

Transference-Focused Psychotherapy Training During Residency: An Aide to Learning Psychodynamic Psychotherapy

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Abstract: Competency in psychodynamic psychotherapy is a requirement for residency training in psychiatry. However, for a variety of reasons, learning psychodynamic psychotherapy is difficult for residents. In this article, we share our experience in an elective in Transference-Focused Psychotherapy (TFP), a manualized treatment for severe personality disorders. Originally, this elective was conceptualized as an advanced component of training, offering specialized training in treating a subgroup of patients with severe personality disorders with a specific type of psychodynamic psychotherapy. However, contrary to the expectations of the residents and the training director, the elective in TFP strengthened understanding of core components of basic psychodynamic psychotherapy with all patients, not just those with severe personality disorders. We discuss various challenges in learning psychodynamic psychotherapy and how TFP served to address them. Two case vignettes illustrate several key points.

A major task of residency training in psychiatry is learning how to practice psychotherapy, including psychodynamic psychotherapy. However, learning psychodynamic psychotherapy is challenging for a number of reasons. These reasons include: (1) the complexity of the theory to which psychodynamic psychotherapy is attached; (2) the many technical challenges of doing psychodynamic psychotherapy; and (3) the emotional difficulties of experiencing and working with transference and countertransference. These challenges are complicated by the changing culture of American psychiatry in which the psychodynamic point of view is no longer dominant. Current residents spend much of

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their time on acute-care units, focusing on biological psychiatry and patient management. They have a wide variety of interests and career plans, including research and hospital administration. It is no longer universal for residents to be in their own psychotherapy. At the same time, the field of psychotherapy, itself, has expanded, and the “types” of psychotherapy have proliferated, so that the Accreditation Council for Graduate Medical Education (ACGME) requires that psychiatry residents learn not only psychodynamic psychotherapy, but also cognitive-behavioral therapy (CBT), supportive psychotherapy, and brief psychotherapy (ACGME, 2011).

As PGY-4 residents in psychiatry at the New York Presbyterian Hospital–Cornell University program, two of the authors of this article (Bernstein and Zimmerman) participated in a year-long Transference-Focused Psychotherapy (TFP) elective. Originally, this elective was conceptualized by the Residency Training Director (Auchincloss) as an advanced component of training, offering specialized training in treating a subgroup of patients with severe personality disorders with a variant of psychodynamic psychotherapy. The restricted focus was intended to develop a more nuanced understanding of borderline personality organization as conceptualized by Kernberg (1970, 1975), and to demonstrate the treatment outlined in the TFP manual by Clarkin, Yeomans, and Kernberg (2006). However, contrary to the expectations of the residents and the training director, the elective in TFP strengthened understanding of core components of basic psychodynamic psychotherapy with all patients, not just those with severe personality disorders.

Zerbo, Cohen, Bielska, and Caligor (2013) have observed that training in TFP helps residents develop “knowledge, attitudes, and skills” that can be deployed to help patients with personality disorders in many settings outside of the outpatient psychotherapy clinic, including many acute settings such as inpatient medical and psychiatric units. In this article, we will argue that TFP training helps residents understand basic psychodynamic psychotherapy with all patients, not just those for whom TFP was designed. We will outline the challenges faced by residents in learning psychodynamic psychotherapy and will elucidate how a TFP elective can be helpful in addressing these challenges. Two case studies will be presented to illustrate several major points.

TRANSFERENCE-FOCUSED PSYCHOTHERAPY

TFP is a twice-weekly psychodynamic treatment for patients diagnosed with severe personality disorders (Clarkin, Yeomans, & Kernberg, 2006). Based on Kernberg’s work in object relations theory, the

treatment is outlined in a theory-driven manual that provides a succinct model of psychopathology, as well as specific means to effect change through psychodynamic interventions. In object relations theory, experience and behavior are conceptualized as reflecting underlying object relations, or “dyads,” that consist of representations of self and object linked through affectively charged interactions. Severe personality disorders are understood to reflect underlying disturbances in object relations, in which experience of pleasurable and painful self-object dyads are dissociated from one another. This split in experience results in the affective instability and interpersonal chaos typical of these disorders, and characteristic of borderline personality organization (Clarkin, Yeomans, & Kernberg, 2006; Kernberg, 1970, 1975).

TFP is based on the premise that underlying object relations are activated in patient–therapist interactions. It emphasizes work in the “here-and-now” transference as offering the most effective means of addressing these underlying object relations. A primary task of the TFP therapist is to observe and interpret object relations dyads as they are activated in the patient–therapist relationship. A manual outlines specific techniques used in all phases of the treatment. Of particular relevance to this article, TFP emphasizes the importance of an explicit treatment contract that “establishes the frame of treatment, defines the responsibilities of each of the participants, and assesses whether the patient is motivated to pursue this type of treatment” (Clarkin, Yeomans, & Kernberg, 2006, p. 179). It also establishes contingency plans for addressing dangerous behavior (such as self-injurious and suicidal behaviors) and co-morbid conditions such as substance use disorders (72.9% in BPD) and mood disorders (75% in BPD; Grant et al., 2008). Several psychotherapy outcome studies have demonstrated that TFP is an effective treatment for borderline personality disorder as defined by the *DSM* (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010; Levy et al., 2006).

