INTERNATIONAL PSYCHOANALYTIC UNIVERSITY

DIE PSYCHOANALYTISCHE UNIVERSITÄT IN BERLIN

PPRS IV

Psychoanalytic Process Research Strategies IV
June, 15-17, 2017

The Process of Interpretation and Change in Transference-Focused Psychotherapy (TFP)

Univ.-Prof. Dr. Stephan Doering

Klinik für Psychoanalyse und Psychotherapie

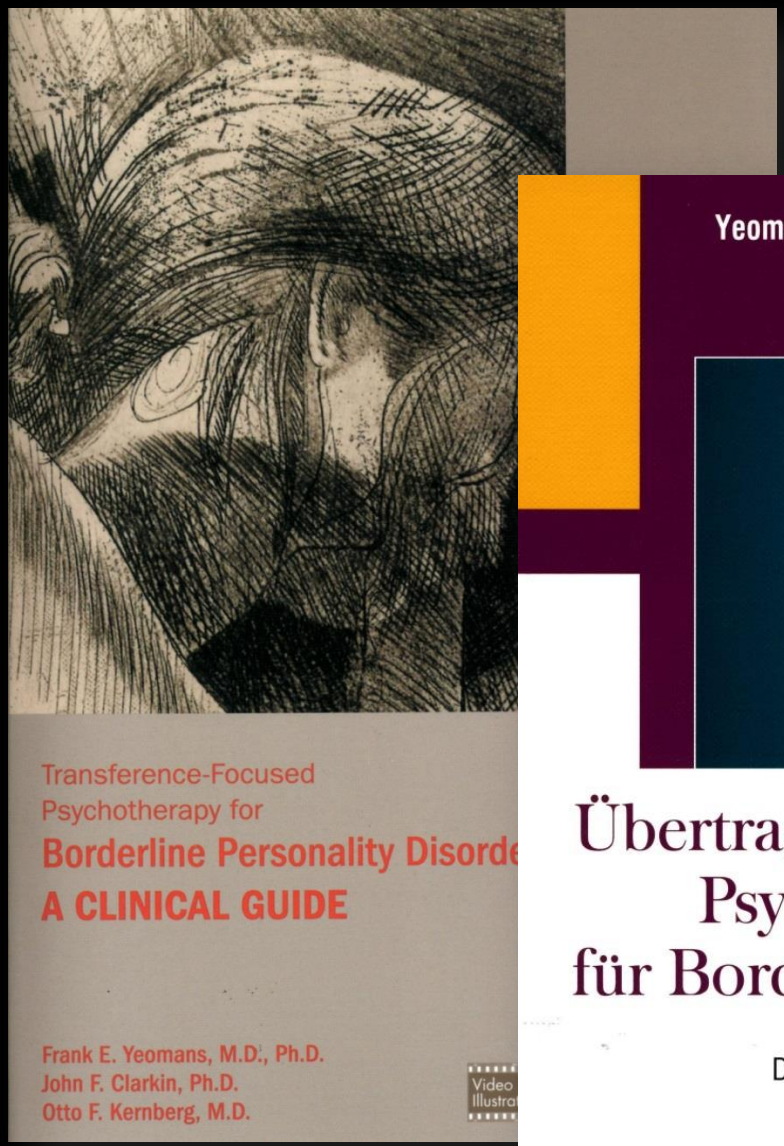
MEDIZINISCHE UNIVERSITÄT WIEN

Transferenz-Focused Psychotherapy (TFP)

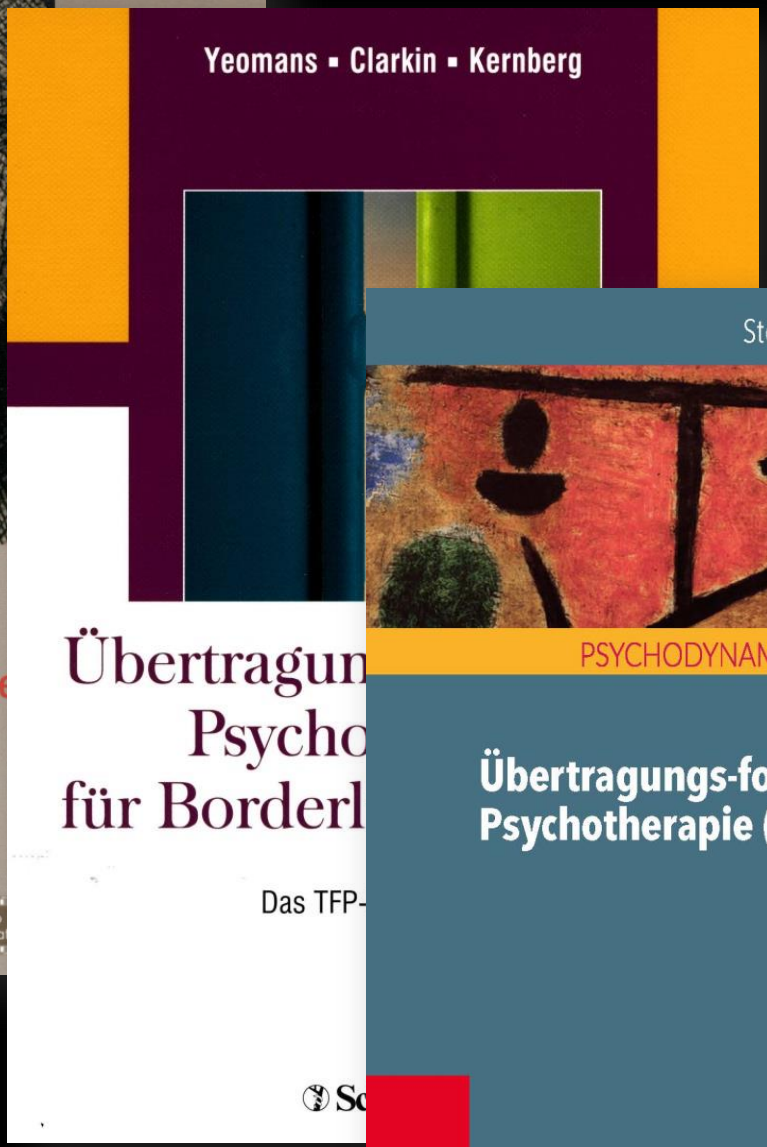
Transference-Focused Psychotherapy (TFP)

- *Developed by Otto F. Kernberg*
- *Modified psychoanalytic psychotherapy*
- *2 sessions per week face-to-face*
- *Focusing on transference interpretations in the here-and-now*
- *Techniques: Clarification, Confrontation and Interpretation*
- *Treatment contract*
- *Maintaining the frame of treatment – management of technical neutrality*

Frank Yeomans
John Clarkin
Otto Kernberg



2015



2017

2016

Article

Evaluating Three Treatments for Borderline Personality Disorder: A Multiwave Study

John F. Clarkin, Ph.D.
Kenneth N. Levy, Ph.D.
Mark F. Lenzenweger, Ph.D.
Otto F. Kernberg, M.D.

BJPsych | The British Journal of Psychiatry (2010) 196, 1–7. doi: 10.1192/bjp.bp.109.070177

Transference-focused psychotherapy *v.* treatment by community psychotherapists for borderline personality

Stephan Doering, Susa
Cord Benecke, Anna B

Background
Transference-focused psych
treatment for borderline per

Aims
To compare transference-fo
treatment by experienced c

Method
In a randomised controlled
out-patients were treated fo
focused psychotherapy or b
psychotherapist.

