



TRANSFERENCE FOCUSED PSYCHOTHERAPY IN SEVERE PERSONALITY DISORDERS

A Lecture at the University of South Florida
Department of Psychiatry



Transference Focused Psychotherapy in Severe Personality Disorders

PERSONALITY DISORDERS INSTITUTE

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COMPONENT STRUCTURES OF PERSONALITY

- Temperament: ATQ
- Character  Identity: IPO
- Intelligence: WAIS Subscale
- Ethical Value systems (“superego”): PPI

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CATEGORIALISTS VS. DIMENSIONALISTS

DSM-IV

ICD 10

5 Factor Theory:

Neuroticism

Extroversion

Conscientiousness

Amiability

Openness

- Strengths and weaknesses of both
- Efforts of integration and the need for a theory of psychopathology that integrates neurobiological and symbolic-representational structures = genetic and environmental dispositions

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Definition of the Borderline Patient Group

- Impulsivity
- Intense anger
- Recurrent suicidal behavior
- Transient paranoid ideation
- Identity disturbance
- Efforts to avoid abandonment
- Chronic feelings of emptiness
- Unstable relations
- Affective instability

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BORDERLINE PERSONALITY ORGANIZATION

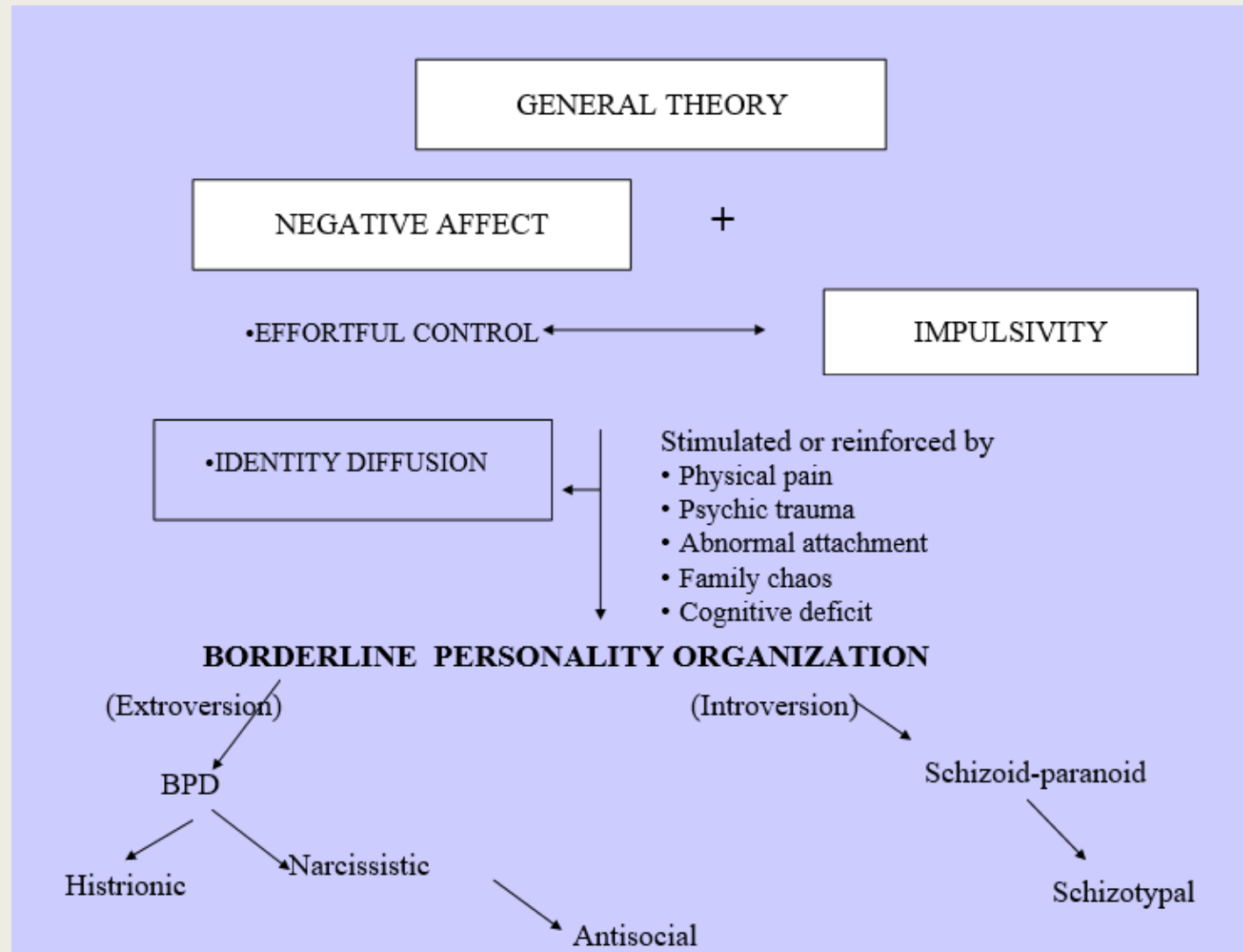
- Identity Diffusion
- Primitive Defenses
- Decreased Reality Testing