TFP ELECTIVE

Our one-year TFP elective for PGY-4 residents consisted of treating a patient diagnosed with borderline personality disorder, narcissistic personality disorder, or both, in twice-weekly psychotherapy. Experienced TFP therapists (Monica Carsky, Ph.D.; Jill Delaney, M.S.W.; Kay Haran, Ph.D.) provided individual supervision on a weekly basis. In addition, along with one other resident and two psychology interns, the residents attended a weekly group supervision and didactic session conducted by Diana Diamond, Ph.D., of the New York Presbyte-

rian Hospital–Cornell University Personality Disorders Institute. The group focused on presentation and discussion of ongoing TFP cases. It also included a discussion of important concepts, modifications of TFP for patients with narcissistic personality disorder, evaluation of therapist adherence to the TFP manual, research findings and controversies, and supplementary readings. Considerable time was devoted to close review of the TFP manual.

THE CONTRIBUTION OF TFP TRAINING IN LEARNING PSYCHODYNAMIC PSYCHOTHERAPY

In our view, TFP addresses several of the major challenges residents face in learning psychodynamic psychotherapy for all patients. Three aspects seem especially useful in this regard: (1) a unified theory; (2) a procedure for managing treatment; and (3) an organized approach to the management of transference and countertransference. Each of these will be discussed in greater detail.

A Unified Theory

The first challenge faced by residents learning psychodynamic psychotherapy is the complexity of the theory on which it is based. The sheer volume of material can be paralyzing for residents, who wonder how to use this material in order to decide what to say to individual patients. Psychodynamic psychotherapy is based on psychoanalysis, which was invented by Sigmund Freud at the turn of the 20th century. In the last 100 years, psychoanalytic theory has grown leaving a vast web of literature. Concepts in psychoanalytic theory include a wide variety of ideas, which often contradict one another. The language of psychoanalysis varies among schools of thought (Auchincloss & Samberg, 2012, Rees, 2007). Classroom teachers often teach theory using a historical framework that can seem irrelevant to residents immersed in clinical work. On the other hand, too much focus on “practical psychodynamics” can seem simplistic, leaving residents with nothing more than a set of “clinical pearls.” To complicate matters, residents are sometimes presented with a wide variety of supervisors, often with many points of view and many styles. Existing books for beginners about psychodynamic psychotherapy offer widely different points of view. A recent survey of training directors in psychiatry about matters pertaining to psychotherapy training reveals that the most widespread

complaint among them is lack of coherence in psychodynamic psychotherapy training (Sudak & Goldberg, 2012). No wonder residents often feel overwhelmed!

TFP offers residents unified psychodynamic theory in a clear and concise format, providing a way to think about the mind, about psychopathology, and about treatment. Based on Kernberg's merging of object relations theory with ego psychology, this theory is both sophisticated and user-friendly. Clear diagrams aid in understanding complex concepts. The standardization inherent in the TFP manual allows residents to set aside the conflicts between various teachers and supervisors or between schools of thought, and to identify with a "definitive" set of ideas. The literature referenced in TFP-focused writings allows interested residents to develop their understanding in an organized way, and to expand this understanding with ever more nuanced theory. Further reading also shows residents that the theory on which TFP is based is not restricted to patients with severe personality disorders (Caligor, Kernberg, & Clarkin, 2007). Empirical evidence that TFP is effective allows residents to feel confident that the practice of psychodynamic psychotherapy does not represent a break from all they have learned until then (Clarkin et al., 2007). Discussion of this evidence invites residents to consider which kinds of psychotherapy might be best for which patients, and to distinguish between concepts such as "indication" and "suitability." Finally, TFP introduces the resident to the important conversation about "Evidence-based Psychiatry" and psychotherapy outcome research, allowing him/her to become more familiar with issues such as: What is evidence-based medicine and psychiatry? What is evidence-based psychotherapy? How is psychotherapy outcome research done? What are the controversies? What is the role of manualization? Where does TFP fit in? (Busch, 2013; Chambless & Hollon, 1968; Gerber et al., 2011; Giesen-Bloo et al., 2006; Gray, 2004; Kachele, 2013; Westen, Novotny, & Thompson-Brenner, 2004).

A Clear Procedure for Treatment

A second challenge faced by residents is learning to use the array of techniques required for psychodynamic psychotherapy. Residents must learn to integrate a wide range of interventions, from those which allow for the patient's increased awareness of unconscious thoughts and feelings, to those meant to support the patient's functioning and safety. In addition, all these interventions must take place in an atmosphere of humane concern (Cabaniss, Arbuckle, & Douglas, 2010). In

other words, residents must understand what it means to be “technically neutral” without becoming underactive, or emotionally disengaged. Again, variation in technical style among supervisors can be confusing. Supervisors often encourage residents to “be yourself,” or to develop a “personal style,” forgetting that they must first feel confident that what they’re doing is acceptable. However well-intentioned, advice to “act human” rarely feels reassuring.

