many other settings including high-turnover clinics, inpatient units, and emergency rooms, clinicians will be asked to consider medication for patients they know little, if at all.

Research on practice trends in recent years has confirmed that most patients receiving psychiatric medications will be treated either by clinicians who are not psychiatrists or in split treatments, with a physician prescribing medication and a non-physician conducting the psychotherapy (Pincus et al., 1998).

Together the points made underscore the particular challenges for prescribing clinicians and reinforce the need for an overarching way of thinking about helping patients and of protecting both patients and the clinicians (Busch & Sandberg, 2007). Medicating personality disordered patients routinely leaves the clinician feeling ineffectual, confused, or resigned. Making a distinction between "psychodynamic" and "biologic" interventions, controversial and for some questionable, approaches futility with severely personality disordered patients.

AN OVERVIEW OF TRANSFERENCE-FOCUSED PSYCHOTHERAPY

The following discussion of TFP principles derived from the treatment manual is intended to highlight the elements of the treatment applicable in the process of medicating patients with significant personality disorder symptomatology.

TFP proceeds along the following lines: first, in the assessment, identifying personality disorder symptoms (placed along a continuum of "personality organization" from the higher-level neurotic organization, to mid-range borderline organization, encompassing borderline and certain other personality disorders, to the lower-level psychotic organization) using the structural interview, prior to disclosure to patient (and, if indicated to family) of diagnoses including personality disorders and recommendation of the treatment; second, setting an overarching treatment strategy of integrating a patient's experience of self and others, addressing the underlying structure of a patient's often chaotic internal world; third, determining treatment tactics, or guidelines for what the treater attends to at every session (this includes establishment and maintenance of the treatment contract, identification of a priority theme, and exploration of the transference); and fourth, employing the techniques of the treatment or the moment-to-moment

TABLE 2. TFP–Based Skills for the Prescriber

1. Use of the Structural Interview will stimulate the clinician to consider both standard descriptive diagnostic categories as well as levels of personality organization
2. Diagnosis of personality disorder symptoms or personality disorders will motivate the clinician to share information about these conditions and provide psychoeducation for patients and families
3. Clinicians will be alert to countertransference phenomenon in their roles as prescriber
4. Clinicians prescribing medication for patients with severe personality disorders will begin by identifying the dominant object relations paradigm and "naming the actors"
5. Clinicians will be alert to expected oscillations in the dominant dyad and will assist patients to develop increased capacities for reflection
6. Clinicians will be alert to expectable splits including with other members of the treatment team or with family members
7. Clinicians will work to "bridge the split" with other treaters or family members as they arise

interventions (using clarification, confrontation, and eventually interpretation, maintaining technical neutrality, and actively integrating countertransference).

A Comprehensive Diagnostic Approach

In the structural interview, the clinician methodically and carefully assesses first medical or otherwise organic factors contributing to a patient's complaint or presentation, and then proceeds to explore major psychiatric illness categories (what were previously described as Axis I disorders), by elucidating specific diagnostic criteria. While assessing for organic and medical processes and major psychiatric disorders, the structural assessment concurrently focuses on levels of personality organization, with particular attention to reality testing, identity consolidation or diffusion, and nature of defensive operations.

The structural interview helps the clinician investigate reality testing, identity consolidation, and nature of defenses (specifically repression-based defenses vs. splitting-based defenses) by beginning with an inventory of the patient's symptoms and exploring the patient's attitude toward these symptoms. The interview next invites the patient to share his or her self-conception ("Describe yourself, your personality, so that I have an understanding of you as a person") as well as the patient's relations with important figures in his or her life ("Tell me about the important people in your life so that I can get a sense of them"). The in-

terviewer uses intuition and curiosity to guide questioning, employing clarification (request for more information about anything unclear or incomplete) or confrontation (bringing to the patient's attention seemingly incompatible information). The interviewer's attitude is informed by TFP's focus on the three channels of communication, aware not only on what the patient reports, but how the patient behaves and how the interviewer experiences the patient.