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ETIOLOGY of BPD

- Abnormal Affectivity:
 - Aggression
- Genetic Disposition
- Neurotransmitter Systems
- Temperament
- Object Relations:
 - Attachment
 - Trauma
 - Family Pathology

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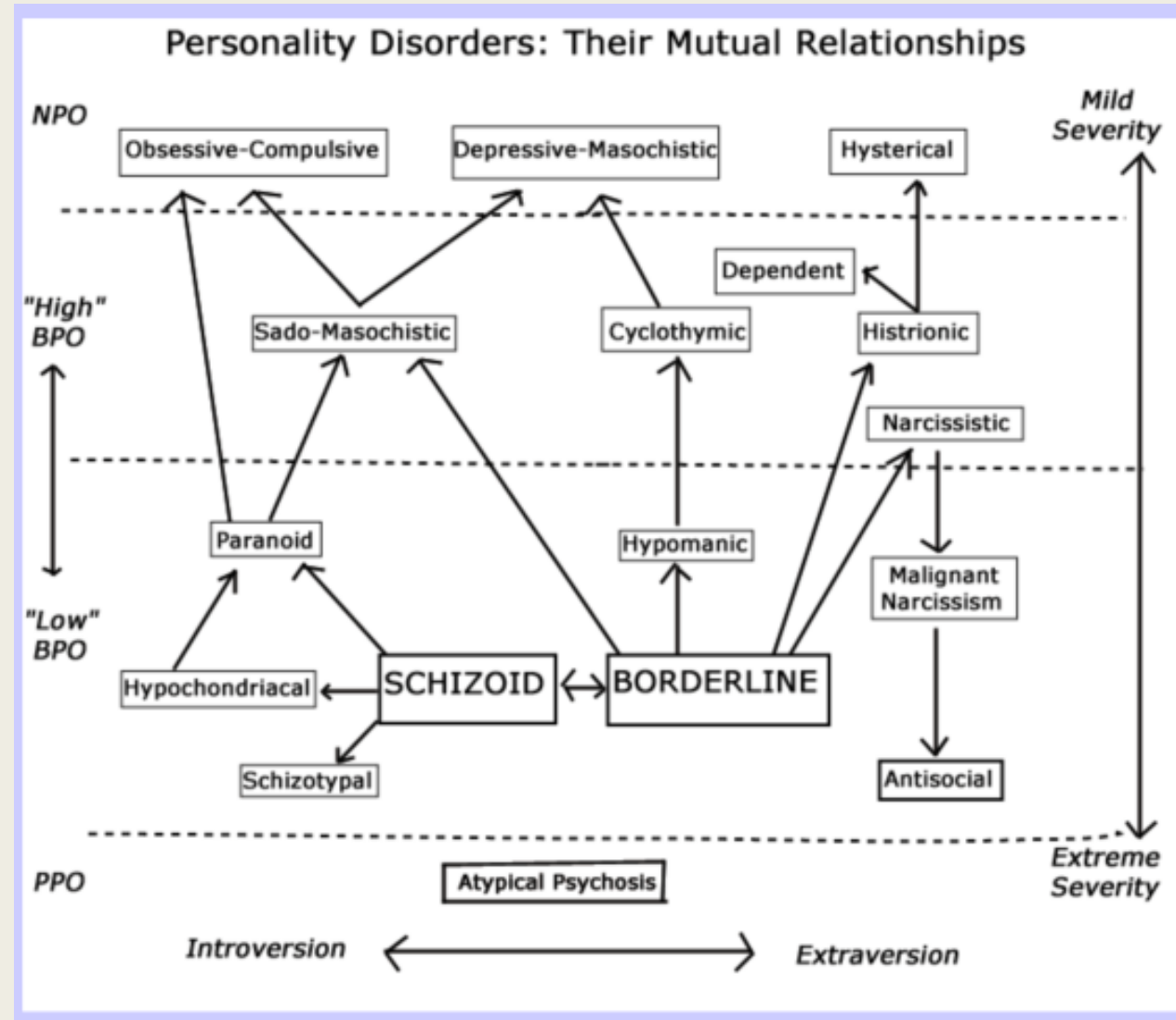


