The Psychodynamic Treatment of Borderline Personality Disorder

An Introduction to Transference-Focused Psychotherapy

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KEYWORDS

• Psychodynamic psychotherapy • Borderline personality disorder
• Exploratory psychotherapy • Transference

KEY POINTS

- The application of a twice-weekly exploratory psychotherapy, transference-focused psychotherapy (TFP), to patients with borderline personality disorder (BPD) is described in this article.
- The authors describe borderline personality as a psychopathology of internal object relations, and outline how TFP working with this internal structure, seeks to treat borderline psychopathology.
- An outline of the assessment and treatment protocol is described along with a case example to illustrate the same.

Borderline personality disorder (BPD) is a disorder characterized by instability in patients' sense of identity, as expressed in a stable representation of the self across situations and time and the ability to direct oneself in a consistent, deliberate, and productive manner in one's interpersonal and occupational functioning.[1] The difficulties in the realm of identity are accompanied by severe difficulties in regulation of emotions (intense anger, mood lability) and poor coping (impulsive, self-destructive behaviors). Patients' problematic experience of the self (identity) and poor emotion

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regulation often play out on the stage of interpersonal relationships, which, for patients with borderline, are notoriously tumultuous.

The challenges for clinicians treating patients with borderline have long been recognized. Helping patients tolerate the intense feelings stimulated in them by the treatment situation and working to prevent the impulsive, often dangerous reactions to the same can be emotionally exhausting. Even when successful, the levels of frustration, concern, fear, and anger activated in us as therapists in response to our work with patients with borderline personality disorder can be difficult to bear.

The authors' task in this article is to provide an overview of how transference-focused psychotherapy (TFP),[2–4] a twice-weekly psychodynamic psychotherapy for BPD that is now being extended to other types of personality pathology,[5–7] conceptualizes, assesses, and treats borderline pathology. It is the intention of psychodynamically oriented clinicians, and TFP therapists in particular, to work at a level of depth that could yield structural change, that is, change in the psychological structures (identity, defensive style), that would in a meaningful and enduring way reshape the patients' experience of the self, subjectively and interpersonally, thus, more durably quieting the maladaptive traits and symptoms associated with borderline pathology. In addition to its effectiveness in reducing BPD symptoms, studies of TFP have indeed found it to be effective, in contrast to supportive psychodynamic therapy and Dialectical Behavior Therapy (DBT), in increasing reflective functioning[8] thought to be an indicator of structural change and in dimensions thought to constitute psychic structure as defined in the authors' model, that is, domains of identity and defensive functioning.[9]

TFP is the outgrowth of a group of clinicians and researchers working and studying over the past 30 years at the Personality Disorders Institute of the Weill Cornell Medical Center. Through weekly consultation and study group meetings, and multiple psychotherapy trials,[3,8,9] a conceptualization of the internal, underlying, psychological structural features of borderline pathology has been developed, along with an assessment method[10,11] and well-operationalized treatment protocol.[2,3] The work of TFP involves analyzing the defensive processes that support the split sense of self that is hypothesized to underlie many of the *Diagnostic and Statistical Manual of Mental Disorders'* (*DSM*) personality disorders, including BPD. The ultimate goal of TFP is to help patients better understand the need for and function of those defensive processes with the hope of promoting and helping patients to tolerate a more realistic, adaptive integration of positive and negative representations of self and others that will translate into a richer sense of self and a fuller appreciation of others; on the broadest level, the treatment helps individuals move from perceiving themselves and others through the lens of simple and extreme internal representations to appreciating their own and others' complexity.

BORDERLINE PERSONALITY ORGANIZATION AS A PATHOLOGY OF INTERNAL OBJECT RELATIONS

The authors' model of personality disorder, deriving from contemporary object relations theory, posits that experiences of the self in relation to others are organized in the developing mind according to a split between experiences that are rewarding, gratifying, and pleasurable and those that are frustrating and painful. Under conditions of adequate nurturance, stability, emotional containment, and within-normal-limits genetic loading, the developing child is eventually able to reach a stance in which important people in their world can be represented in a more realistic, balanced, and mixed representation, one in which the good qualities of the person are not lost

to conscious awareness under conditions of stress or frustration (a whole-object position or object constancy). However, under adverse conditions (characterized by chronic trauma, parental abuse or neglect, a poor match between child temperament and parental attunement or empathic capacities, and/or a genetic loading for aggressive temperament), the frustrations presented to the child overwhelm the developing coping systems, resulting in a defensive split in the experience of the parental figures in which good experiences and representations of those figures are kept separate in the mind from bad/frustrating experiences and representations and with an overall emotional valence that is negative and tinged with aggression. Over time, these various experiences of the self-in-relation-to-other, whether good and bad representations are split or not, are consolidated or organized and internalized as a set of expectancies or relationship templates in the mind at which point they can be referred to as internal object relations or simply object relations.