Here, too, TFP is helpful to residents in several ways. The TFP manual attempts to fulfill the resident’s fantasy that there is, indeed, a step-by-step guide for psychodynamic psychotherapy (at least a “good-enough” one!). Paradoxically, because it was developed for patients with severe personality disorders, this style of treatment brings clarity to the integration of various aspects of psychodynamic technique with all patients. The tasks of uncovering and understanding psychologically meaningful material, providing necessary support, and maintaining a therapeutic environment can seem particularly at odds in patients with borderline personality organization. For that reason, these elements are given close individual attention, which facilitates an understanding of how they must work together in order for the treatment to proceed safely and effectively. Central to TFP, these topics overlap with areas of difficulty in learning psychodynamic psychotherapy more generally.

First, the TFP manual offers clear instruction on the use of free association. It explains not only how to encourage this type of patient communication, but also how to hear it in a psychologically meaningful way. While free association may be an intellectually appealing strategy, a beginning therapist has little, if any, experience organizing what he or she is hearing. In TFP, deciding on a focus is based on monitoring several channels of communication that are present in all patients, but which are exaggerated in patients with severe personality disorders. While the communications of sicker patients may appear less organized than those of higher functioning individuals, the disorganization has its own patterns that allow residents to hear common themes. The TFP manual instructs the resident to listen first for affectively laden material, then to pay attention to the transference, and finally to examine countertransference. Perhaps the most useful advice found in the TFP manual is that when the therapist cannot orient himself/herself to one of these three channels, it is wise to just listen and wait. As the manual explains, “rather than resist or deny the experience of confusion, or attempt to quash it immediately by reaching premature closure, the therapist should experience the confusion freely” (Clarkin, Yeomans, & Kernberg, 2006, p. 48).

Listening to the patient within the framework described above, the resident learns to recognize which object relations are active. The resi-

dent then proceeds to name recurring scenarios which reflect these activated object relations. (For example, "You're feeling as if I'm disinterested in you, or even cruelly withholding help, because I did not accommodate changes in your schedule. Your silence and downcast eyes suggest you feel hurt and powerless to get what feels so important to you.") The resident may also point out the rapid alteration of roles in a given pair of representations of self and object. (To continue the example, "It is striking that you've now decided to cancel the next several sessions, and you're beginning to smile as I get the idea that you're not willing to discuss what this means with regard to our treatment agreement. It's as if I'm now the powerless one and you're experiencing what you thought I felt toward you when I didn't reschedule last week's meeting—a willful disinterest in me despite knowing how important I believe it is that we meet regularly.") Suddenly the resident can do sophisticated work! He or she recognizes recurring patterns, links them to underlying object relations, and names them for the patient, who can then see and explore them. TFP has enabled the resident to learn the task of turning action into narrative—an important aspect of psychodynamic psychotherapy with all patients.

Second, TFP includes the imperative to become active when the integrity of the treatment or the patient's safety is at risk. Suicidal behavior, and co-morbid disorders requiring treatment, are both anticipated in patients with severe personality disorders in whom they are very common. However, they are a concern for residents in the treatment of all patients. Indeed, from the resident's point of view, psychodynamic therapy can feel quite separate from acute care psychiatry, in which learning to manage acute disturbances is a central part of the work. With TFP, the resident need not worry that management of co-morbid substance-use disorder or affective disorder is at odds with, or "ruining," psychodynamic treatment. Most important, the resident need not worry that he or she can't do anything when the patient puts him/herself at risk. In TFP, these issues receive proper attention as a matter of course, addressed up front in the treatment contract, which always stipulates how patient and therapist will act in order to maintain safety. This treatment contract helps residents integrate the use of technical neutrality with the action needed to provide necessary support, preserve the treatment, and, at times, protect the patient's life.

Third, TFP insures that all treatment takes place in an atmosphere of compassion and concern. While descriptions of continued focus on the transference, including some attributions of negative feelings to the patient, may elicit images of a therapist confronting patients with severe personality disorders, the TFP manual makes clear that the therapist must treat the patient "with civility and courtesy rather than the cold

neutrality that is the caricature of a psychoanalytic therapist" (Clarkin, Yeomans, & Kernberg, 2006, p. 41). In summary, then, in the course of learning TFP, residents learn to practice psychotherapy in a deep and complex way that integrates psychological exploration with support and safety in the context of a humane relationship.