The structural assessment allows clinicians identifying personality disorder symptomatology first to identify co-occurring conditions, medical or psychiatric, which could impact the psychotherapy treatment contemplated. It then gives clinicians a way of organizing material with the goal of identifying the degree of personality disorder psychopathology thereby informing recommendations for treatment beyond standard "medical model" interventions. The structural assessment helps clinicians to gage relative treatability with TFP (or other psychotherapy) and tentatively to establish prognosis, critical in the process of engaging patients in an informed consent dialogue optimal at the initiation of any psychotherapeutic intervention. In general, the lower the level of personality organization as evidenced by more impairment in reality testing, more primitive (splitting-based) defenses dominating, and more pronounced identity diffusion, the more clearly defined and maintained the treatment framework will be required, and the more guarded the prognosis of effectiveness of TFP.

The prescribing clinician focused only on descriptive *DSM-5* diagnostic categories or prone to lumping identified personality disorder symptoms in a "personality disorder not otherwise specified" category may overlook important data from an initial encounter. The clinician familiar with the structural interview will be alert to likely pitfalls associated with the process of medicating. An appreciation of a patient's level of organization can help the prescriber anticipate the limitations of pharmacotherapy, in some cases, and the likely barriers to effective treatment which may become apparent in the context of the patient-clinician relationship.

TFP clinicians will routinely discuss with patients and, if indicated, with families, their comprehensive diagnostic impression which can include personality disorder or personality disorder trait diagnoses. The benefits of conveying a diagnosis of personality disorder generally and borderline personality disorder specifically can be significant. Discussion of a borderline personality disorder enables clinicians to educate patients and families about the disorder and its prognosis (informed by multiple prospective studies), available evidence-based treatments, and likely treatment complications (Zanarini, Frankenburg, & Reich, 2010, Weinberg, Ronningstam, & Goldblatt, 2011). Of note, frank dis-

cussion of the borderline personality disorder diagnosis is part of the other manualized, evidence-based treatments for BPD including Supportive Psychotherapy, Dialectical Behavioral Therapy, Mentalization-Based Treatment, and Good Psychiatric Management for Borderline Personality Disorder (Bateman & Fonagy, 2006; Gunderson & Links, 2014; Linehan, 1993; Rockland, 1992).

Many clinicians may be reluctant to share their borderline personality disorder diagnosis with patients fearing that doing so might make the patient angry or suicidal. The results of a psychoeducation study which included disclosure of the borderline diagnosis suggest that clinicians' concerns about the risks in doing so are ill-founded; in fact, it can be a relief for patients to hear about a diagnosis which accurately captures their symptoms and history, particularly for those patients who feel they have for years "failed" standard treatments for mood and anxiety disorders (Zanarini & Frankenburg, 2008).

A patient in TFP may have a *primary* personality disorder, suggesting that the patient's symptoms and presentation can be fully understood as part of the personality disorder diagnosis, or the patient may have personality disorder symptoms and another co-occurring psychiatric disorder, such as a mood, anxiety, eating, or substance use disorder. In both scenarios, the patient with a primary personality disorder or the patient with personality disorder symptoms with a co-occurring psychiatric disorder, the TFP clinician will aim to engage the patient in a discussion of the realistic likelihood of benefits from medication. Patients should be educated about the limits of pharmacotherapy in addressing core elements of personality pathology *and* the effect personality pathology may have on the expected effectiveness of pharmacotherapy for the co-occurring psychiatric conditions.

In TFP a clinician may provide both psychotherapy and pharmacotherapy or may split the treatment so that one clinician provides the psychotherapy and another manages a patient's medications. In both cases clear and direct discussion of personality disorder symptoms is considered imperative. The TFP therapist should work only with prescribers who are comfortable first recognizing and then openly discussing personality disorder symptoms.

Overarching Theoretical Orientation

Critical to the TFP clinician's orientation is an understanding of the centrality of the patient's internalized experiences of self and others, namely, their object relations. The object relations theory approach ex-

pects that a patient will have specific affects attached to relationships and that in patients with severe personality disorders their experience of others will be marked by the splitting of positive and negative experiences.