The authors indeed think of these internal representations as *relations*, that is, a representation of the self, *linked by an affect*, to a representation of another (Fig. 1). Examples include, an inadequate self, linked by fear, to a critical other; a mistreated self, linked by rage, to an exploitive other; an accomplished self, linked by pride, to an admiring other. These relationships are *internal* relationships, all encoded in the psyche early in life through the impact of highly salient, patterned, *actual* relationships that, because of the impact of unconscious processes (desires, fears, fantasies), may take on an exaggerated nature as they are internalized in the psyche. In turn, these internal representations of relationships color and to some extent distort actual relationship experiences based on one's internal expectancies, wishes, and fears. It is the internal array of these self-object dyads, whether the positively and negatively valenced dyads are split or integrated, which are more prominent, regularly experienced, and affectively charged, that defines the quality of the individual's developing *identity*. Identity can be thought of as the ego function that organizes our internal object relations, in turn shaping both the structure (integrated, flexible vs split, rigid) and outward expression of the individual's personality as revealed to us in the consulting room.[11,12,13]

Identity pathology or diffusion is considered a hallmark of borderline disorders and is diagnosed when such a defensive split between good and bad internal representations or experiences of the self and others persists into adult life. Patients with BPD are characterized by black and white thinking, in which the self and others are experienced as caricatured extremes, with little nuance or integration of positive and negative attributes, and with rapid shifts between positive and negative experiences of self and others. This internal split leaves patients vulnerable to typical borderline symptoms, such as mood lability, idealization/devaluation, instability, and a lack of

Fig. 1. The object relations dyad.

coherence in the sense of self, with corresponding difficulties in the steady, realistic experience of others.

Identity pathology is supported by patients' predominant use of what psychodynamic clinicians call splitting-based or primitive defenses. These defensive processes, which operate out of conscious awareness, serve to maintain the split between radically negative and positive experiences of the self and others that, were it to break down, would lead to affective experiences that would be disturbing or even overwhelming. Individuals with such split internal psychological organization do not generally consciously experience the aggressive, hostile affect within them as their own (even though they may express them in action). Aggressive affects are generally projected and seen as coming from others. This perception leads to a generally untrusting, even paranoid stance toward others, while protecting the self from the disturbing awareness that one's emotional difficulties emanate from within the self. Because of this, borderline patients often use the defense mechanism of omnipotent control. A strategy operating largely outside conscious awareness, in which the interpersonal dialogue and interaction with others are subtly or grossly controlled so as to bypass experiences or discussions that would be threatening to the self by challenging the patients' dominant narrative. This control operates so that the interpersonal dialogue and interaction bypass experiences or discussions that would be threatening to the self by challenging the patients' narrative version of how things are. Idealization/devaluation helps patients maintain the wished-for, all-good representations of the self or others, for example, but frequently results in sharp shifts to disappointments in self and others, thus, avoiding a more complicated, anxiety-laden but more realistic experience of self and others. Similarly, externalization helps patients maintain favorable images of the self, whereas projective identification results in the assignment (and often unconscious induction) of unwanted self-representations to others, with the patients still expressing (identifying with) those very characteristics, albeit unconsciously.

It is likely that many of the problems that characterize the personality disorder diagnostic system in the latest iterations of the *DSM* (eg, criterion overlap, heterogeneity within diagnostic categories)[14,15] can be explained, in part, by the hypothesis that most personality disorders share underlying features that have yet to be fully elaborated and incorporated into the diagnostic system. The *DSM* in versions IV and 5 suggest this very fact in the narrative introduction to the personality disorders, noting that the personality disorders as a group are defined by some combination of problems in self-regulation, the experience of self and others, and corresponding interpersonal difficulties. The Alternative Model for the assessment of personality disorders in *DSM 5* elaborates these criteria even further. In combination with several maladaptive personality traits that vary across the various personality disorders, the general criteria specify impairment in self and interpersonal functioning, defined further as difficulties in the areas of identity and self-direction (self) and empathy and intimacy (interpersonal relations), criteria that are congruent with the Kernberg's concept of borderline personality organization (BPO) as a pathology of internal object relations, described earlier.[12,13]

Assessment of Borderline Personality Organization

A careful evaluation typically extending across 2 initial meetings is central to the initiation of TFP. The evaluation sessions are directed by the therapist, allowing him or her to obtain the information necessary for establishing both phenomenological (*DSM*) and structural diagnoses and identifying borderline features, such as impulsivity or self-injury/suicidality, that might complicate or threaten the nature of the treatment being proposed. During the evaluation session, the TFP-trained therapist typically follows the outline of the structural interview, a free-form clinical interview that asks the

patients to describe current areas of difficulty (emotional, physical, and cognitive) with the therapist listening and probing the nature, extent, and history of those difficulties.[12] While establishing the presence or absence of axis I pathology, the therapist is also taking note of the patients' behavior during the interview and defensive style in response to the interviewer's questions: are patients guarded, defensive, and hostile or are the patients' responses believable, elaborated, and realistic, clarifying openly issues that may have been at first unclear? And what is the interviewer's feeling during the interview: are his or her probes welcome and considered or are they dismissed, with him or her feeling devalued, stonewalled, and controlled? The concurrent test of the defensive system through gentle bids for elaboration and from the presentation of conflicting pieces of information in the patients' narrative that make the presentation unclear, points either toward or away from a diagnosis of splitting as a predominant defensive strategy.