Results
Significantly fewer participar
transference-focused psych
and also significantly fewer
$P = 0.009$). Transference-focu
significantly superior in the

Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. (2014)
Published online in Wiley Online Library (wileyonlinelibrary.com). **DOI:** 10.1002/cpp.1915

Change in Identity Diffusion and Psychopathology in a Specialized Inpatient Treatment for Borderline Personality Disorder

Daniel Sollberger,[1]* Daniela Gremaud-Heitz,[1,2] Anke Riemenschneider,[1] Puspa Agarwalla,[3] Cord Benecke,[4] Oliver Schwald,[5] Joachim Küchenhoff,[1,3] Marc Walter[1] and Gerhard Dammann[1,2]

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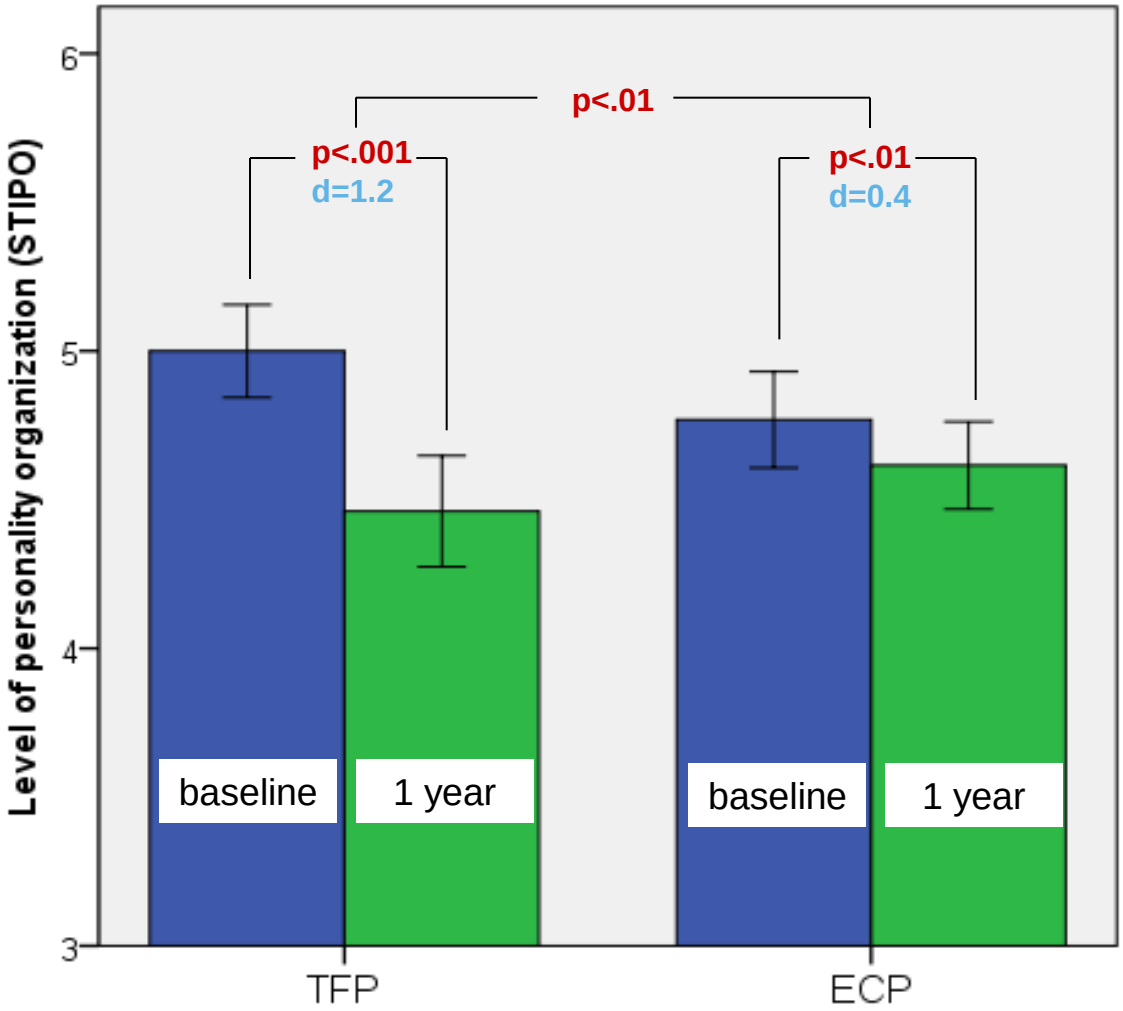
Objectives: Patients with borderline personality disorder (BPD) show various psychopathological symptoms and suffer especially from disturbance in their identity. The purpose of the study was to investigate changes—particularly in affective BPD symptoms and identity diffusion—during a structured, disorder-specific inpatient treatment (DST) that combined a psychodynamic transference-focused psychotherapy approach with modules of dialectical behavioural skills training.
Method: In a prospective, two-group comparison trial, 44 patients with BPD were assessed with questionnaires addressing identity diffusion and state, as well as trait affective psychopathology, before and after 12 weeks of inpatient treatment. Thirty-two patients received DST, whereas 12 patients were given inpatient treatment-as-usual (TAU). The patients were allocated in a non-random procedure for two groups, in order of admission and availability of treatment options in the DST unit.
Results: In the pre-post-comparison, the DST group showed a significant decrease in identity diffusion ($p < 0.001$) and improvements in instability of the image of self and others ($p < 0.008$), as well as in pathological (trait and state) symptoms. However, there was no significant improvement in the TAU group.
Conclusions: After a 12-week inpatient treatment, the findings indicate significant improvements in the DST group in typical affective borderline symptomatology and in the personality structure feature of identity diffusion. This highlights the significance of a short-term specific inpatient therapy for BPD.



ANCOVA
F=12.136; df=1, 101;
p=0.001

Significantly higher improvement of personality organization in TFP

BJPsych The British Journal of Psychiatry
1–2. doi: 10.1192/bjp.bp.113.143842

Short report

Transference-focused psychotherapy for borderline personality disorder: change in reflective function

Melitta Fischer-Kern, Stephan Doering, Svenja Taubner, Susanne Hörz, Johannes Zimmermann, Michael Rentrop, Peter Schuster, Peter Buchheim and Anna Buchheim

Summary
Borderline personality disorder is associated with … s in reflective function were significantly personality functioning and mentalisation. In a ra… th improvements in personality organisation. controlled trial 104 people with borderline person…

Table DS2 Paired *t*-tests and analyses of covariance of reflective function … to deal with missing values[a]

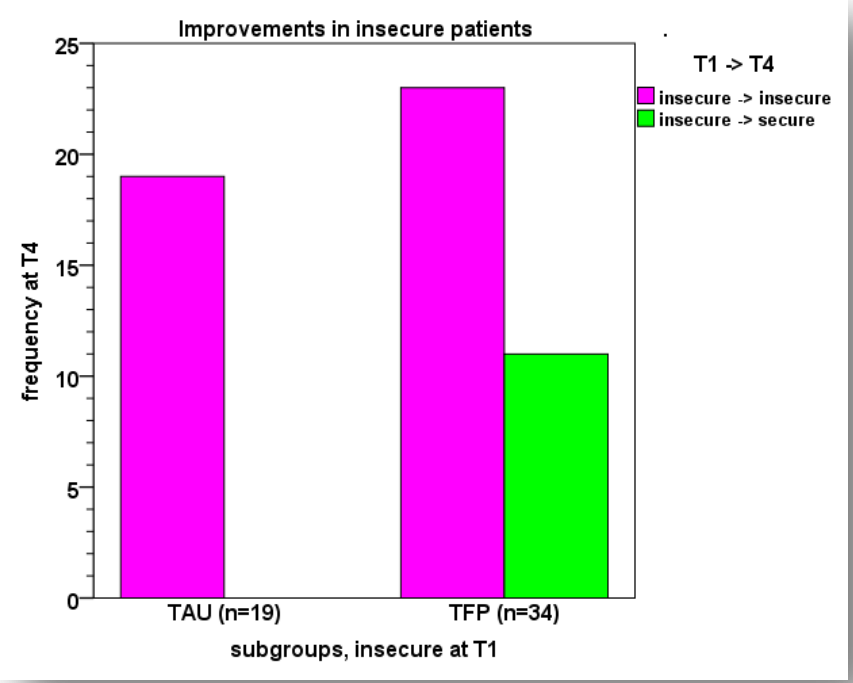
Measure	*n*	Transference-focused psyc… Baseline 1 year, mean (s.d.)	Paired *t* (d.f.)	… eatment by experienced community psychotherapists Baseline 1 year, mean (s.d.)	Paired *t*-test *t* (d.f.)	*P*	Within-group effect size, *d*	A… *F* (d.f.
Last observation carried forward	47							
Reflective function score			−2.998 (46		−1.000 (44)	0.323	0.07	6.648 (
Baseline		2.74 (1.28)		2.69 (0.95)				
1 year		3.15 (1.08)		2.76 (0.98)				
Observed cases	38							
Reflective function score			−3.062 (37		−1.000 (24)	0.327	0.12	4.280 (
Baseline		2.82 (1.29)		2.80 (0.96)				
1 year		3.32 (0.99)		2.92 (1.00)				
Multiple imputation	52							
Reflective function score			−4.047 (51		−1.235 (51)	0.317	0.14	5.394 (
Baseline		2.75 (1.26)		2.68 (0.98)				
1 year		3.31 (1.03)		2.82 (1.00)				