In practice this compels the clinician to keep uppermost in mind the dominant object relations dyads, or recurrent, variable ways patients experience others. TFP assumes the clinician at the beginning will be overwhelmed by a patient with a severe personality disorder, and the ability to tolerate the confusion of the patient's internal world is a key element of the treatment strategy. Slowly the clinician is able to identify the dominant object relations dyads, often amid unsettling confusion. The clinician aims to "name the actors" or to put into words what the clinician understands is the dominant experience of self and others for the patient at that time. This process of "naming the actors" can have a containing effect, conveying to the patient a sense of being understood at that moment. After indentifying and naming the dominant object relations dyads, the clinician then listens for the expected oscillation in dyads, ways that the experience of others most available to a patient at a given time (for example: the patient is vulnerable and dismissed, the clinician is indifferent and callous, in the dominant dyad) will then be reversed (the clinician will feel ignored and experience the patient as indifferent). Over time the clinician becomes familiar with the dynamic of the opposing object relations dyads (e.g., hurt patient, abusive clinician alternating with clinician feeling hurt and experiencing the patient as abusive) and introduces to the patient a motivation for the "split" as evidenced in the seemingly contradictory experiences of self and other.

The motivation for the "split" usually involves dissociation of active dyads, one on the surface characterized by hatefulness and negativity, and one less available characterized by positive feelings and an experience of caring. How would a prescriber identify this process in a personality disordered patient? A common scenario would be the patient who is initially focused on feelings of fear or suspicion, for example: the clinician who is "withholding" a helpful medication or imposing an unfair set of requirements for ongoing treatment. This sense of being attacked by the clinician might oscillate with the patient taking an attacking, accusatory stance with the prescriber. Less available to the patient and likely revealed over time would be an experience of the prescriber as highly idealized, with the prescriber as a provider as a source of unconditional support and the patient as well cared for and satisfied. This dyad might reflect the patient's hope the prescriber has almost magical powers and can, through medication, provide a wished-for sense of nurturance.

The prescriber accustomed to treating more stable patients can be surprised when engaging a more chaotic patient alternating between dyads. (For example: a healthier patient with panic disorder may approach the treating psychiatrist with an ambivalent but stable attitude, integrating hope that the clinician's prescription will relieve the symptoms with appropriate concern it may not work. The patient with borderline personality disorder may present to the clinician feeling suffering and uncared for at the mercy of abusive, powerful doctors, with a rapid shift in the session to an abusive stance berating the vulnerable-feeling clinician.) The TFP-trained prescribing clinician will be alert to the likely discrepancy between what a patient might say ("I'm being mistreated by my doctor") and how the patient might act (dismissive or devaluing of what the doctor recommends).

Specific Tactics and Techniques

TFP tactics include the establishment of a treatment contract, identification of a priority theme in each session, and monitoring of three channels of communication: what the patient says, how the patient behaves, and how the therapist feels. Attention to tactics allows the treatment to unfold in a productive way and helps to avoid digressive, aimless periods in the treatment.

The establishment of the treatment contract in TFP can take a number of sessions and focuses on the respective responsibilities of both parties as well as the possible, even likely, patient behaviors which could undermine the treatment. The contract is designed so that both parties feel safe in the treatment; of particular importance for the clinician when treating patients with powerfully destructive impulses and marked affective shifts. The contract communicates to the patient that the treatment is not passive and amorphous, but rather informed by obligations for both the patient and the clinician, with defined personal and treatment goals.

The clinician identifies the priority theme of each session alerted by the dominant affect at the time, actively monitoring three channels of communication. For the more severely personality disordered patient, what the patient says may be less vital than how the patient acts and what the clinician feels.

Prescribing psychiatrists do not routinely establish the kind of treatment contract required in TFP, but certain elements of the TFP contract may be of practical value for the prescriber. A TFP-informed approach may start with a challenge to a familiar dynamic assumed by person-

ality disordered patients: that because the patient experiences himself or herself as sick, the prescriber is required to assume responsibility for the patient without regard to the patient's behavior. Establishing a treatment frame in the practice of pharmacotherapy, while not being the same as the TFP frame, will nevertheless impart an important message.