The diagnosis of BPO is further clarified through the therapist's direct inquiry related to the patients' sense of identity, his or her sense of coherence and authenticity across time and situations, the narrative description of self (elaborated, multifaceted, nuanced vs superficial, caricatured, stilted), and the sense of stability of moods and self-esteem over time. The patients' ability to direct themselves in the area of the primary role (work/school), the capacity to invest the self in these areas as well as in recreational pursuits, is also diagnostic of identity health or pathology.[a]

Direct assessment of features of BPD, including mood lability and a propensity toward anger and impulsivity, including self-injury and suicidality, is also required in order to establish the specific personality disorder diagnosis. Assessment of stability and valence of self-esteem, feelings of entitlement, the capacity for empathy, the experience of envy, and the patients' need for and response to admiration and its absence would help to clarify the presence of significant narcissistic features within the borderline range. Within the borderline range, 3 specific factors help locate patients on a spectrum of severity and provide a guideline for prognosis:

- What is the nature of the patients' aggression? How controlled, severe, and frequent is their expressed aggression; is it directed against the self, others, or both?
- What is the patients' capacity for guilt, remorse, concern for their actions, and the effects of the same on others? Are patients guided by any internal moral compass that can serve as a check against impulsive, reactive aggression?
- What is the state of the patients' interpersonal relationships? Are patients socially connected, are there social supports, and do patients have any nonexploitive, reciprocal relationships with others?

The greater the extent of the aggression, as described earlier, the less concern and remorse related to that aggression; the poorer the state of the patients' interpersonal relationships, the lower in the BPO spectrum the patients fall and the poorer the patients' prognosis in TFP.

After confirming the diagnosis, 2 further crucial steps are required to complete the pretreatment process. First, the patients' *DSM* diagnosis, and the syndrome of BPO, the structural diagnosis, must be shared with patients. Although controversial, the

[a] The Structured Interview of Personality Organization, a semistructured interview that operationalizes the aforementioned structural interview, provides clear language for the assessment of identity, primitive defenses, and several additional domains relevant to the assessment of personality organization.[11]

authors often find that sharing this diagnosis, and explaining the patients' symptoms as reflecting an inner problem with one's sense of self (identity), with corresponding difficulties in self-regulation and emotion regulation, and difficulties in interpersonal relationships, helps patients to contextualize the PD symptoms in the story of the person. Said differently, that one's underlying difficulties feeling at home in oneself, stable in one's sense of self over time, with corresponding shifts in the experience of self and others, helps to explain the symptoms of BPD as well as the related feelings of emptiness, depression, and anxiety that often bring patients into treatment in the first place.

Second, and the last step before initiating TFP proper, is the establishment of a *treatment contract*, an agreement with patients as to the conditions of treatment, the mutual expectations of the therapist and patients, and an agreement concerning the management of patients' behaviors that have the potential to disrupt the conduct of an exploratory, psychodynamic treatment.[16] For patients prone to self-injury, medication misuse or alcohol/drug abuse, eating disordered behavior, or excessive out-of-session contact with the therapist, these behaviors can at times pose a serious threat to the patients' well-being and also to the treatment and, if uncontrolled, can compromise the therapist's ability to work with patients from the exploratory stance required to conduct TFP. Participation in adjunctive treatment groups related to alcohol or drug abuse or eating disorders or merely an agreement to refrain from and promptly report and seek treatment of self-injury when it does occur are examples of parameters that provide both the patients and therapist some reassurance that the treatment can proceed without these issues compromising either's ability to participate in the treatment. Adherence to the treatment contract is often inconsistent in the treatment of patients with BPD, and instances of a lack of adherence would be explored in the therapy; but without establishing such parameters at the outset, the treatment cannot become the sufficiently bounded and containing venue for the discussion and analysis of the patients' inner conflicts and lived difficulties (for further elucidation of issues related to treatment contracting see [2,16]). An additional aspect of the treatment contract involves a stipulation that patients engage in some structured activity (job, education, training) during the course of treatment. This stipulation guards against the treatment supporting secondary gain of the illness in the form of passive, or exploitative, retreat from the responsibilities of living. This aspect of the treatment contract also forces patients to confront the actual capacities for functioning, as well as their limitations, to engage in real-time conflicts related to submission and collaboration, ambition, striving, and the associated impulse to withdraw from life's challenges.

In addition to these patient-specific parameters, the universal features of TFP treatments (the twice-weekly frequency, clearly establishing that the treatment takes place in person during the sessions, and limiting extra session contact to logistical matters, ie, issues related to vacations, scheduling, and billing) are also clarified. Establishing these aspects at the start of treatment allows the therapist and patients the ability to explore deviations, or expressed wishes to deviate from the contract (and the meaning of the same), and what they say about the patients' personality as it gets played out in the relationship between patients and therapist in the treatment process.

CASE OVERVIEW

When Tina presented to the therapist, self-referred, for the treatment of her BPD, the therapist was somewhat taken aback. "I found you on the web, and need an expert in borderline; I know I can't afford you, but I'll get a job to pay for the treatment because I know I'll die if I can't get help for this." She was self-educated about her condition,

spot-on in her self-diagnosis, and indeed serious in her desire for treatment. Tina had been through various treatments for depression and anxiety, none of which had addressed her outbursts of rage, her impulsive suicidality, the volatile social and romantic relationships that she had burned through, and the toxic attachment to what seemed to be a bipolar and highly abusive mother, with whom she was currently living.