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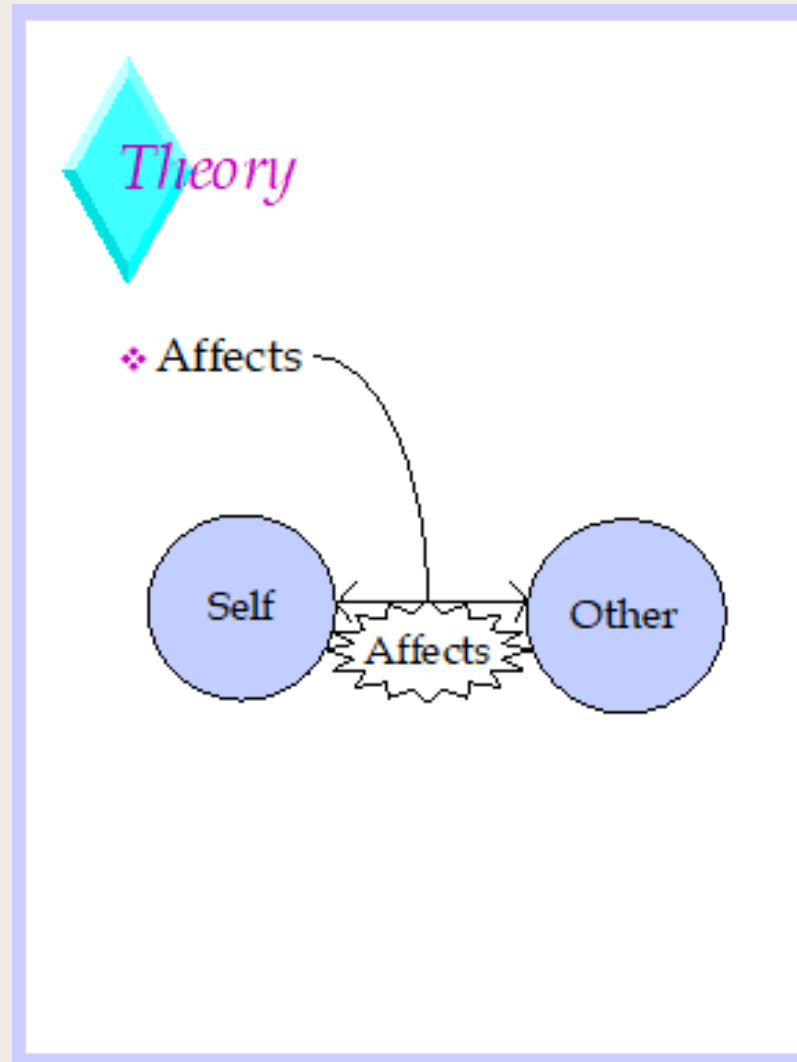
BPO: CLINICAL IMPLICATIONS and CONSEQUENCES