The Management of Transference and Countertransference

A final challenge faced by residents learning psychodynamic psychotherapy is the task of recognizing and managing transference and countertransference. Transference, which can be defined as "the patient's conscious and unconscious experience of the analyst in the psychoanalytic situation" is a core concept in psychodynamic psychotherapy (Auchincloss & Samberg, 2012). The counterpart to transference is countertransference, which can be defined as "all of the analyst's emotional responses to the patient," some from his own inner life and some induced by the patient (Auchincloss & Samberg, 2012). A major task of learning psychodynamic psychotherapy is to identify, tolerate, and make use of transference and countertransference feelings. However, these feelings can be overwhelming for both patient and therapist. Again, TFP is useful for residents learning how to manage transference/countertransference, as it was developed for patients suffering from severe personality disorders, in whom these feelings are intense. TFP anticipates that patients will experience strong and rapidly shifting feelings about the therapist, who, in turn, will experience strong feelings about the patient (Kernberg, 1965, 1975).

As its name suggests, TFP pays particular attention to the transference, which serves as the major vehicle for understanding the patient. The method explains how transference phenomena can be used as a source of information about underlying object relations. Techniques are recommended for its management and exploration. For example, the TFP manual likens the patient–therapist interchange to a dramatic scene wherein the roles into which patient and therapist have been cast reflect the underlying self and object representations (Clarkin, Yeomans, & Kernberg, 2006, pp. 50–51). Examples of roles pairs are provided, alerting residents to common transference reactions. Residents may, in turn, find this explicit and clear discussion of transference helpful in their treatment of all patients.

For the resident, the most notable challenge in learning psychodynamic psychotherapy is the task of managing countertransference. Several countertransference experiences are common among residents.

Among the most common feelings is a fear that the patient will not be safe. As a result, the resident may feel unsafe him/herself, or, may feel a need to save the patient and/or the treatment. As noted earlier, because TFP expects that patients with severe personality disorders may engage in risky behavior, these concerns are dealt at the outset of the treatment when patient and therapist negotiate the treatment contract. Indeed, TFP emphasizes that both patient and therapist must feel confident and safe for meaningful work to proceed.

Furthermore, TFP shows the resident how to bring matters of safety and high-risk behavior into the domain of transference and countertransference. While negotiating the treatment contract, risky behavior (such as lateness, suicidality, and substance abuse, to mention a few) is conceptualized explicitly as endangering not only the patient, but the treatment relationship. When contract expectations are not met, the therapist confronts the patient with this fact. Depending on the nature of the situation, the patient may have to modify his/her behavior for treatment to continue. In other words, adherence to the contract allows therapist and patient to bring action into the realm of transference/countertransference by connecting treatment-threatening behavior with feelings about the treatment itself.

Anxiety and guilt are also common countertransference feelings experienced by residents. Both can result from the experience of listening to intense, negative affect expressed by the patient. The resident often feels as if he or she should do something in order to soothe the patient. As a result, the resident may engage in behavior that has the opposite effect, as attempts to sooth the patient may communicate discomfort with intense affect, heightening the patient's own fears. TFP helps residents learn to tolerate displays of emotion. As noted above, the TFP manual takes the stance that for many patients, efforts to understand the patient's experience, as opposed to trying to quell it, are supportive in themselves (Clarkin, Yeomans, & Kernberg, 2006, p. 48). It is a relief for residents to be told that it is not only okay, but actually useful for many patients if the therapist "does nothing" but listen and try to make sense of chaotic experience.

Anxiety and guilt are often complicated by feeling ineffective. TFP is useful to residents in managing feelings of ineffectiveness through this "understanding over responding" stance. The treatment contract is useful again in that the responsibilities of both therapist and patient are made clear to each. The therapist is explicit with the patient exactly what he or she will be offering. Setting explicit expectations alleviates the resident's anxiety about what he or she can do for the patient, and helps to promote awareness of countertransference feelings that he or she should do more. The treatment contract also outlines a minimum

duration of treatment (typically one year), thereby addressing the anxiety of both patient and therapist that change must happen rapidly.

A final countertransference commonly experienced by residents is the common experience of feeling "mean." This feeling occurs most often when setting limits. For example, when a resident ends a session on time even when the patient is distressed, or when the resident refers the patient to the emergency room for the evaluation of suicidal ideation, the resident often feels that he or she has done something "cruel." TFP is helpful in managing these feelings. As noted earlier, from the outset, the treatment contract specifies procedures for how treatment-sabotaging behaviors will be addressed. In other words, TFP increases the resident's comfort with the task of limit setting with the reminder that the resident is not being "mean" or "uncaring," but rather protecting the contract, and thereby the patient and the treatment. Also, because TFP was designed for patients with severe personality disorders who often struggle with strong sadomasochistic feelings, the resident's feeling of being sadistic (or submissive and masochistic) is also expected. When feelings such as these are activated, often in the context of the patient's self-destructive behavior, TFP shows residents how to understand them as representing underlying self-object dyads. The therapist and patient can then consider the meaning of sadomasochistic transference/countertransference enactments. Even in the face of experience distressing to both, exploration, safety, and humanity are preserved.

CLINICAL CASE VIGNETTES

In our effort to describe how our TFP elective helped us to better manage the experience of treating patients in psychodynamic psychotherapy, we will present two case vignettes. In both cases, the patient's identifying data have been disguised to preserve confidentiality.