Tall and attractive, Tina glided down the halls of the therapist's suite and fell into the office chair, immediately dropping her head dramatically onto the armrest and flipping her long hair over her face. From this awkward physical perch, in the most childlike voice imaginable, she articulated her self experience: "Nobody loves me. I feel like a mishmash of broken parts that nobody else wants." She described never feeling sufficiently attended to, from periods of severe and traumatic early childhood neglect to her current life when she could never obtain sufficient attention or praise from those close to her along with associated outbursts of rage when she experienced insufficient regard or attention. She described the experience of feeling repeatedly let down, taken advantage of, and mistreated, a victim, in her mind, of a callous, cruel world. Collateral reports from the hospital from which she had recently been discharged (after being hospitalized for 2 weeks after a suicide gesture) indicated that she had spat on the admitting nurse and had several outbursts of rage while on the unit, with little demonstration of remorse. Tina dismissed these incidents, still in her most high-pitched, childish voice, as completely justified and in no way contradicting her sense of self as a victim. She became silent and angry with the therapist when pressed further on this contradiction, which suggested the operation of splitting-based defenses that serve to reinstate in her mind the internal situation with herself as the helpless victim of a cruel, persecutory outside world while elucidating that very same dyad, for the first time, in the transference.[b]

Tina had graduated college but with tremendous difficulty, including 2 leaves of absence due to depression. The therapist's inquiry into these episodes yielded a vague report that did not confirm the presence of a major affective illness. Rather, both involved lengthy stories of interpersonal drama and conflict, one involving her mother and the other involving the breakup of a chaotic long-term relationship. Tina's history of alcohol abuse and cutting were explored and, again, seem to be related to the volatility of her interpersonal relationships. Rage at the hint of abandonment by boyfriends, impulsive coping with interpersonal stressors, associated with rage and mood lability, all suggested a borderline diagnosis. Tina's experience of the self alternated sharply, with her enacting rage and control while alternately feeling weak and victimized. Her tastes and preferences shifted according to whom she was with as did her dress and her expression of her values (*very* strongly held but at the same time regularly shifting). Her self-esteem vacillated between her feeling broken and incompetent and a realistic appraisal of her actual talent and intellect; Tina had in fact begun studies at a prestigious law school only to drop out late in her first term under the stress and volatility associated with a new romantic relationship.

Tina's prognosis was guarded; severe hostility and aggression were typical, somewhat uncontrolled, and expressed without apparent concern for their effects on

[b] In the case of patients operating under the influence of splitting-based defenses, the therapist's bid to have patients clarify conflicting pieces of data (between either 2 aspects of a verbal report, perhaps been 2 informants, or between the patients' verbal report and behavior outside the session) often results in a more paranoid stance and in the enactment of the internal world *in the transference*. Once in the transference, it can be explored from an emotionally active stance in the very moment when it is being experienced, a feature of the treatment process that is central to TFP.

others. Tina's interpersonal relationships were chaotic, on and off, and unsatisfying; she had almost no true social and emotional supports. Tina's work ethic, intelligence, and the absence of antisocial features, however, suggested the potential for growth in TFP. Tina agreed to a treatment contract in which she would refrain from cutting herself or from other self-injury, agreeing that she would contact an emergency department or call 911 if she experienced urges that she could not control to hurt herself in such a manner. She agreed to adjunctive Alcoholics Anonymous meetings if she continued to engage in binge-drinking episodes and also agreed to seek employment. And indeed, shortly after the start of treatment, Tina found a job as a paralegal, which she sustained throughout our work, and at which she excelled.

THE PRACTICE OF TRANSFERENCE-FOCUSED PSYCHOTHERAPY

The work of TFP involves setting up a therapeutic environment in which the patients' split-off, internalized object relations (ones that are subjectively experienced by patients and ones that are enacted in behavior or experienced via projection by those in the patients' surround) are reenacted and observed in the treatment relationship. The conditions of treatment include elements such as session frequency, the instruction to the patients to engage in a modified free-associative style with particular attention to priorities related to self-destructive and treatment-interfering behaviors, and the therapist's stance, which is limited to efforts to clarify, challenge, and explicate through interpretation rather than providing overt guidance and support. All of these elements are designed to facilitate the reactivation of the patients' internal object relations in the treatment, where they can be explored, interpreted, and discussed.

The authors' summary of TFP as a treatment involves a description of 3 elements (Fig. 2). The authors refer to strategies in TFP as the long-term goals over the course of treatment, their efforts to help patients make sense of their inner world of object relations, the associated emotional states, and to track the manifestations of the same in their daily interpersonal life and in the treatment relationship. The tactics of TFP establish the boundaries and priorities of the therapeutic process, much of

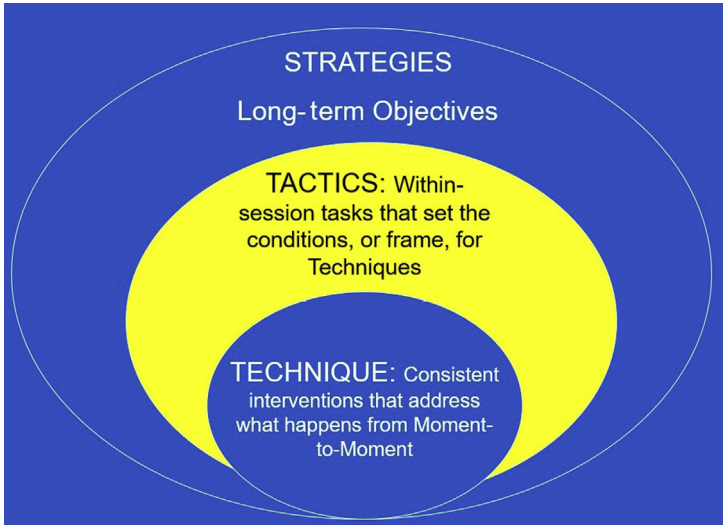

Fig. 2. The relationship of strategies, tactics, and techniques.

what clinicians mean when speaking of the treatment frame. Last, the techniques of TFP are the interventions that the authors practice within the sessions, including the nuances of their interpretive technique, the stance from which they interpret, and the data they use to inform their interpretations. All 3 of these aspects are discussed in turn, below.