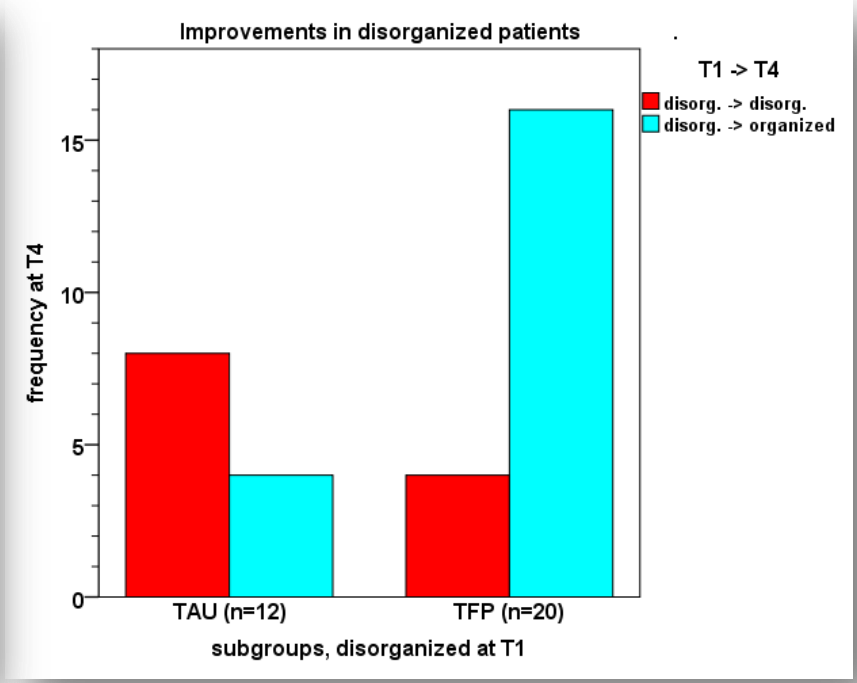
a. We used estimated marginal means (i.e. means controlled for baseline differences) and the pooled s… …pute Cohen's *d*. Since individuals who drop-out are unlikely to be missing complet… on multiple imputation can be expected to be the most accurate because they take into account that r… …or demographical and clinical characteristics at baseline (see online Table DS1).[14]

Within-group effect size, *d*	Between-group effect size, *d*
0.37	0.34
0.51	0.39
0.54	0.45

Change in Attachment Style

Buchheim et al. (Psychotherapy & Psychosomatics, 2017)





Significant improvement in TFP:

- *insecure -> secure attachment style*
- *disorganized -> organized attachment style*

Psychiatry and Clinical Neurosciences 2015 doi:10.1111/pcn.12357

Regular Article

Frontolimbic neural circuit changes in emotional processing and inhibitory following tran personality dis

David L. Perez, MD,[1†]
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Nicole M. Cain, PhD,[5]
Otto F. Kernberg, MD
Emily Stern, MD[1,2]*

[1]*Functional Neuroimaging L*
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Memorial Sloan Kettering Ca
New York, [6]*Department of P*
[7]*Department of Neurology, U*
Psychotherapy, University Ma

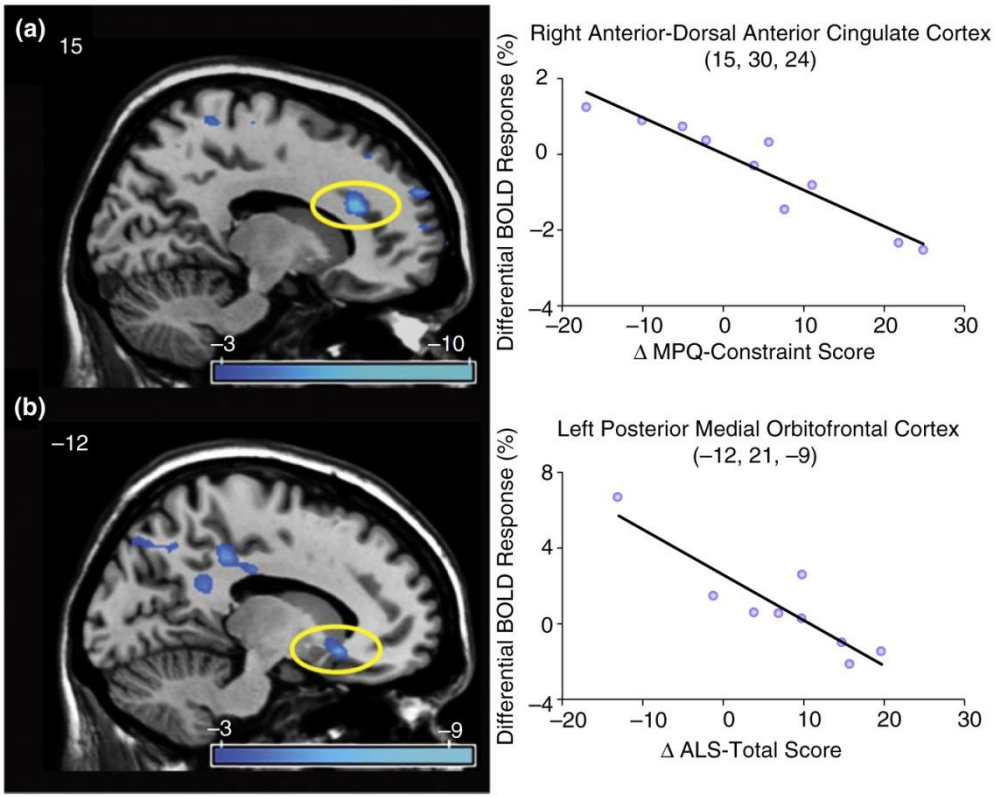


Figure 3. Pre-treatment dorsal anterior cingulate and posterior medial orbitofrontal activation negatively correlated with clinical improvement.

Panels (a)–(b) depict correlational analyses of pre-treatment-related effects on constraint and affective lability for the interaction (*pre-treatment*: [*negative* vs *neutral*] × [*no-go* vs *go*]) (Supplementary Table S2 and S4). Statistical parametric maps are thresholded at a voxelwise *P*-value of 0.01. Panel (a) shows an inverse correlation between pre-treatment activation in the right anterior-dorsal anterior cingulate cortex and post-treatment improvements in Multidimensional Personality Questionnaire (MPQ) – Constraint score (voxel-wise P-value < 0.001, corrected P-value = 0.002). Panel (b) shows an inverse correlation between pre-treatment activation in the left posterior-medial orbitofrontal cortex/ventral striatum and post-treatment improvements in Affective Lability Scale (ALS) – Total score (voxel-wise P-value < 0.001, corrected P-value = 0.013). X-axes formatted so that increasing values reflect clinical improvement. BOLD, blood-oxygen-level-dependent.

2012

Psychological therapies for people with borderline personality disorder (Review)

Stoffers JM, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K

Authors' conclusions

There are indications of beneficial effects for both comprehensive psychotherapies as well as non-comprehensive psychotherapeutic interventions for BPD core pathology and associated general psychopathology. DBT has been studied most intensely, followed by MBT, TFP, SFT and STEPPS. However, none of the treatments has a very robust evidence base, and there are some concerns regarding the quality of individual studies. Overall, the findings support a substantial role for psychotherapy in the treatment of people with BPD but clearly indicate a need for replicatory studies.