- Nonspecific ego weakness
 - *Lack of anxiety tolerance and time perspective*
- Disturbed object relations
- Non-commitment to work and love
- Sexual pathology (Two levels: inhibition of all sexual functioning; chaotic sexuality)
- Superego pathology

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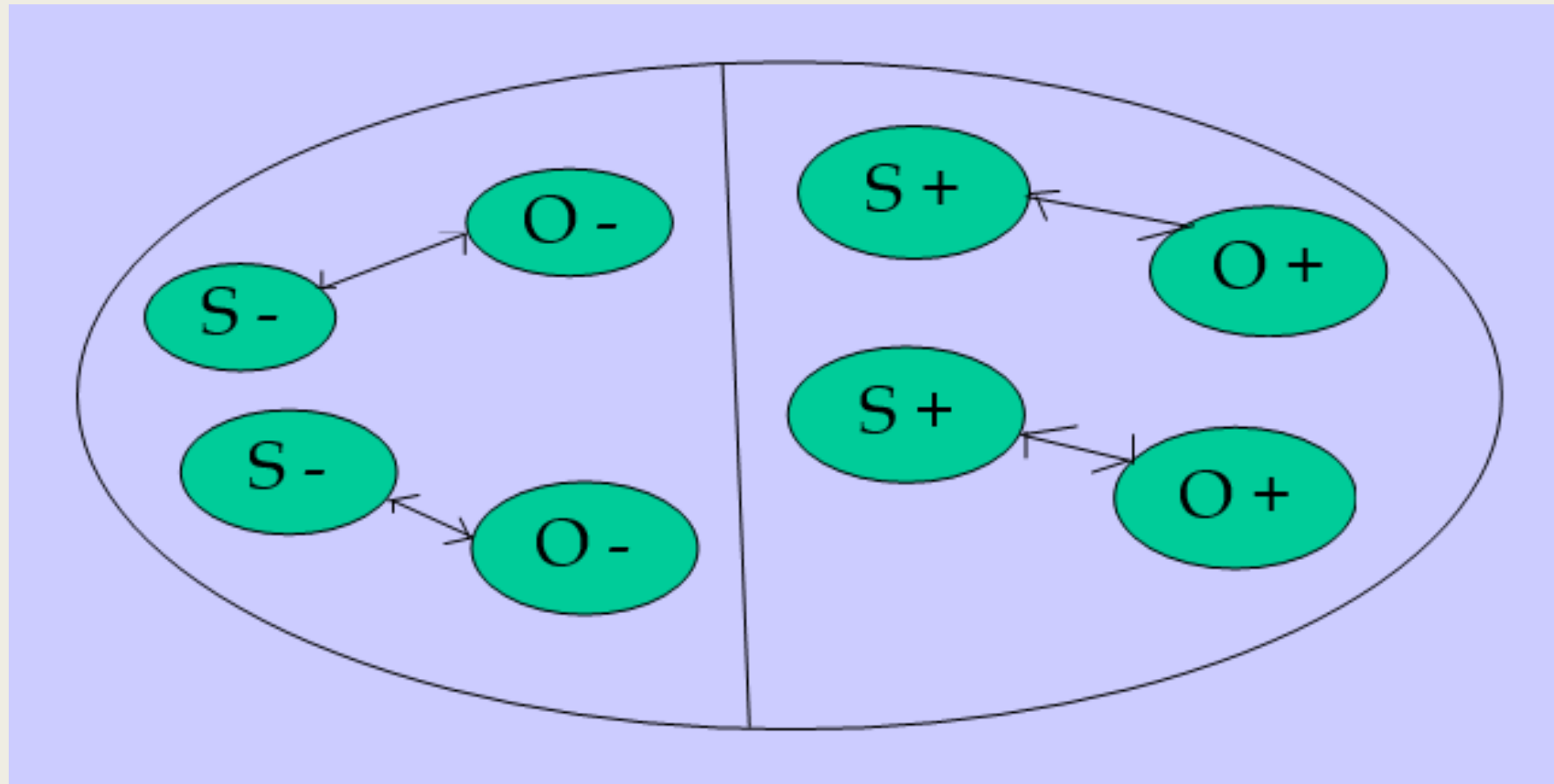


