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Evidence-based psychotherapeutic approach to borderline personality disorder: Transference focused therapy

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ABSTRACT

Borderline Personality Disorder consists of a pattern of instability of interpersonal relationships, identity and affectivity, and impulsivity in various areas, which usually begins in early adulthood. In the treatment of this personality disorder, Transference-Focused Therapy (PTT) is one of the main forms of contemporary psychotherapeutic approach with empirical evidence. It is a psychodynamic therapy that focuses on improving patients' understanding of their unconscious motives and feelings that cause symptoms and aims to expose and resolve intra-psychic conflicts. In structural terms, TFP has the general objective of enabling the patient to function at a neurotic level of personality organization (ONP), with a preserved reality test, the predominance of defensive operations around repression, and an integrated identity, developing coherent and three-dimensional representations of self and

others. which would manifest itself in the reduction of symptoms, integration of identity, and reintegration into intimate relationships.

INTRODUCTION

A personality disorder involves a particularly rigid and inflexible pattern of thinking, feelings, behaviors, and social functioning, which generates significant distress to the person and/or others (Lingiardi & McWilliams, 2017). One of the main types of personality disorder is Borderline Personality Disorder (BPD), which exhibits a "pervasive pattern of instability and dysregulation across all domains of functioning" (Barlow 2021, p. 382), and is characterized by high sensitivity to perceived interpersonal conflicts, an unstable sense of self, intense emotions, and impulsivity (Gunderson et al., 2018), with high suicide risk (Barlow, 2021).

In the Diagnostic and Statistical Manual of Mental Disorders (APA, 2014), BPD is defined as "a pattern of instability of interpersonal relationships, self-image, and affect, marked impulsivity, beginning in early adulthood and presenting in a variety of contexts" (p. 663), and includes five or more of the following indicators (APA, 2014): efforts to prevent abandonment; a pattern of unstable and intense interpersonal relationships; alteration of identity; potentially self-destructive impulsivity; recurrent suicidal behaviors or self-harm; Affective instability and mood reactivity; feelings of emptiness; intense anger and difficulty controlling it; Transient paranoid ideas or dissociative symptoms.

Patients with BPD exhibit a characteristic pattern of impairments in ego functioning, such as difficulty planning realistically, inability to regulate impulses, and dominance of the primary process (Videler et al., 2019). Grinker et al. (1968, cited in Gabbard, 2017) identified the predominance of anger as the main effect, the presence of problems in social relationships, diffusion of identity, and depressive symptomatology together with affective instability.

In general, BPD is characterized by problems in a variety of areas including "extreme and intolerable negative emotions that are quickly activated... in the context of unstable relationships with other people, characterized by extreme sensitivity to rejection and intense fears of abandonment" (Behn & Fischer, 2021), they also exhibit chronic identity problems, impulsive behaviors, aggressiveness, and suicidal behaviors, including self-harm without suicidal intent that they engage in to avoid intense emotional pain (Behn & Fischer, 2021), they are concerned with establishing exclusive relationships without the risk of abandonment, which overwhelms others (Gabbard, 2017).

In the treatment of BPD, four forms of psychotherapy have demonstrated efficacy in Randomized Clinical Trials (RCTs; Stoffers-Winterling et al. 2012) and have achieved widespread recognition, are based on theories of BPD and have training opportunities. These

therapies are Transference-Centered Psychotherapy (TFP); Dialectical Behavior Therapy (DBT), Mentalization-Based Therapy (MBT), and General Psychiatric Management (GPM), all of these decrease suicide and self-harm, depression, anxiety, and hospital and emergency room use in patients with BPD (Gunderson et al., 2018).

This text aims to present the generalities of Transference Focused Therapy (TFP), one of the main forms of contemporary psychotherapeutic approach with empirical evidence that supports the effectiveness of treatment in people with personality disorders including BPD.

DEVELOPMENT

The TFP is based on Kernberg's conceptualization of the Borderline Organization of Personality (PLO; Gabbard, 2014), which would be a broad phenomenological framework, where BPD would be a specific symptomatic picture within this level of organization.

Borderline Personality Disorder from Otto Kernberg's Perspective

Kernberg (1987) proposes a descriptive, structural, and dynamic analysis for patients with BPD from the perspective of PLO. In the descriptive analysis (Labbé et al., 2020), OLP contains general clinical features such as unstable mood, disproportionate emotional responses, and impulsive behaviors; difficulties in the ability to establish intimate interpersonal relationships; in addition, the diffusion of identity; Finally, there are flaws in the integration of the superego.

In the structural analysis (Labbé et al., 2020), the OLP is characterized as a test of preserved reality, vulnerable in intense affective states; the predominance of low-level defenses around the split; in addition to moderate to severe identity diffusion that would develop in adolescence (Foelsch et al., 2015).

In the dynamic description (Labbé et al., 2020), the predominance of defenses around the split, would result in the alterations and subjectivization of the perception of reality in moments of anguish, the lack of integration of the internal mental representations of the self and others, and the consequent diffusion of identity and problems in object relations, with a predominance of schizo-paranoid conflicts that hinder the establishment of intimate and deep relationships.

In the model of Kernberg et al. (2008), people with OLP are considered to have identity diffusion syndrome, characterized by:

> A chronic and stable lack of integration of the concept of self and the concept of significant others, and the ultimate cause of this syndrome was the failure of psychological integration resulting from the predominance of aggressive internalized object relations over over-idealized ones. (p. 602)

The diffusion of identity is observed in the difficulty of integrating and evaluating oneself and others, committing oneself to work, and maintaining stable intimate relationships. Primitive defenses and the diffusion of identity present themselves in behavior through difficulties in managing negative affect and conflicts, which causes various difficulties in social life (Kernberg et al., 2008).