2012, Issue 8

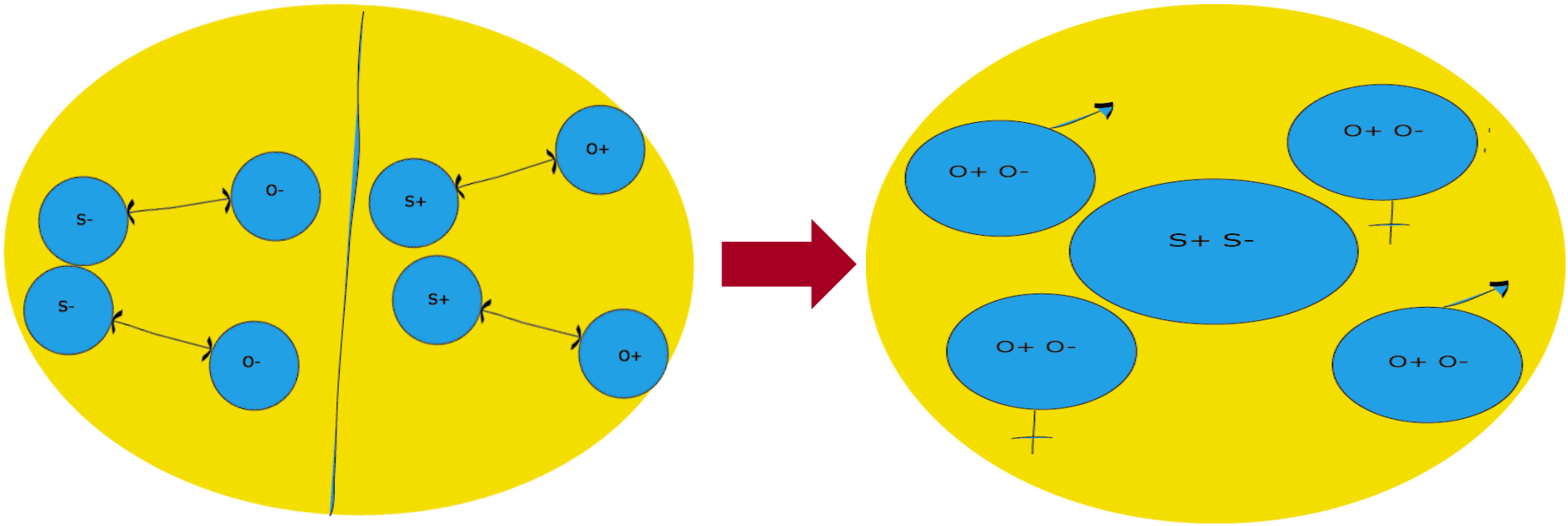
http://www.thecochranelibrary.com

Compared to the other borderline treatments, the strength of TFP might be its potential to change personality functioning and attachment status. TFP might be particularly indicated in patients with problems in the domains of interpersonal relationships and social adaptation.

Rationale of TFP

1. *Internalized split-off object relations become manifest (reactivated) in the transference realtionship between patient and therapist.*
2. *These relationship patterns are observed, identified, and denominated by the therapist.*
3. *Transference interpretation is the core technique of TFP.*
4. *The patient´s recognition and affective experience of split-of parts of his/her self leads to integration and overcoming identity diffusion.*
5. *Integration of identity -> improvement of personality functioning -> remission of symptoms.*

Identity diffusion: Core pathology of borderline patients -> impaired personality functioning -> symptoms of BPD



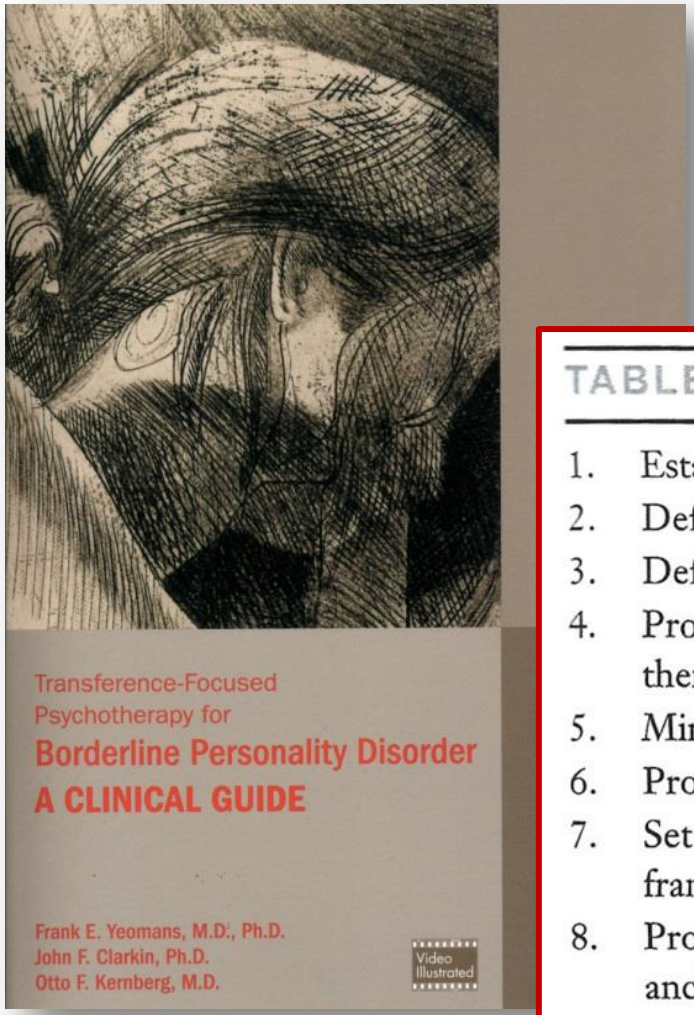
Internal world of a borderline patient

Internal world of a mature person

Process of Interpretation in TFP

1. *Treatment Frame*
2. *Technical Neutrality*
3. *Containment*
4. *Relationship Experience I („Tolerance“)*
5. *Transference Work (Taktics, Technique)*
6. *Relationship Experience II („Understanding“)*
7. *Transfer*

1. Treatment Frame



2015

TABLE 5–1. Functions of the treatment contract

1. Establish a mutual understanding of problem(s) to address in treatment
2. Define the reality of the treatment relationship
3. Define patient and therapist responsibilities to the treatment
4. Protect the patient, the therapist, and the therapy, including protecting the therapist's ability to think clearly
5. Minimize secondary gains of illness
6. Provide a safe place for the patient's dynamics to unfold
7. Set the stage for interpreting the meaning of deviations from the treatment frame established by the contract
8. Provide an organizing therapeutic frame that permits therapy to become an anchor in the patient's life; internalization of the contract discussions often becomes a first internal link with the therapist
9. Begin to define patient's choices; discussion of possible life activities begins to clarify elements of identity and conflicts therein

1. *Protection of the patient*
2. *Protection of the possibility to work in the transference*

2. Technical Neutrality

Technical neurality in the treatment of borderline paients: Keeping equally distant towards conflicting self- and object respresentations, as well as towards split-off good or bad dyads.

3. Containment

Paula Heimann (1899-1982)

International Journal of Psychoanalysis 31: 81-84, 1950

ON COUNTER-TRANSFERENCE[1]

By PAULA HEIMANN, LONDON

This short note on counter-transference has been stimulated by certain observations I made in seminars and control analyses. I have been struck by the widespread belief amongst candidates that the counter-transference is nothing but a source of trouble. Many candidates are afraid and feel guilty when they become aware of feelings towards their patients and consequently aim at avoiding any emotional response and at becoming completely unfeeling and 'detached'.