Case #1

Case #1 illustrates how the resident therapist learned how to manage countertransference feelings that arose both in response to Ms. A's intense affect, and in response to her self-destructive behavior. In this case, we can see how the TFP treatment contract allowed the resident to contain his own anxiety, and to engage Ms. A in exploration of the meaning of her behavior. Together, they were able to deepen the treatment in a useful way.

Ms. A was a 26-year-old single, childless, African-American woman, living alone in Queens, New York, who sought psychotherapy because of interpersonal chaos and failed romantic relationships. She reported that, beginning at the age of 12, she had suffered from tantrums characterized by head banging, most often provoked by feeling judged. Ms. A reported that her head banging usually took place in front of other people, and that several boyfriends had attempted to prevent her from harming herself. While she was concerned about difficulties with memory caused by her behavior, she had never been medically evaluated. Ms. A reported that she had disclosed her behavior to previous therapists, but had downplayed its significance. Ms. A also described chronic feelings of emptiness, difficulty being alone, and intense mood swings. She reported multiple instances of being abandoned by friends and boyfriends, with whom she often had dramatic fights and break-ups. Ms. A had seen therapists and psychiatrists since college, but had never remained in treatment for longer than six months. Ms. A grew up with married parents and two younger brothers. She met all developmental milestones on time and had no history of trauma or abuse. She denied a family history of psychosis, bipolar disorder, psychiatric hospitalizations, imprisonment, suicidality, addiction, or head banging.

Ms. A was diagnosed with borderline personality disorder, according to the *DSM*. The evaluating resident was interested in learning about TFP, felt that Ms. A met criteria for it, and, thus, recommended treatment with a course of TFP. When presented with the *DSM-IV* criteria for BPD and the treatment plan, Ms. A enthusiastically agreed. Two sessions were spent establishing a treatment contract. The resident and Ms. A agreed that the goal of therapy was to increase Ms. A's understanding of herself and her relationship to others. The resident's responsibilities were enumerated: (1) to provide regularly scheduled sessions with adequate notice of any breaks or changes, (2) to be open and attentive to all communications, and (3) to make every effort to help Ms. A achieve a better understanding of herself. Ms. A's responsibilities were enumerated: (1) to come to two appointments per week and to arrive on time, (2) to commit to treatment for at least one year, (3) to report all thoughts and feelings without censoring, (4) to work toward stopping head banging, and (5) to consult with a neurologist. Ms. A was pleased with this negotiation, and stated that she had not engaged in such explicit discussion of goals and responsibilities with prior therapists. However, she was nervous about consulting a neurologist, as she imagined that this would be a humiliating experience. Because of Ms. A's history of leaving previous treatments prematurely, the resident asked Ms. A to reflect on the commitment to one year of therapy. Ms. A acknowledged that she might again want to leave treat-

ment, and she agreed to discuss her feelings with the resident rather than just abandon the therapy.

As the therapy moved from the contract setting into the early treatment phase, the resident felt great anxiety in response to Ms. A's intense affect. However, the explicit delineation of responsibilities in the TFP treatment contract was helpful in managing this anxiety. Ms. A's responsibilities included expressing her thoughts and feelings uncensored. The resident had agreed to be open and attentive to Ms. A's communication, so as to help Ms. A better understand herself. This expectation led the resident to feel relieved of the responsibility to mitigate Ms. A's painful feelings. As a result, the resident felt less anxious in response to these feelings. He better understood that the treatment contract served as a communication to Ms. A that the resident would be able to hear and be comfortable with Ms. A's feelings, however intense.

During the next two months, Ms. A appeared to be engaged in treatment, attending all appointments, and arriving mostly on time. She spoke at length about her anger at her father for his harsh and seemingly unwarranted criticisms of her. She talked about her extreme sensitivity to perceived slights, and about how this sensitivity led to antagonistic relationships with boyfriends. To the resident's surprise, Ms. A denied any instances of head banging during this two-month period, reporting that she did not have the urge. However, when he asked Ms. A about seeing a neurologist, she stated that she did not yet feel comfortable enough to do this.

In the third month of treatment, Ms. A reported that her current boyfriend had ended their relationship in response to her chaotic behavior. She was distraught, expressing a wish to leave New York. She repeatedly stated that she imagined her problems would disappear were she to relocate to Florida. The resident felt renewed anxiety, this time about the patient's commitment to therapy. Again, however, the TFP treatment contract, which anticipated treatment-interfering behaviors and specified a commitment to one year of therapy, enabled the resident to manage his anxiety and to address the problem with the patient. He reminded Ms. A about her commitment to one year of treatment, pointing out how Ms. A's constant references to moving prevented deepening of the therapeutic relationship. Ms. A admitted that she had been thinking about quitting therapy, and acknowledged that it was at times like this that she had left treatment in the past. When the resident urged Ms. A to think about her impulse to leave therapy, Ms. A stated that she had sought treatment only at the behest of her boyfriend. Now that he had ended their relationship, she did not feel it was "worth the effort." For the next several sessions, the resident and Ms. A talked about Ms.