The authors' discussion of the strategies, tactics, and techniques of TFP takes place through the lens of the treatment of Tina. The initial several months of treatment were marked by Tina's presentation of the chaos and emotional volatility of her life. Anger at her mother's verbal abuse, which in turn amplified an internal sense of being unworthy of love, stupid, and unable to make good life choices. Tina tested the treatment contract, calling the therapist provocatively one evening, drunk after a fight with a man she had been seeing, unclear if she could keep herself safe or not (The therapist was able to speak with a friend who agreed in this instance to get her home safely, which in fact occurred.) Their discussions of such incidents and of her rage at others and at the therapist dominated their early work, with Tina experiencing the therapist in 2 ways: as a cold, uncaring, neglectful parent, with her a victim of the therapist's neglect and as an idealized savior who, if she could only get the therapist to, would love her and make all her difficulties and conflicts go away.

STRATEGIES

Every mode of treatment must answer the following question: For what do we listen in the treatment and where and when do we choose to intervene? In TFP, within a session and over time, therapeutic attention is constantly tracking the dominant affect at any given moment. Are patients angry, sad, contemptuous, arrogant, for example, and how is the affect being expressed? One consistent observation from the authors' work with patients with BPD is that often the most important information at any given moment is being conveyed less through the patients' verbal narrative than through the patients' behavior, or via projection, experienced in the countertransference. Indeed, the therapist's reflection on his or her own affect at any point (why am I feeling unsettled, confused, compassionate, loving, rageful?) can be very helpful identifying the dominant affect.

Once the dominant affect is identified, we can begin to attach to it the patients' self-representation that is active at that moment and the corresponding representation of the therapist. It is this basic framework, described visually in **Fig. 1**, that is the primary compass for intervention in TFP. The first task is to name the actors and the interaction or to share with patients how they seem to be experiencing themselves and the therapist, as the affects shift across the session, and to ask questions (clarifications) that help to better understand both the affects and self states active in those moments. Helping patients learn to track their affective states and how they are feeling about themselves and the therapist at those moments is the baseline work of TFP. What the authors often find in patients whose internal world is unintegrated as described earlier is that they experience abrupt shifts in their self-other experience, that is, that the roles, or poles of the dyad reflected in **Fig. 1**, reverse: At one moment the patients feel weak, inferior, and are fearful (the dominant affect in patients) of attack. Yet, in response to an intervention inviting the patients to reflect on something painful, or to attempt to clarify something confusing to the therapist, or perhaps in absence of some expected validation or support, the patients may move suddenly to the attack, berating the therapist (**Fig. 3**). Such reversals in the dominant self-object dyad can also happen unprompted by the therapist: in one session a patient

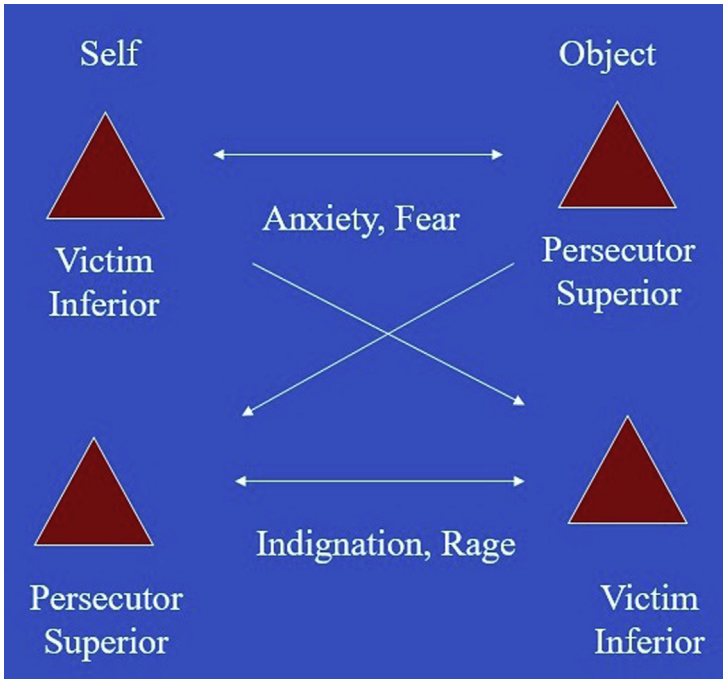

Fig. 3. Oscillation of the object relations dyad. The identification is with the entire relationship not just with the self-representation or the object representation. The dyad exists within the individual; its basic impact is on the self relating to self, although it regularly gets expressed between self and others.

arrives feeling downtrodden, ineffective, weak, and envious of those whom she sees as more comfortable, healthy, attractive, or successful; another time the patient may come in full of indignant rage, contemptuous and superior, of others and the therapist. Part of the strategies of TFP is to track these shifts, or oscillations in the self-object dyads as they unfold in the treatment process.