When I tried to trace the origin of this ideal of the 'detached' analyst, I found that our literature does indeed contain descriptions of the analytic work which can give rise to the notion that a good analyst does not feel anything beyond a uniform and mild benevolence towards his patients, and that any ripple of emotional waves on this smooth surface represents a disturbance to be overcome. This may possibly derive from a misreading of some of Freud's statements, such as his comparison with the surgeon's state of mind during an operation, or his simile of the mirror. At least these have been quoted to me in this connection in discussions on the nature of the counter-transference.

On the other hand, there is an opposite school of thought, like that of Ferenczi, which not only acknowledges that the analyst has a wide variety of feelings towards his patient, but recommends that he should at times express them openly. In her warm-hearted paper 'Handhabung der Übertragung auf Grund der Ferenczischen Versuche' (*Int. Zeitschr. f. Psychoanal.*, Bd. XXII, 1936) Alice Balint suggested that such honesty on the part of the analyst is helpful and in keeping with the respect for truth inherent in psycho-analysis. While I admire her attitude, I cannot agree with her conclusions. Other analysts again have claimed that it makes the analyst more 'human' when he expresses his feelings to his patient and that it helps him to build up a 'human' relationship with him.

For the purpose of this paper I am using the term 'counter-transference' to cover all the feelings which the analyst experiences towards his patient.

It may be argued that this use of the term is not correct, and that counter-transference simply means transference on the part of the analyst. However, I would suggest that the prefix 'counter' implies additional factors.

In passing it is worth while remembering that transference feelings cannot be sharply divided from those which refer to another person in his own right and not as a parent substitute. It is often pointed out that not everything a patient feels about his analyst is due to transference, and that, as the analysis progresses, he becomes increasingly more capable of 'realistic' feelings. This warning itself shows that the differentiation between the two kinds of feelings is not always easy.

My thesis is that the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's counter-transference is an instrument of research into the patient's unconscious.

The analytic situation has been investigated and described from many angles, and there is general agreement about its unique character. But my impression is that it has not been sufficiently stressed that it is a *relationship* between two persons. What distinguishes this relationship from others, is not the presence of feelings in one partner, the patient, and their absence in the other, the analyst, but above all the degree

[1] Paper read at the 16th International Psycho-Analytical Congress, Zürich, 1949. After presenting this paper at the Congress my attention was drawn to a paper by Leo Berman: 'Countertransferences and Attitudes of the Analyst in the Therapeutic Process,' *Psychiatry*, Vol. XII, No. 2, May, 1949. The fact that the problem of the counter-transference has been put forward for discussion practically simultaneously by different workers indicates that the time is ripe for a more thorough research into the nature and function of the counter-transference. I agree with Berman's basic rejection of emotional coldness on the part of the analyst, but I differ in my conclusions concerning the use to be made of the analyst's feelings towards his patient.

„My thesis is that the analyst´s emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst´s countertransference is an instrument of research into the patient´s unconscious.“

Paula Heimann, 1950

„Our basic assumption is that the analyst´s unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his `counter-transference´.“

Paula Heimann, 1950

Joseph Sandler (1927-1998)

International Review of Psychoanalysis 1976; 3: 43-47

Int. Rev. Psycho-Anal. (1976) 3, 43

COUNTERTRANSFERENCE AND ROLE-RESPONSIVENESS

JOSEPH SANDLER, LONDON

As we know, the term 'countertransference' has a great many meanings, just as the term 'transference' has. Freud first saw countertransference as referring to the analyst's blind spots which presented an obstacle to the analysis. From the beginning, countertransference was consistently seen by Freud 'as an obstruction to the freedom of the analyst's understanding of the patient.' In this context Freud regarded the analyst's mind as an 'instrument . . ., its effective functioning in the analytic situation being impeded by countertransference'. Countertransference in the analyst was equated with the resistance in the patient (Sandler, Dare & Holder, 1973).

As far as *transference* is concerned, it will be remembered that Freud saw it first as a hindrance, but later regarded it as an indispensable vehicle for the analytic work. However, he did not take a similar step in regard to countertransference, but this inevitable step was taken after Freud. It was a crucial development in the psychoanalytic literature when the countertransference 'began to be seen as a phenomenon of importance in helping the analyst to understand the hidden meaning of material brought by the patient. The essential idea . . . is that the analyst has elements of understanding and appreciation of the processes occurring in his patient, that these elements are not immediately conscious and that they can be discovered by the analyst if he monitors his own mental associations while listening to the patient' (Sandler, Dare & Holder, 1973). The first explicit statement of the *positive* value of countertransference was made by Paula Heimann (1950). Others have written on and developed the topic. However, the two papers by Paula Heimann (1950, 1960) have to be singled out as landmarks in the change of view of countertransference. She started by considering countertransference as referring to all the feelings which the analyst may experience towards his patient. Heimann remarks that the analyst has to be able to '*sustain* the feelings which are stirred up in him, as opposed to discharging them (as does the patient), in order to *subordinate* them to the analytic task in which he functions as the patient's mirror reflection'. She assumes 'that the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his "countertransference"' (Heimann, 1950).

I shall not mention the other important writings in this field, except to say that, of course, countertransference had been written about before Heimann's work and it had been pointed out that countertransference is a normal phenomenon. But what seems to have been stressed has been the differences between what one might call the 'appropriate' and 'useful' countertransference on the one hand and the 'dangerous' or 'undesirable' countertransference response on the other. Heimann's contribution was to show clearly that the reaction of the analyst may usefully be the first clue to what is going on in the patient.

In *The Patient and the Analyst* the literature on transference was discussed in some detail (Sandler, Dare & Holder, 1973) and we concluded by commenting that, in our view,

> . . . transference need not be restricted to the illusory apperception of another person . . ., but can be taken to include the unconscious (and often subtle) attempts to manipulate or to provoke situations with

---

A contribution to a Symposium on 'The Importance of Countertransference in Current Psychoanalytic Practice', held at the English-speaking Conference of the British Psycho-Analytical Society, London, September 1974.

Free-floating responsiveness

The therapist accepts the role that the patient is unconsciously imposes on her or him in a controlled way.

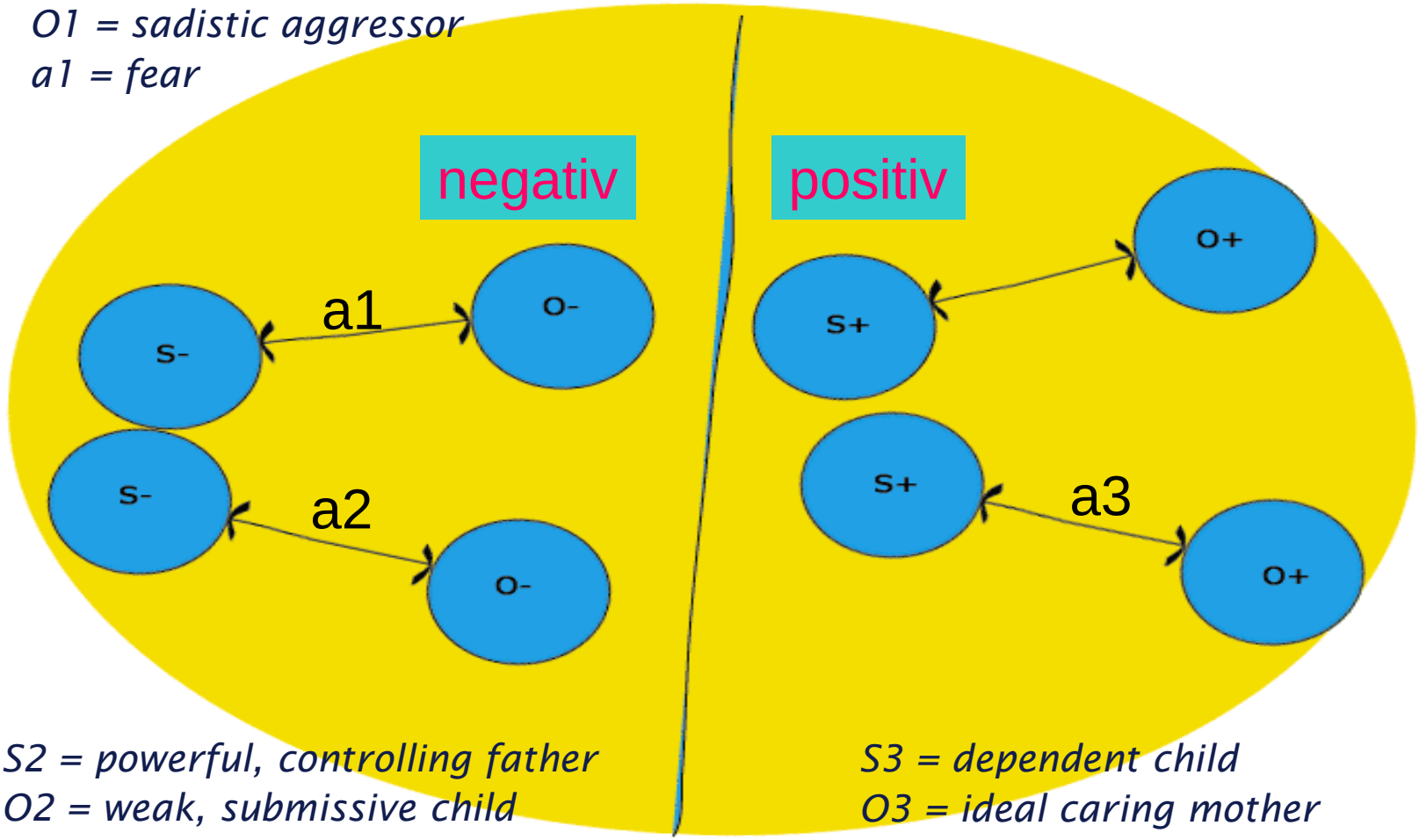
-> The role is not acted out, but "experienced" intra-psychically and, thus, contributes to the processing of the split of parts of the patient.