A's devaluation of herself, exploring how her pursuit of a boyfriend served to manage feelings of emptiness. Thereafter, Ms. A reported an increased commitment to therapy. She no longer spoke about relocating. Indeed, she even talked about passing up several out-of-state opportunities because she wanted to pursue her treatment.

After ending her relationship with her boyfriend and intensifying her commitment to treatment, Ms. A began head banging approximately once per week. She talked about the events that seemed to bring on this behavior and about the guilt and remorse that she experienced. While the resident felt that there was meaningful dialogue between them about the object relations underlying Ms. A's self-injury, he noted that Ms. A appeared oddly detached from her behavior, giving no indication of attempting to stop. The resident was alarmed for Ms. A's safety, yet felt helpless to intervene. In an effort to manage these feelings, the resident again reminded Ms. A of the treatment contract and her responsibility to work toward stopping her head banging. He also pointed out to Ms. A that by violating the treatment contract, her persistent self-injury was a direct threat to the treatment. In order to connect Ms. A's behavior to transference feelings, the resident suggested to Ms. A that her behavior was a communication of her feelings about the treatment and about their relationship. In response to this intervention, Ms. A stated that she did feel angry at and disappointed with the resident. She reported that she felt frustrated at having failed at another relationship even while she was in therapy, and she wished that the resident could have prevented this from happening. While noting that he could very well have felt anxious again in response to Ms. A's accusation that he had failed to intervene actively enough, the resident was able to use their conversation to demonstrate to Ms. A how she used head banging as a means of communication when she could not articulate angry feelings. Ms. A found this interpretation to be surprising, yet accurate. Since this intervention, Ms. A has not engaged in head banging.

As her treatment progressed into the fourth and fifth month, Ms. A had still not seen a neurologist. The resident was hesitant to raise the issue with Ms. A, feeling simultaneously "over-bearing" and "helpless." After discussing his feelings with his TFP supervisor, the resident was able to confront Ms. A, pointing out that her failure to consult a neurologist was a direct "attack" on the treatment—it violated the treatment contract. While Ms. A acknowledged that this might be so, she pointed out that she also felt the opposite, explaining that she felt like a teenager rebelling against her demanding parents. Together, the resident and Ms. A explored Ms. A's tendency to experience herself as the passive victim, helpless in the face of others' aggression. They also explored

how Ms. A's own aggressive behavior enabled her to feel powerful and in control. In the course of this discussion, Ms. A went to an appointment with a neurologist, who reviewed her history and performed a neurologic exam with no abnormal findings.

Case #2

Case #2 illustrates how another resident therapist used TFP training to master many similar anxieties while learning psychodynamic psychotherapy. He also used TFP to recognize and to find a way out of a serious enactment in which he colluded with his patient to avoid painful feelings. Collusions are common in the treatment of patients with borderline personality disorder. Patients with BPD often use projective identification, by which painful self experiences are projected onto the therapist and combined with efforts to control the therapist's behavior and experience. This use of projective identification finds fertile ground in the beginning therapist, who is often struggling with fears of either "being too mean," or "ruining" the therapy by being "too supportive." The result is often a shared avoidance of painful feeling, which both parties find difficult to manage. Because the resident began work with his patient in a less structured psychodynamic psychotherapy, only later changing their treatment to TFP, Case #2 allows us to see how a TFP elective helped the resident to learn how to do this difficult work. In this case, traditional psychodynamic psychotherapy, as taught to most residents, aggravated collusion between patient and therapist, which, in this case, took the form of the appearance of doing useful treatment. The TFP treatment contract shattered this appearance of useful treatment by bringing painful feelings to the surface. At the same time, the structure of TFP allowed the resident to understand and to deal with the consequences.

Mr. B was a 31-year-old single, childless Hispanic man, supported by his wealthy mother, who was referred to the resident clinic for treatment of difficulty motivating himself to work. Mr. B suffered from major depressive disorder and co-morbid personality disorder NOS with narcissistic and dependent traits, according to the *DSM*. Mr. B had suffered the onset of depressive symptoms at age 24. He grew up as an only child, met all major developmental milestones on time and denied a family history of psychosis, bipolar disorder, psychiatric hospitalizations, imprisonment, suicidality, or addiction. He denied a history of abuse or trauma. Mr. B reported that he had not worked in the two and a half years since finishing graduate school, despite wishing to have

a career. Mr. B's lack of achievement was not consistent with his high level of intelligence or with his superficial likability. He reported having several close friends with whom he maintained contact over many years. Although Mr. B agreed that his primary problem was the disparity between his ambition and his achievement, he did not understand how he might be contributing to the problem. Indeed, he joked that others were the cause of his "real problems."