Although much of the work with the authors' patients in the borderline range is dominated by the work with their patients' negative affects, their anger, contempt, disappointment, and frustration. In TFP, the authors always strive to bear in mind that these persecutory dyads generally defend against awareness of a set of wished-for relationships in which an idealized self is met by and cared for by an idealized world and therapist/caretaker. The authors' experience with patients in the borderline range, however, is that these ideal wished-for relationship dyads are also fraught, because they, like the negative persecutory dyads, do not fit the complexity of the real world. Because the internal world is managed through splitting-based defenses, the wished-for relationship is not simply a realistic good enough other but an idealized other, one that is unrealistic in that it never disappoints, frustrates, or deprives. The following might be the expression of an idealized dyad: I want to be your perfect patient, saying the right things, deserving of praise and affection, and I long for your perfect, never-wavering attention and care.

Although patients might on the surface deny this wish as unrealistic, their difficulty tolerating a view of the self that could be kind and smart but at times demanding, angry, and confused generates a pressure for perfection in the self and a

corresponding need for perfection in the therapist, constituting an idealized dyad that superficially feels positively valenced but that also screens considerable aggression, an aggression that inevitably arises with the frustration of not finding the other, as ideal as hoped (or, alternately, not being the ideal self). When the brittle, idealized bubble bursts in the process, the shift is often abrupt, throwing the patient and therapist right back into the persecutory sphere: I was no longer the therapist from whom you wanted care (because I presumably have something of value that you need); I am now a depriving sadist who never understands you and endlessly frustrates you because I do not provide perfect care.

In this manner, the authors think in TFP of the layering of dyads (**Fig. 4**). Persecutory dyads can often shield (underneath the surface level fear and anger) a powerfully longed-for relationship that patients can hardly bear to express. This situation is frequently the case with narcissistic patients for whom the admission of any desire for something or someone not part of or fully possessed or controlled by the self would be a humiliating admission of dependency and need.[7,17,18] Analysis of the idealized dyad, along with the implicit intolerance of *any* imperfection in self or therapist/other, and of the relationship between the idealized and persecutory sphere is the last and most far-reaching level of the longer-term TFP strategies and the level that ultimately contributes to the easing of the rigid splitting of positive and negative sectors of experience that characterize the internal world of patients in the borderline range.

TACTICS

The tactics of TFP involve the establishment of conditions for psychodynamic treatment that will allow for the safe and effective conduct of TFP, that is, the exploration and containment of the urgent priorities and clinical difficulties in the patients' life, in a format that the authors have outlined as effective for borderline pathology. As discussed earlier, the treatment contract establishes the logistical frame of the treatment as well as patient-specific conditions designed to limit self-destructive acting out so as to protect both patient and therapist, and their abiltity together to conduct TFP. Other tactics in TFP involve the patients' adherence to the treatment priorities, in which free association is modified to reflect a prioritization of self-destructive or

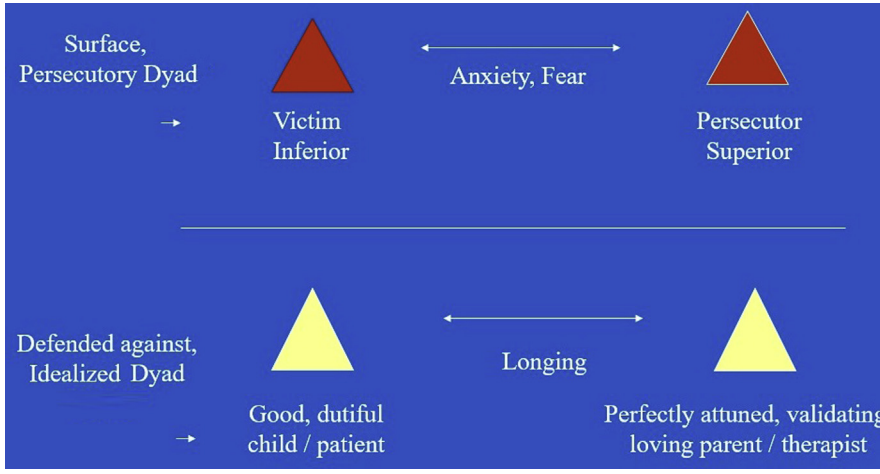

Fig. 4. Layering object relations dyads.

suicidal impulses, followed by behaviors that might interfere with the treatment (urges to skip sessions, quit, change medications, make major life changes, and so forth) followed by any other material that reflects the central conflicts and difficulties in the patients' life and for which they sought treatment. The aforementioned tactics, and the central guideline for the therapist's listening stance of tracking and intervening around the area of the dominant affect, is a final within-session tactic in TFP.