Joseph Sandler, 1976

Self and object representations in normal personality organisation

(Clarkin et al. 2006)

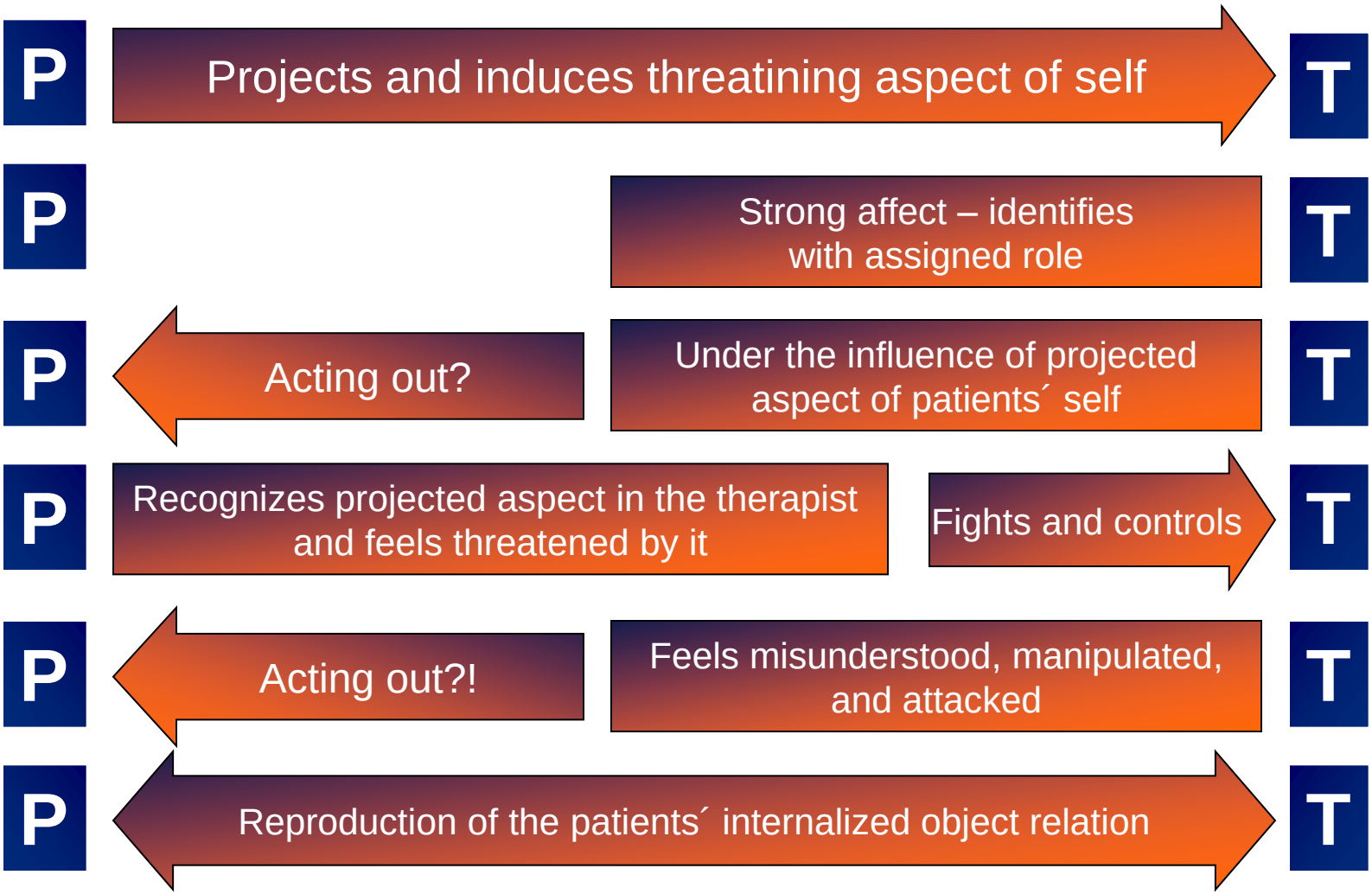
S1 = abused victim
O1 = sadistic aggressor
a1 = fear

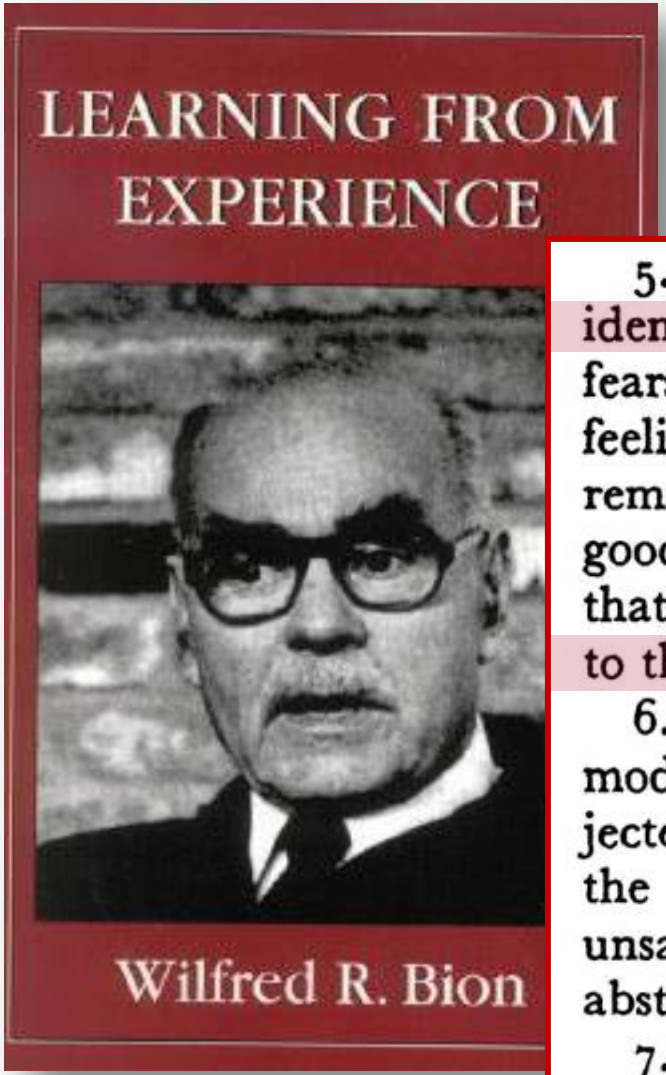


S2 = powerful, controlling father
O2 = weak, submissive child
a2 = rage

S3 = dependent child
O3 = ideal caring mother
a3 = love

Projective Identification





Wilfred Bion
(1897-1979)