Treatment techniques are the minute-by-minute interventions used by the clinician throughout the sessions. In TFP the clinician uses clarification questions to shed light on material which is not clear or not fully explained. Clarification can also serve to communicate to the patient that the treater does not automatically understand what the patient is experiencing. This can be a source of friction when a more primitively organized patient has an idealized experience of a treater and expects an almost magical ability of the treater to read a patient's mind. Confrontation is a technique bringing to a patient's attention apparently contradictory material. This can be done by calling attention to a patient's actions, expressions, or pointing out discrepancies in material the patient has conveyed. Confrontation in this case does not mean the clinician takes an adversarial stance but instead politely points out what he or she has observed that is seemingly at odds. The interpretation, or hypothesis conveyed to a patient, is often done in psychotherapy after extensive preparation.

CLINCIAL VIGNETTES

The following two clinical vignettes involving patients* with different subtypes of severe personality disorders will illustrate the utility of employing core clinical skills derived from TFP. In both examples, the prescription of psychotropic medication became the subject of an affectively charged exchange between the patient and psychiatrist.

Vignette 1

Susan, a 31-year-old single woman, has been seeing a psychologist in a supportive psychotherapy twice weekly over the past two years. Susan has a history of bulimia nervosa dating back to her teen years which required two hospitalizations for metabolic instability during her time in college. Susan has become increasingly distressed in recent

*Names and details have been changed to protect patient privacy.

weeks following a break-up with her boyfriend. In the context of this break-up she has described her mood as "depressed" to her therapist, has had a recurrence of binge-purge activity and has resumed a pattern of cutting her forearm to relieve upsetting feelings. Susan has also become increasingly suicidal, has purchased a bottle of acetaminophen which she keeps on her bedside table "because having that reinforces that I have the choice to end things if the pain I feel every day becomes intolerable."

A Comprehensive Diagnostic Approach and Management of Countertransference. Susan meets with Dr. S. for the first time at the behest of her therapist who is alarmed and wants Susan seen "emergently" for treatment of her "depression." Susan's therapist explains to Dr. S. that the patient abruptly fired her former psychiatrist (who had given the patient a diagnosis of Bipolar Disorder, Type II) when he was 15 minutes late for their last appointment. Dr. S. uses his immediate countertransference reaction (feeling anxious because of the urgency conveyed by the therapist and patient), as well as data gathered in his first meeting to begin considering a borderline personality disorder or borderline organization, along with the possible mood disorder.

At the end of their first meeting Dr. S. outlines for Susan his plan to complete his own diagnostic assessment, review her history with her psychologist, and to obtain recent laboratory test results from her primary care physician before making any decisions about medication.

Susan becomes first distressed and then agitated. She tells Dr. S., "My therapist told me you would give me the antidepressant I want today! I won't take a medication that causes weight gain. Now you're telling me I'm going to have to suffer even more than I have because of your whims. That's unfair!" Dr. S. replied that he was certain he had reviewed his plans when he and Susan had spoken on the phone to arrange their appointment and that he had been clear he could not assure Susan he would prescribe the antidepressant she demanded, bupropion. Dr. S., aware the patient was already taking two mood stabilizers, a sedative-hypnotic and a beta-blocker for medication side effects, was reluctant to add yet another medication.

Dr. S. was initially overwhelmed by a mix of countertransference reactions: anxiety, about the prospect of assuming care for this suicidal patient, anger at feeling "set up" to have to set limits with Susan, and ineffectual, given his knowledge that Susan was not a candidate for the medication she was requesting given her bulimia and the associated seizure risk.

Identifying the Dominant Object Relations Dyad and "Naming the Actors." Dr. S., informed by his diagnostic impression and aware of his

countertransference, invoked his TFP training to manage the impasse with Susan. He first accepted that he would likely feel overwhelmed and confused at the start and accepted this as a reflection of the patient's underlying pathology. He then began by "naming the actors" in an effort to contain the patient's explosive affect, in this case saying to Susan: "You sound panicked that I will be indifferent to your pain, that you're vulnerable and I'm callous." Susan responded, her voice lowered, but still upset: "Well of course I'm vulnerable. I need the medication and I can only get it from you. I'm spending this extra money and I'm going to leave here empty-handed."