After adjusting citalopram to optimize the pharmacologic treatment of Mr. B's major depression, the resident and Mr. B agreed to begin a course of psychodynamic psychotherapy to address what appeared to be an inhibition in the area of work. The treatment began with Mr. B understanding that his responsibilities included: arriving on time for his twice-weekly, 45-minute sessions with the resident, and, communicating all his thoughts as openly as possible. At this early point, neither Mr. B nor the resident was clear how this strategy would lead to significant change. However, the resident was eager to apply what he had learned about psychodynamic psychotherapy, hoping that insight about Mr. B would be helpful. During their initial discussion of treatment, Mr. B was quiet—noticeably so in retrospect—about his ambivalent feelings about treatment. Reflecting later, the resident felt that if discussion about treatment had been structured in a TFP format, the initial contracting phase might have uncovered feelings of hope and excitement, and fears of failure, experienced by both the patient and himself. Decreased vagueness at the outset might have been helpful to both.

As the treatment proceeded, Mr. B began to reveal strong feelings of entitlement and a tendency to spend much of his time in grandiose fantasy. He also revealed extreme sensitivity, reacting to even gentle confrontation with rage. The resident began to consider a diagnosis of narcissistic personality disorder, organized at a borderline level. He used the emerging observations and formulations in efforts to arrive at interpretation, suggesting to Mr. B that his "style of thinking might be related to his difficulty attaining what he claimed to want." However, the information also awakened new countertransference feelings, as the resident worried that Mr. B would perceive his new therapist as "cruel." As there had been hints of aggression in response to perceived slights, he also feared that Mr. B might become angry. The resident worried about being able to handle Mr. B's feelings, and rationalized his decision to avoid "too much detail" and the discomfort that might follow, as helping to develop a therapeutic alliance. Again in retrospect, the resident felt that while he and Mr. B might have maintained superficially friendly interaction, they missed out on a chance to deepen their rela-

tionship through a candid discussion of feeling. The contracting phase of TFP would have been useful in providing a way to explore central conflicts. In contrast, the psychodynamic treatment fostered an unacknowledged transference-countertransference enactment between Mr. B and the resident that functioned as a collusion to avoid the patient's depressing reality, his feelings of worthlessness, and his anger in response to it. From the beginning of treatment, the so-called therapeutic alliance was based on an unspoken, partially unconscious commitment to stay away from subjects that felt too risky, with both Mr. B and the resident using a combination of disavowal and suppression. Their unconscious collusion to avoid painful feelings was only to become more pronounced as the therapy progressed.

Within the first month of treatment, Mr. B came to the office in an unusual state of panic. As part of his mother's confusion about how best to manage her difficult son, she had told Mr. B that she planned to decrease her financial support, citing his carefree spending habits. Mr. B would need to find an alternate source of income quickly in order to maintain the lifestyle he had been enjoying. However, Mr. B appeared unable to organize such a response. The resident felt pressure to act in the face of Mr. B's demand for support. Worrying that an "analytic stance" would be cold and unhelpful in Mr. B's "time of need," the resident tried to brainstorm with Mr. B about how he might quickly get back on his feet. In response to this brainstorming, Mr. B decided to seek input from a career counselor, but after several visits and what sounded like helpful advice, Mr. B dismissed the counselor, feeling that she was "telling me things I already know." The resident's other "supportive" interventions were similarly received. Similar crises followed, and the resident found himself deviating often from the initial frame in ways that left him feeling he was not carrying out a "real" psychodynamic treatment. Adding to his distress, he found that supervision from various sources conflicted. Did Mr. B need the strict limits often encouraged for patients with borderline personality disorder, or did he need a warmer and more supportive therapist? Perhaps Mr. B needed a day treatment or residential program? The resident felt tortured, and worried that, in turn, he might be torturing Mr. B.

After reflecting on Mr. B's failure to respond to supportive intervention, the resident decided to try to interpret the meaning of their transference-countertransference interaction. He began by questioning Mr. B's expressed need for support. The resident suggested that Mr. B's experience of crises as requiring intervention from his therapist was analogous to his present-day relationship with his mother. Mr. B acknowledged feeling "needy" with both his therapist and his mother,

hypothesizing that his feeling was related to his father's distant attitude toward him. "I think I'm used to looking for practical things as a replacement for feeling cared for," he said. Mr. B appeared to be doing the work of therapy, reflecting on and accepting many interpretations, bringing up associated dreams and childhood memories, and referring to past sessions. During their sessions, the resident felt satisfied with the interactions. However, in supervision, he felt that the sessions often sounded "hollow." At the same time, Mr. B made little progress toward his goal of finding a job, and once again, in response to his distress, his mother agreed to support him. In retrospect, the resident understood this failure as reflecting Mr. B's defensive desire to focus on material distant from his actual day-to-day experience. Mr. B was able to control the sessions in order to continue to avoid confrontation with a humiliating and depressing reality. The resident's collusion with Mr. B deepened, so that both avoided painful feelings, even while appearing to work in therapy. Mr. B avoided depression and rage, and the resident avoided feelings of "meanness" and sadism. However, the resident began to be frustrated with himself and with Mr. B, feeling that they had "wasted" nearly a year in an "unhelpful pseudo-treatment." At the same time, and in contrast to his therapist, Mr. B felt little frustration. While he could discuss his conflict on an intellectual level, his lack of progress bothered him less than it did those around him. Feelings of responsibility, urgency, and failure were lessened both through projective identification, as the resident felt more worried about Mr. B's future than he did. His mother's financial support also created a situation that negatively affected his motivation for change, as together they lived in a carefree world in which her support seemed limitless.