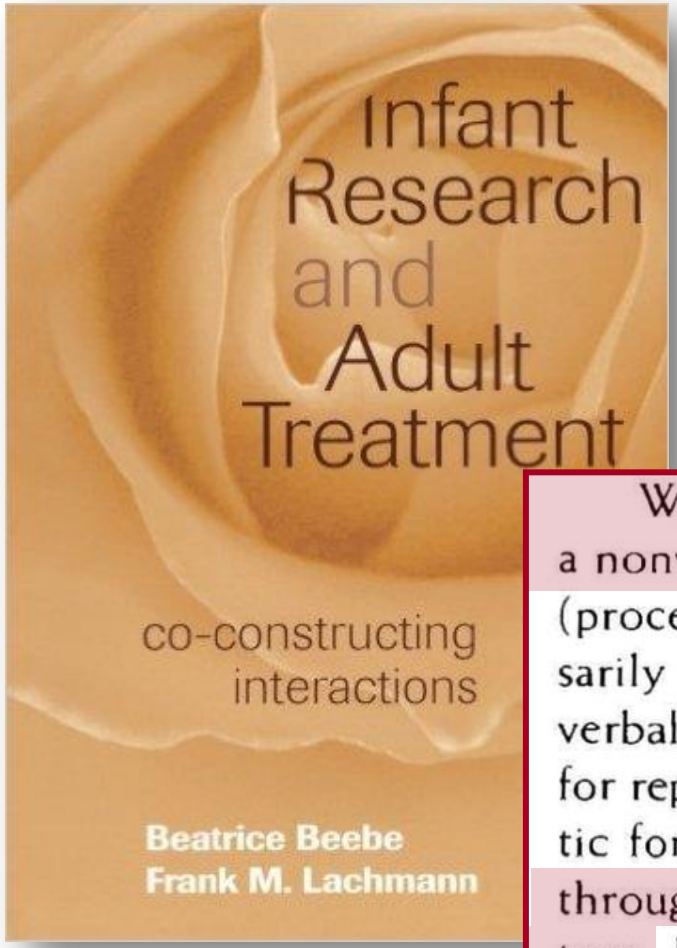
1962

5. Melanie Klein has described an aspect of projective identification concerned with the modification of infantile fears; the infant projects a part of its psyche, namely its bad feelings, into a good breast. Thence in due course they are removed and re-introjected. During their sojourn in the good breast they are felt to have been modified in such a way that the object that is re-introjected has become tolerable to the infant's psyche.

6. From the above theory I shall abstract for use as a model the idea of a container into which an object is projected and the object that can be projected into the container: the latter I shall designate by the term contained. The unsatisfactory nature of both terms points the need for further abstraction.

7. Container and contained are susceptible of conjunction and permeation by emotion. Thus conjoined or permeated or both they change in a manner usually described as growth. When disjoined or denuded of emotion they diminish in vitality, that is, approximate to inanimate objects. Both container and contained are models of abstract representations of psycho-analytic realizations.

4. Relationship experience I („Tolerance“)



Embodied Memories

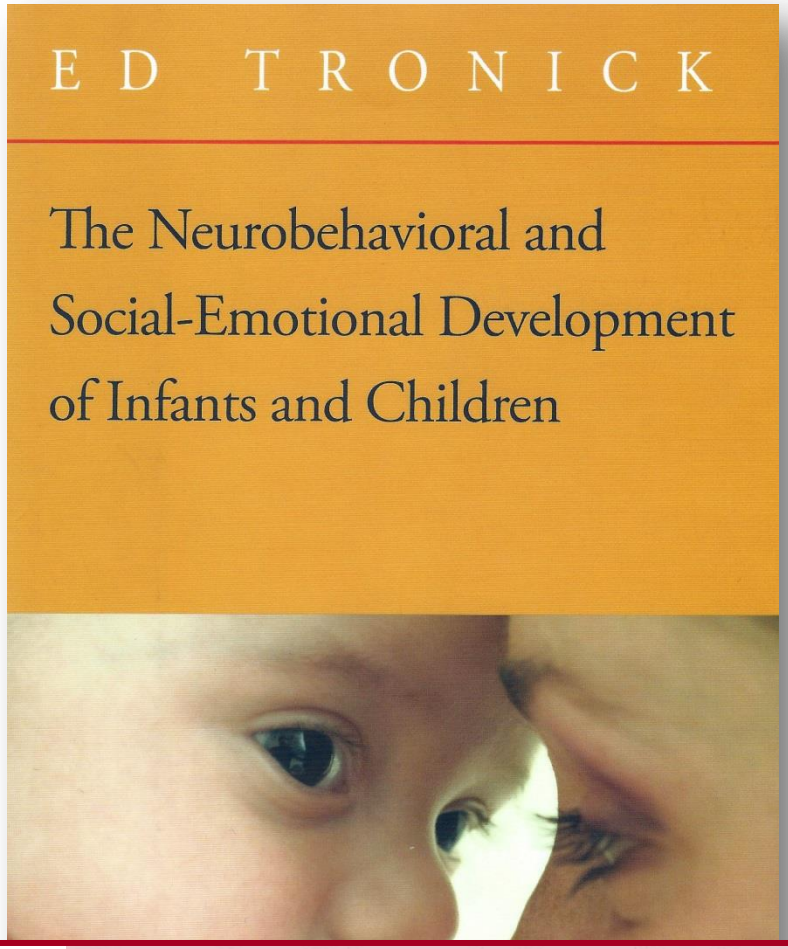
CHAPTER

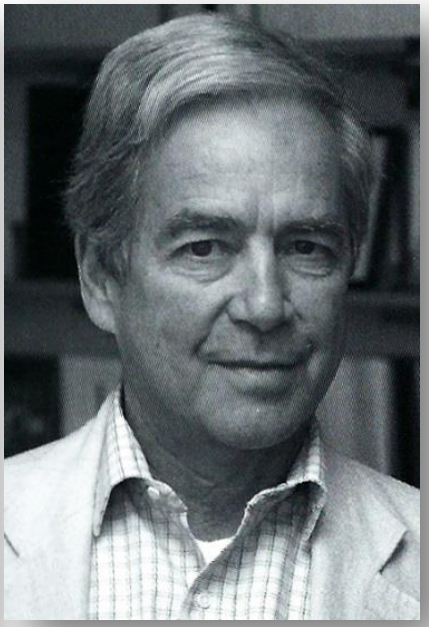
7

REPRESENTATION AND INTERNALIZATION IN INFANCY

Three Principles of Salience

We assume that representations in the first year are encoded in a nonverbal, implicit mode of information, which may be motoric (procedural), imagistic, acoustic, or visceral. They may not necessarily be translated into linguistic form. Bucci (1985) suggests that verbal and nonverbal information have separate specialized systems for representation. Whereas verbal information is stored in linguistic form, nonverbal information is stored in perceptual channels through, for example, images, sounds, smells, touch, and temperature. Both systems are potentially accessible to consciousness. However, implicit processing, such as motoric or imagistic schemas, may under certain circumstances be inaccessible to attention or language, but may nevertheless continue to operate and affect how we act and feel. The nonverbal representational system begins in the first year of life, and the three principles of salience provide hypotheses about how such perceptual information will be organized.