Identifying the Oscillation in Dyads and Helping Reflect. Dr. S., aware of the dominant affect (anger), the dominant dyad at play (vulnerable patient, uncaring authority figure) and his own feelings of distress, suggested to Susan that another dyad was operating. "I'm aware that at the same time you're experiencing me as uncaring, you're demanding I do something, prescribe a medication to you contraindicated because of your medical history. In that case, you're indifferent to my need to complete a though evaluation and to prescribe in a way I see is safe for you and acceptable to me." Susan paused after hearing Dr. S.'s comments. Dr. S. continued: "I'd rather simplify you medications, not add another medication. You're not doing well and you're already taking a number of agents. I'm willing to do a thorough assessment and work with you and your therapist on trying to identify what works and what doesn't at this point." Susan mollified, agreed to an extended evaluation and deliberate review of her medication regimen.

Bridging a Split. At their next meeting Dr. S. arranged a brief conference call with Susan and her psychologist. He outlined his diagnostic thinking and his plan to proceed cautiously by avoiding further complicating Susan's medication regimen by crisis-driven decision making. By engaging Susan's therapist this way Dr. S. was able to address the possibility of a developing split, in this case Dr. S. as powerful and uncaring and the therapist as concerned and nurturing. Susan grudgingly agreed to cooperate with Dr. S. with a more deliberate process of medicating.

Vignette 2

Dan, a 26-year-old man, the son of two eminent physicians, was referred to Dr. M. after Dan moved back to his hometown at his parents' insistence. Dan had gone away to college in another state and had graduated college after six years marked by periods of cannabis use

and poor academic performance. After graduating Dan had continued to live near the college, had been sporadically taking courses toward application to graduate school, but had not been working and was financially supported by his parents.

At college Dan had been evaluated at the student health center and diagnosed at different times with a depressive disorder, attention deficit disorder, and primary insomnia. Dan had taken antidepressants, benzodiazepines, and psychostimulants. Dan was hospitalized twice during college, once when he had an adverse reaction after taking twice the recommended dose of stimulants in an effort to stay up all night to finish a paper, and a second time when he had combined alcohol and benzodiazepines to help with his sleep and had been found unresponsive by his roommates.

Dan told Dr. M. on the phone before their first appointment that he would prefer to be treated by "an experienced, senior psychopharmacologist" as he felt the care he had received at the student health center was "not up to par." Dr. M. was struck by Dan's use of the term "psychopharmacologist" in this case, given the relatively simple medication regimen Dan had been prescribed in the past.

A Comprehensive Diagnostic Approach and Management of Countertransference. In his evaluation of Dan, Dr. M. noted that while Dan, his former psychiatrist, and his family were focused on Dan's possible mood, attention, and sleep disorders, Dan also conveyed important information about his generally limited functioning, history of impulsivity, and poor judgment and possible dependence on, if not exploitation of, his parents.

On exam, Dr. M. was struck by the variability of Dan's mood; he noted that while Dan had decided to postpone school and defer work because of his depression, he maintained an active social and dating life and appeared to enjoy participation in his local soccer league. Dr. M. could not identify a full constellation of depressive symptoms, although Dan reiterated that he felt "paralyzed" by his depression and wondered if he might be a candidate for ECT.

Dr. M. was aware of his countertransference of confusion, not seeing clearly the degree to which Dan was impaired by mood disorder symptoms, and irritation, feeling pressured to prescribe a combination of medications including simultaneous stimulants and sedative-hypnotics, which he would prefer not to do.

On further questioning, Dr. M. explored with Dan the ways Dan had evaded responsibilities of different kinds, such as working, attending classes, and going to appointments on time, while maintaining his different disorders had made these responsibilities impossible. Dr. M. gra-

dually became aware of Dan's sense of entitlement to be taken care of by his parents and others, and his expectations that he would be seen as special and required particularly skilled treaters. Dr. M. began to consider that along with possible mood, attention, and sleep disorder symptoms, Dan's level of functioning, most prominent defenses employed, and pattern of subtle exploitation might suggest a mid- or low-level borderline organization with narcissistic traits. Dr. M. invoked his TFP training at this point, aware that he would need to have in place a more clear treatment frame given the severity of the patient's pathology.