TECHNIQUES

TFP therapists strive to intervene with their patients from a stance of *technical neutrality*. Such a listening and interpretive stance does not imply indifference or a lack of affective engagement but rather one in which the therapists' affective responses are used to inform them as to the dominant self-object dyad, and their interventions remain focused on elucidating and interpreting, rather than taking one particular side in the patients' conflicts or promoting one part of themselves in contradiction to another. In fact, a key difference between TFP and more supportive-expressive psychodynamic techniques[19] is that in TFP therapists do not see their role as one of actively promoting the healthier, more likable or socially desirable parts of the patients. Rather, their task is help patients see the complexity of their selves and others and understand their difficulty retaining and living with that complexity and the need for the defensive processes used to keep unwanted experiences of self and others separate. Technical neutrality is not a pure state that can be objectively discerned. Our own internal pressures, desires, and limitations pull us in one direction or another with respect to patients' conflicts. And for sure our patients would, in many cases, love for us to tell them what to do and whom to love and to play the role of the guru. Part of our therapeutic awareness in TFP involves attending to neutrality, thinking about why we have deviated, and how to return to a more neutral stance. In certain cases, say involving dangerous acting out, we need to move out of neutrality deliberately and authoritatively to protect the patient or the treatment. Such deviations are to be expected. Once the crisis is averted, however, a discussion with patients of the conditions that drew the therapist into such a supportive or directive role should ensue.

The technique of *transference analysis* is used throughout the process of TFP. In tracking affects that emerge in the treatment process, and through our interventions, we invariably witness the reactivation of patients' internal object relations as experienced in the patient-therapist dyad. We see a dominant self-object representation say, in the case of Tina, figuring herself as a weak victim, needing the therapist's care and of the therapist figured as dismissive, mean, and insufficiently attentive. The identification of the dyad active at any given moment in the patient-therapist relationship (see **Fig. 1**), and the dominant affect in the patients associated with the self-representation, and the dominant affect associated with what is projected by the patients, that is, the countertransference, is the main thinking activity of the therapist in TFP.

Associated with the consistent attention to and analysis of transference is the therapists' attention to their *countertransference*, here defined as reactions to the patients in total, but particularly in response to the patients' transference, their projection into to the therapist of unwanted, difficult-to-tolerate self states and representations. It is well known that patients in the borderline range, because of the intensity of affects and the predominance of projection-based defenses, pose significant countertransference challenges to therapists. We feel pressured to be the

good object, sensing our patients' needs and/or fearing our patients' anger, and can easily be seduced by their loving and erotic feelings (sometimes more a manifestation of their aggression or devaluation than love) and repelled by their shamelessness and callous disregard for self and others. Awareness and tolerance of one's countertransference and the capacity to contain one's own intense affects are central features of countertransference management and also central to our ability to intervene from a technically neutral position.

The primary technique of TFP involves the interpretive process,[2,3,20] one that closely tracks the strategies of TFP outlined earlier, that is, identifying and naming the dyads as they emerge, their oscillation in the treatment process, and their defensive function against other layers of dyads. *Clarification* involves efforts to understand with the patients what dyad is dominant at a given moment, to *seek* clarification as to what the patients are telling us at a given moment and why, and how they feel about what they are saying. Our clarifications help us to identify the dyad, for example, with Tina, her sense of self as a weak victim, needing the therapist's care, and of the therapist figured as dismissive, mean, and insufficiently attentive. *Confrontation* should not be confrontational or adversarial but rather involves the tactful presentation of contradictory aspects of the patients' experience to then, for examination: You say you're so afraid, yet you are scowling, in a manner one might take to be threatening. You're speaking about an event you said was extremely painful, yet your expression seems to have a wry smile, as though you were almost playfully curious about what my reaction will be. Confrontations, which are essentially an invitation to reflect, can be difficult for patients, as they serve as the gateway technique for the analysis of splitting; through confrontation we effectively point to different parts of patients that are being kept separate from one another. Confrontations are also central to the second level of interpretation and strategy in TFP wherein we work with the rapid reversal of the dominant surface dyads (see **Fig. 3**).

	Have you noticed, Tina, that in most sessions, you start off in this very quiet, meek voice, as though you're this lost child needing someone to take care of her?
Tina	(childlike, pouty, but with a smile) Why are you picking on me?
	I'm struck here: you navigated college and did well, and are now doing sophisticated legal work at a high level of skill and organization - seems hard to reconcile that with the little girl you present to me.
Tina	That's different. That's there, at work. That's not how I really am.
	Really are, or is it that there are two parts that are both really you, but that it's hard to show me both sides. Here, I have to be the strong/competent one, and you the one needing the attention and care.
Tina	I've never been taken care of; nobody cares to pay attention to me.
	So I wonder if that's the point: if seeing me as competent and you as the weak one needing care keeps you from avoiding the anxiety of being competent yourself. If you're competent, I imagine you feel anxious you might lose the attention and care that you for so long have been fixated on.

In this example, the therapist works to present to Tina a contradiction between her verbal report and behavior in session and information from elsewhere in her life, offering a trial interpretation related to her need to keep these parts of herself separate.

This dyad was just one of the dominant dyads that Tina presented in the authors' work. Early in the treatment, they also began to explore the vicissitudes of the dismissing, cruel parts of herself previously projected into and experienced in the person

of the therapist, now enacted at various points by Tina herself. The task was to help Tina become aware, through tracking these oscillations, that both of these poles belonged to *her*. Tina was highly argumentative, ironic for someone overtly demanding greater attention and care, frequently rejecting the therapist's observations, finding them difficult to tolerate and in turn dismissing the therapist. Over the initial months of the treatment, Tina would at times present in a state of disappointment or contempt for the therapist and the treatment, for example, "This isn't helping, what are we even talking about anyway, how is *this* supposed to help me?" In these moments, the therapist had access to a part of Tina that could be cold, unforgiving, and dismissive, with the therapist in the role of passive victim to her attacks, representations quite at odds with her dominant experience. The task here is both to acknowledge the shift in roles and to propose a hypothesis as what might motivate both the shift and necessitate the more polarized experience of self and other. This segment followed Tina's discussion of an annoyance related to her work and a brief mutual pause of several seconds in which the therapist was contemplating privately what she had shared.