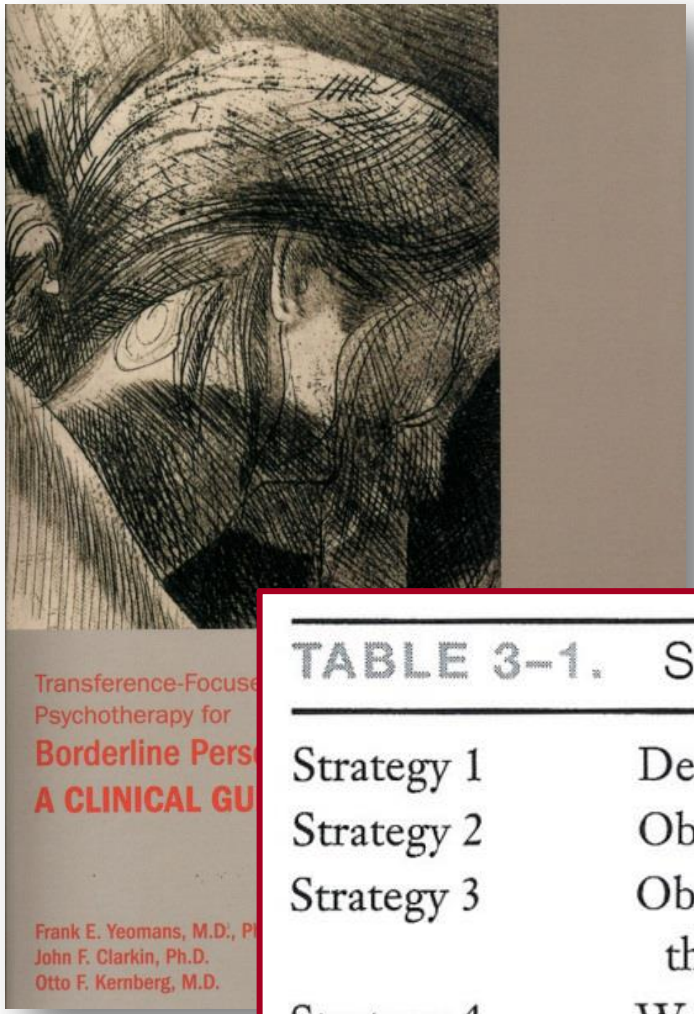
Embodied Memories

Procedural knowledge of relationships, on the other hand, is implicit, operating outside both focal attention and conscious verbal experience. This knowledge is represented nonsymbolically in the form of what we will call *implicit relational knowing.*

When the therapist accepts the role imposed to him by the patient and functions as a container, the patient unconsciously experiences:

- *Relief from persecutory and destructive aspects of the self and internalized object representations, respectively.*
- *Experiences that the projected part does neither destroy the therapist nor him-/herself.*
  - *The early (»primitive«) destructive relationship experience takes an alternative pathway.*

5. Transference work (Tactics, Technique)



2015

TABLE 3–1. Strategies of transference-focused psychotherapy

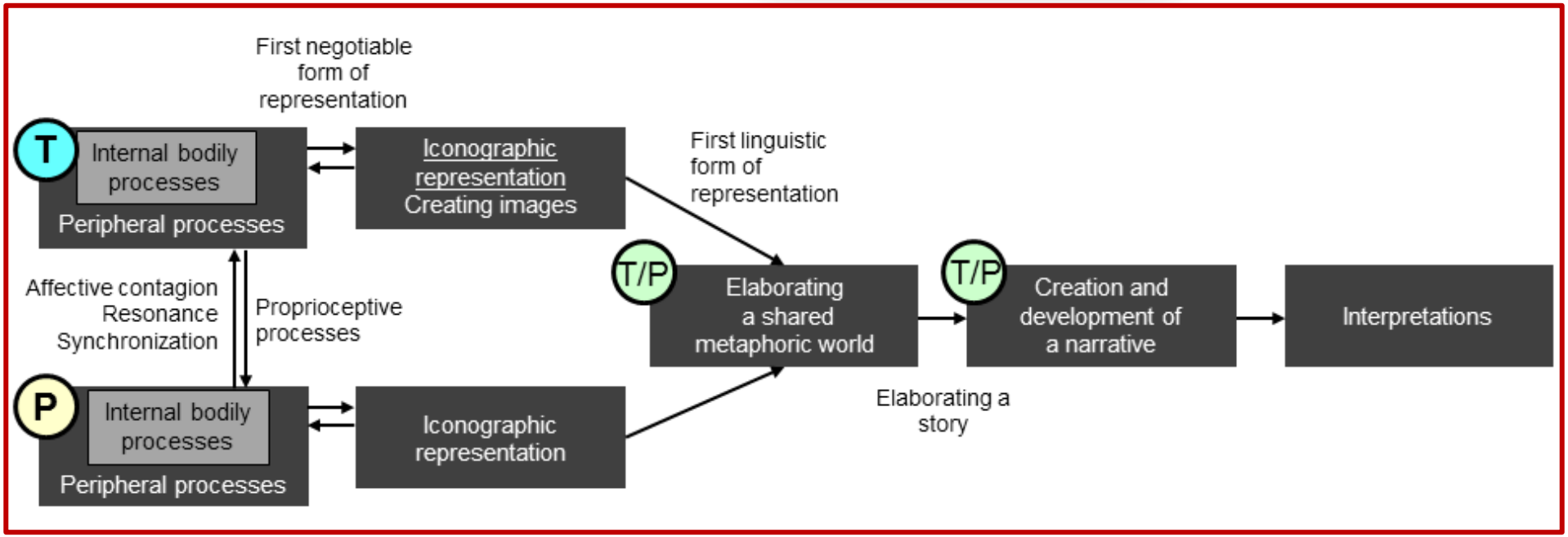
Strategy 1	Define the dominant object relations dyads
Strategy 2	Observe and interpret role reversals with the dyad
Strategy 3	Observe and interpret linkages between object relations dyads that defend against each other
Strategy 4	Work through the patient's capacity to experience a relationship differently in the transference and review the patient's other significant relationships

Searching the »Missing Link« between Analyst and Analysand, their Bodies, and their Shared Mind

Or: How is the Intersubjective Space Constructed and Lined?

Rainer Krause

from: Krause (2016)



6. Relationship experience II („Understanding“)

When the therapist communicates his/her understanding, the patient also consciously experiences:

- *A new „working model“ of relationship, he/she makes a corrective relational experience.*
- *The therapist´s containment and understanding allows the patient to take the risk of integrating formerly split-off representations of self and others.*

7. Transfer

As a consequence of the modified working model of relationships and the resolved splitting the patient finds new relationship partners in the real world and can rehearse new relational patterns.

1. *Treatment Frame*
2. *Technical Neutrality*
3. *Containment*
4. *Relationship Experience I („Tolerance“)*
5. *Transference Work (Taktics, Technique)*
6. *Relationship Experience II („Understanding“)*
7. *Transfer*

Implicit relational knowing

Explicit, symbolized, verbalized knowing

Summary

- *Already during the initial phase of the interview there was an unconscious rapport and pre-verbal understanding.*
- *Otto Kernberg´s respectful, valuating, and fearless personality and attitude enabled the patient to talk openly about her problems.*
- *She made unconscious and conscious corrective relational experiences.*
- *Not enough for a change of personality, but from a TFP she might have benefited.*

Conclusions

We should keep in mind that an interpretation is only the very last step of a process.

Conclusions

b. Bring the „affect on the table“:

- *address the patient´s emotional experience,*
- *verbalize the patient´s emotional experience,*
- *transfer the patient´s emotional experience into the transference.*

c. Focus the patient´s fantasies of and feelings for the therapist.

d. Thus, create a joint affective relational experience that can be shared in a symbolized way.

Conclusions

Only after this preparatory work, an interpretation can be effective.

Interpretations sequentially refer to the unconscious motives behind:

a. *the patient´s affective experience,*
b. *the patient´s fantasy about the therapist,*
c. *the patient´s experience of the therapist in the here-and-now,*
d. *the activated dyad between patient and therapist,*
e. *relation between split-off dyads.*

Conclusions

The interpretation consolidates the symbolization of the primary process and creates a shared narrative.

Conclusions

The mutual influence of implicit relational experiences that generate relational knowing and the interpretations that create explicit knowing produce change in the patient.

Thank you very much for your attention!