Identifying the Dominant Object Relations. At their second meeting Dan expressed to Dr. M. his concern about his parents' insistence he move back home. Dan continued to report that his erratic sleep precluded him from looking for work as he could not reliably predict what time he would get out of bed in the morning. Dan was particularly irked by Dr. M.'s limited availability which meant that he and Dr. M. met at ten o'clock in the morning, a time Dan considered an inconvenience. In fact, Dan had had his mother call Dr. M. to implore him to find a time later in the day for the two to meet.

Dan slept through his third meeting with Dr. M. but left a message for the doctor asking him to renew his medications and have them delivered. Dan revealed at their next meeting that he had taken twice the prescribed dose of sleeping medication the previous evening and Dan expressed his apprehension to Dr. M., feeling "threatened" after Dr. M. had expressed concern about Dan's use of stimulants and benzodiazepines and ongoing use of cannabis.

Dr. M. began to formulate what he thought might be the dominant object relations dyad in operation, specifically a powerless, enfeebled patient distressed and at the mercy of capricious parents or doctors. He suggested this to Dan: "It sounds like you're feeling more distressed because your parents required you to move back home and have pressured you to complete your classes or look for work." Dan agreed: "Yes, they can snap their fingers and order me around and there's nothing I can do about it." Dr. M. suggested that Dan was concerned that he too would have expectations for Dan if he were to prescribe his medications going forward and if this too felt as though he was powerless in the face of an authority figure's whims. Dan agreed: "I can't write prescriptions for medications myself so I do need you."

Identifying Oscillations in the Dyad and Helping Reflect. Dr. M. told Dan he was aware that in general Dan felt at the mercy of others, specifically his parents and now Dr. M., seeing himself as generally weak and vulnerable. Dan agreed, adding that he felt it was "unacceptable" that his parents were now insisting Dan look for a part-time job. Dr.

M. reflected on his own experience of Dan during their brief period working together. "While I realize you feel pushed around a lot of the time, I'm also aware that in our brief time together you've done a number of things to assert your authority with me which imply that I'm at your mercy." Dan looked surprised at Dr. M.'s observation. "You slept through our appointment and took twice the dose of sleeping medication I recommended, to begin with. In those cases it seems to me you're the one in charge and that I'm at your mercy." Dr. M. went on to explain that he thought Dan was hoping that Dr. M. would be able to operate as a "magician" of sorts, who would have special skills and be able to prescribe a "cocktail" which would allow Dan to feel better about himself without having to expend any effort himself.

Dr. M. went on to explain: "You're dependent on your parents financially and dependent on me for your medications and I'm guessing that's not a comfortable feeling. I'm aware that you assert yourself in ways which may undermine your progress in general." Dan agreed that he felt poorly about himself and "inferior" in ways to his parents who had high-powered careers.

Bridging a Split. Dr. M. asked Dan to include his mother at their next meeting. Dr. M. used the meeting to outline his diagnostic impression and to stress what he felt were the possible benefits and likely limitations of pharmacotherapy. Dr. M. also used the meeting to address Dan's mother's concern about the scheduling of Dan's meetings and in this context Dr. M. underscored what he felt were reasonable expectations for Dan which included coming to his appointments, taking his medications as prescribed, and engaging in treatment toward abstinence from cannabis use. Dr. M. used the meeting to outline what he would require for his own sense of safety and comfort as prescriber. Dr. M. and Dan's mother found the meeting clarifying as both came to understand their expectations for Dan as reasonable and not, as Dan had framed them, unfair or burdensome.

CONCLUSION

TFP training offers a specific, useful approach to clinicians medicating patients with severe personality disorders even if these clinicians are not seeing the patient in the twice-weekly psychotherapy format. The central tenets of TFP—tolerating confusion and heightened affect, monitoring of countertransference, and identifying and naming dominant object relations dyads—can have a containing effect on patients. Use of TFP training can help clinicians avoid or minimize frequently ob-

served pitfalls in the pharmacotherapy of severe personality disorders which can include ineffective polypharmacy, patients' overreliance on medication, and the prescriber's passive acceptance of patients' non-compliance with treatment recommendations.

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