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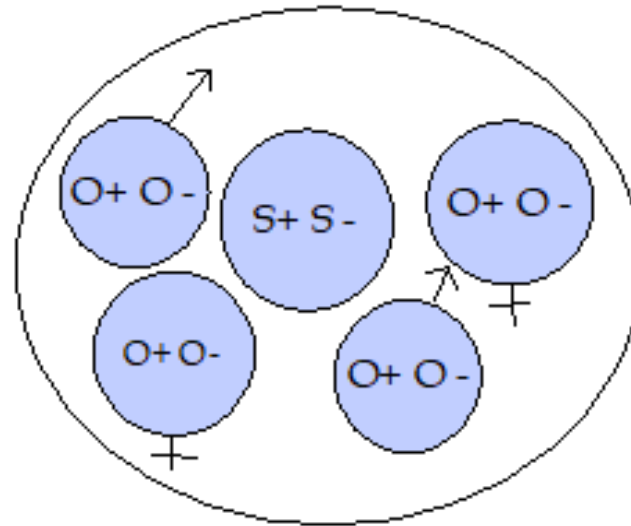
Split Organization



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Normal Organization



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A WORKING MODEL OF THE INTERNAL WORLD OF THE BORDERLINE PATIENT

1. Under peak affect states, the infant internalizes a memory of self in relation to other.
2. These experiences coalesce into those with positive affect and those with negative affect.
3. Under the stress of maltreatment or aggressive constitutional loading, the negative experiences outweigh the positive experiences.
4. The negative representations are isolated and split off from the positive experience.
5. The normal integration into total representations does not take place

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Treatment

- Psychopharmacology
 - *SSRI's, Neuroleptics, Mood Stabilizers*
- Psychotherapy
 - *Supportive Psychotherapy*
 - *Dialectical Behavior Therapy*
 - *Transference-Focused Psychotherapy*

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TREATMENT

■ TRANSFERENCE FOCUSED PSYCHOTHERAPY

A. STRATEGY:

- Clarify self and object representations in the transference
- Analyze interchange of self and object representations in positive and negative interactions
- Integrate neutrally split off representations of self, and, in that context, of others as well

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TREATMENT (cont'd)

■ TRANSFERENCE FOCUSED PSYCHOTHERAPY

- B. TACTICS:
- Control setting
 - Protection of treatment frame
 - Focus on affective and transference dominant themes
 - Contain affect storms
 - Decrease acting out and somatization by facilitating cognitive clarity of emotional experiences
 - Follow priority of urgent interventions to protect patient, treatment, honesty of communication, and safety of therapist

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TREATMENT (cont'd)

■ TRANSFERENCE FOCUSED PSYCHOTHERAPY

- C. TECHNIQUES:
- Interpretation
 - Transference analysis
 - Technical neutrality
 - Countertransference utilization

- PSYCHOPHARMACOLOGY:
- Indications (Soloff algorithm)
 - Contraindications
 - Limitations

DIFFERENT MODES OF ACTION: WHICH TECHNIQUES HELP WHICH PATIENTS, BY WHAT MECHANISMS, AND HOW EFFECTIVELY? WHO CAN BE HELPED BY WHICH TREATMENT? WHO CAN NOT BE HELPED AND IN WHAT CONTEXT, OR WHY?

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RATIONALITY OF TREATMENT AND RATIONALE OF CHANGE