Tina	You're not saying anything. Well this really is helpful (sarcasm).
Th	Tell me more about what was going on in your mind during my silence?
Tina	In my mind? I'm thinking great. You never give me anything. I tell you I'm upset about this work situation and you're silent. All I want to do is feel better, and that's what I come to you for, and you tell me all these bad things about myself or you're silent.
Th	You're anticipating I'm going to disappoint or be critical of you, that it won't be enough, that I…
Tina	You got it right for once! Bravo. Yes, you give me nothing. NOTHING.
Th	You seem more bent on telling me what I'm not giving you, what I'm going to do or not do, much more than actually *listening* to anything I might have to say. (Playfully now) You're giving *me* nothing now, in terms of *your* attention, and now I'm rejected.
Tina	Ha ha…nice move (pause)
Th	Nice as in manipulative….or nice as in *maybe something to look at here*? You can get into a mode with me at times where you need to insist on my uselessness, are not open to anything I might have to offer. You become the rejecting one: fair?
Tina	A bit.
Th	It seems that you look to me anticipating that I'll be cruel and rejecting, leaving you with nothing. To see *yourself* as the one who can also be rejecting is overwhelming, you feel then like *you* are the bad one. And I wonder if that leads to the uncomfortable question of whether people might actually have things to offer you, that you have a hard time accepting.

Tracking these shifts or oscillations within the persecutory sphere was central in expanding Tina's understanding of the link between various parts of her self and her emotional states and helping her form a more balanced and full appreciation of herself. It is only at this point, when patients can reclaim some aspects of the self previously managed through projection, that patients can begin to see the self and others with increased complexity rather than in the exaggerated ways that reflect the distortions of self and others affected by projection and other splitting-based mechanisms.

Although the aforementioned excerpt focused on oscillation of the dyad within the persecutory sphere, note also the hint of the idealizing dyad: "All I want is to feel better…." This point provides a useful transition to the third level of interpretation in TFP and the third aspect of the treatment strategies discussed earlier, namely, the interpretation of the layering of dyads.

Tina	Ok, so I'm dismissive. Now what? (pause) Sometimes your silence…I just don't know what to do with it. I feel like you're just leaving the problem with me.
Th	Your sarcasm around that, earlier, was biting: you are so ready for me to fail you.
Tina	This doesn't feel good. I don't leave here feeling better.
Th	You sought this treatment out from the part of you that knows that I'm not some therapy guru or emotional surgeon… no ability here to extract those bad feelings fully…
Tina	Of course I know that.
Th	And I know you do…Yet it seems that you also come in here with a different part of you active: the compliant, dutiful patient, expecting a response from me that is fully validating and that will somehow eradicate all the bad feelings you are sitting with, uncertainty, insecurity, your sense of being alone in the world, your impatience and frustration… and when I hesitate or pause, and you expect I'm going to fail you…
Tina	IT DOESN'T HELP ME OUTSIDE OF HERE, when I feel this way
Th	And then I'm nothing: the therapist you wanted something important from 2 minutes ago, who can really, really help you, becomes totally useless, depriving and cruel.
Tina	It feels that way.
Th	So hard to hold both experiences of me in mind: someone from whom you want something important, even if it leaves you with some difficult feelings and work to do. Holding onto an experience of me as both giving yet frustrating, caring yet at times disagreeing with you, is so difficult and threatening. The feeling is that what you need so much is compromised, *totally*, if I can't take care of everything, perfectly.

Tina would often portray herself as an attentive, compliant, and dutiful patient (child); she paid her bill regularly, got a job as discussed in the initial meetings, promptly, and said proudly how she had incorporated things they had discussed in their work. This experience of herself in the treatment paralleled her desire to be a dutiful, attentive daughter, friend, and girlfriend. And this representation of an all-good, dutiful self was accompanied by her longing for a fully receptive, admiring, and validating other (therapist, parent, friend, and so forth). The only flaw in this model is its failure to account for human fallibilty, that is, reality. The therapist's failure to understand her quickly enough, seeing things that felt important but of which she seemed unaware, and, above all, the fact that the therapist's best work would still not fully resolve her difficulties, leaving her with some painful feelings and difficult choices, was at times utterly intolerable. At such moments, the brittle idealized dyad would abruptly shatter and the dominant object-relation would become reinstated, with the therapist being cruel, dismissive, and useless.

Segments such as these, repeated over time and across various sets of dyads, ultimately help to break down the rigid split between idealized and persecutory segments of relationship experiences, leading to their integration, the resolution of identity diffusion as primitive defenses start to relax, and the corresponding ability to better modulate the intense affect states that characterize our patients' lives. That is, the brittle hypomanic, euphoric states become more integrated with other periods associated with persecutory, hostile, dysphoric states.

The authors hope that this overview of TFP and the case illustrating TFP with Tina has helped provide a lively and realistic sense of how this modified psychoanalytic treatment, specifically tailored to the pathology of split internal object relations, can be helpful in the treatment of borderline pathology. As a group, the authors continue to work to refine their theory and technique, particularly in response to developing empirical work on borderline pathology and their psychotherapeutic study of patients with personality disorder.

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