As the resident began his PGY-4 year, and his TFP elective, he discussed the case of Mr. B with his TFP supervisor. Given Mr. B's borderline personality organization, and the difficulty both patient and therapist had in maintaining the treatment frame, the supervisor and the resident agreed that a trial of TFP was indicated. The supervisor also helped the resident to see that Mr. B's plan to find a job was split off from pleasure in dependence on his mother, expressed in his failure to get a job. Indeed, when presented with the option of TFP treatment, Mr. B agreed without any objection, feeling in the moment that he "did want to get a job." He and the resident negotiated an explicit treatment contract, which included not only the responsibilities of the previous treatment, but the requirement that Mr. B begin to support himself. This last stipulation was made with explicit recognition that Mr. B needed to escape the shielding effect that financial support from the family had

provided, so as to confront, and learn to manage painful feelings that he had been avoiding associated with his need to work.

In the setting of this new treatment contract, and with the likelihood of having to work on the horizon, Mr. B responded to renewed interpretation of his entitlement and his avoidance of reality with increasingly affect-laden responses. Mr. B sobbed as he experienced intense feelings of worthlessness, acknowledging that much of his effort to develop himself had been half-hearted at best. The resident understood his own feelings of meanness in response to his patient's increasingly conscious pain as sources of information, rather than as signals that he should avoid certain topics. In fact, he was relieved to see that there was finally some movement in the treatment. He felt a sense of accomplishment as Mr. B appeared to be engaged on a deeper level. He also felt excited that the issue of Mr. B's failure to work had become part of the treatment. In addition to a temporary resolution of the treatment stalemate with Mr. B, the resident also felt that he had a better theoretical grasp of what was going on between him and his patient. The earlier treatment took on meaning, as the resident conceptualized it not just as a technical failure, but as an enactment of powerful object relations, in which patient and therapist colluded in the creation a "perfect world," unconstrained by a need to work. He understood their previous treatment, in which they appeared to be doing meaningful psychotherapy work, as an extension of this world. Indeed, the resident began to look forward to sessions that had previously been a source of dread, feeling that he was now able to understand and to point out to the patient what was going on.

When the resident held fast to the stipulation that Mr. B find work, the patient initially seemed reluctant to accept a firm deadline. However, to his surprise, Mr. B soon took action, secondary to what he perceived as the resident's serious "threat to end treatment." Mr. B went on his first job interview in several years, which resulted in his experiencing an unpleasant sense of competition. Subsequent failure to enter the workforce at what he felt was the "proper level" confronted Mr. B with a painful reality he had been in touch with before only in an intellectual way. Mr. B began to work on a part-time basis, allowing the resident and Mr. B to notice a pattern. In sessions that took place after Mr. B had been at work, he was distraught over feelings of failure about not having achieved more, resentment at having to start at a point lower than he felt he deserved, and regret over having wasted so much time. In contrast, sessions that took place after Mr. B had a few days off were often filled with pseudo-insight, reminiscent of earlier points in the treat-

ment during which he and the resident were engaged in painless yet meaningless work. Mr. B continued to deny feelings of anger toward the resident, attributing his frustration to a general sense of unfairness. While there remained significant work to do, the psychotherapy now had the potential to proceed.

CONCLUSION

Until recently, in the psychiatric residency program at New York-Presbyterian Hospital Weill Cornell Medical Center, transference-focused psychotherapy has been limited to a PGY-4 elective, conceptualized as advanced training in psychodynamic psychotherapy with patients suffering from severe personality disorders. However, in our experience in this elective in transference-focused psychotherapy, we stumbled upon a useful way to address many of the difficulties encountered when learning to practice psychodynamic psychotherapy with all patients. As we have described in this article, after an elective in TFP, we were better able to: focus on a concise and coherent theory of mind and of psychopathology; learn to use interventions associated with this theory; and manage difficult transference and countertransference experiences. We believe that training in transference-focused psychotherapy is one way to become more familiar and comfortable with the wider field of psychodynamic psychotherapy. Both efficient and complete—and with many built-in ways to understand and deal with feeling overwhelmed—it offers a strategy to approach challenges inherent in learning this complex treatment modality. We have also found that the self-contained nature of TFP—something difficult to find in psychodynamic psychotherapy—allows it to fit snugly into today's time-crunched, contemporary psychiatric education. Indeed, as a result of our experience, the Education Team in the Cornell Psychiatry Residency program has introduced transference-focused psychotherapy earlier into the curriculum, so that a 10-hour course in TFP is required for all beginning PGY-3 residents. This course will be taken as residents start work in psychodynamic psychotherapy. Our hope is that with this new course, psychiatry residents will be better prepared to face the challenges inherent in learning to do psychodynamic psychotherapy with all patients.

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