Thus, the key components of the therapeutic model involve identity diffusion; problems with negative affect, especially hostility and aggression; and poor self-regulation manifested by impulsive behaviors. From the above, one of the main hypotheses is that mental representations of oneself and others are derived from the internalization of attachment relationships with caregivers and are experienced again with the therapist (Gabbard, 2014)hence, the therapeutic process focuses on the analysis of transference.

Transference-Based Therapy (TFP)

TFP, proposed by Kernberg et al. (2008), is a psychodynamic therapy that focuses on improving patients' understanding of their unconscious motives and feelings and is believed to cause symptoms, so it aims to expose and resolve intra-psychic conflicts (Barlow, 2021), to change patients' psychological functions through knowledge, instruction, and corrective interpersonal experiences (Gunderson et al., 2018).

Therapeutic strategies in TFP

In structural terms, TFP has the general objective of the patient being able to function at a neurotic level of personality organization (ONP), which implies a test of preserved reality, the predominance of high-level defensive operations around repression and an integrated identity, developing coherent and three-dimensional representations of self and others. which would manifest itself in the reduction of symptoms; identity integration, reintegration into intimate relationships, work, and leisure (Clarkin et al., 2006).

In the particular case of adolescent patients, Foelsch et al. (2015) state that the objective is to eliminate the obstructions that prevent the normal development of identity to improve behavioral, affective, and moral functioning. In the first sessions, the objective is to build a reason for consultation and establish a therapeutic alliance with the adolescent and both parents or guardians, who are an important part of the development of the therapeutic process.

In general, therapy sessions are conducted in a one-on-one format and take place twice a week, with a structured treatment framework based on an initial treatment contract and clear treatment priorities (Gabbard, 2014). First, it seeks to establish the necessary conditions through the treatment contract that describes the structure to address difficulties that may threaten the physical safety or survival of the patient, that of other people, or the continuation of treatment (Kernberg et al., 2008).

In the treatment of BPD patients from this model, general priorities that must be addressed immediately are taken into account, which include: suicidal or homicidal behavior; threats of treatment discontinuation; severe performance in the session, threatening the patient's life or treatment; dishonesty; trivialization of the content of the hour; and narcissistic resistances, which must be resolved through a coherent analysis of the transferential implications of the grandiose pathological self (Clarkin et al., 2006).

Once the conditions for initiating treatment have been established, the main strategy in TFP is to "facilitate the (re)activation in the treatment of the patient's internalized and split object relations that are then observed and interpreted in the transference" (Kernberg et al., 2008, p. 603). Therefore, TFP "encourages change by reactivating primitive object relationships under controlled circumstances without the vicious circle of provoking the feared reaction of the environment when the patient behaves with emotion dysregulation" (Clarkin et al., 2006, p. 40), thus encouraging the patient to experience their internal representations in a controlled environment, This would be the essence of transference. The mechanism of change would be "the facilitation of the reactivation of internalized object relations dissociated, repressed or projected under controlled circumstances" (Clarkin et al., 2006, p. 41), and together with the development of the patient's capacity for self-observation and reflection, are essential mechanisms of change.

As a general procedure, the patient is asked to make a free association based on the problems that led to the treatment, and the therapist observes the activation of split regressive dyadic relationships (positive and negative) in the transference, which reflect a dyadic unity of a self-representation, an object representation, and a dominant affect that links them by helping to identify and interpret them (Kernberg et al., 2008).

Psychotherapeutic techniques in TFP

The main technical instruments of TFP are the basic techniques of psychoanalysis: interpretation, transference analysis, and technical neutrality, including countertransference analysis as an additional technique (Kernberg et al., 2008).

In the early stages of the interpretation process, clarification and confrontation of the patient's subjective experience are used. Clarification consists of asking the patient to explore and explain unclear or contradictory information and seeks to facilitate the development of the patient's awareness of his or her own experience, while allowing for the identification and toleration of effects that emerge from awareness of the experience and associated meanings (Foelsch et al., 2015). Confrontation seeks to draw attention to any inconsistency or contradiction in the patient's communication, awareness of repetitive and conflicting patterns increases through confrontation, gradual integration is sought, greater tolerance of affects and impulses, and interpersonal functioning is improved (Foelsch et al., 2015).

These techniques allow for the implementation of interpretation, which consists of providing hypotheses for the patient to consider and helping to organize and develop meaning for their thoughts and actions. It focuses on intra-psychic functioning based on the material that presents conflicts and the goal is to articulate the relationship between conscious material and connect it with the inferred unconscious, which influences its motivation and functioning, seeking to integrate contradictory aspects (Foelsch et al., 2015). According to Kernberg et al. (2008), The aim of interpretation is to:

> Linking dissociated positive and negative dyads/transferences, leading to an integration of mutually exclusive idealized and persecutory experience segments, helping the patient achieve a coherent sense of self and others, thus resolving identity diffusion. (p. 604).

The reactivation of a dyad occurs with rapid role reversals in the transference so that the patient can identify with a primitive self-representation while projecting a corresponding object representation onto the therapist, where the patient then identifies with the object representation while projecting the self-representation onto the therapist (Kernberg et al., 2008).

As a general rule, interpretation should be performed where the effect is most intense, this will determine the focus of the interpretation, which has to begin in the external situation invested effectively, progressively moving to transferential interpretation when the corresponding transferential development occupies the center of the patient's current interaction with the therapist (Kernberg et al., 2008).

As for technical neutrality, due to the instability of the patient with BPD, it is sometimes necessary to interrupt it due to the urgency of establishing limits to make a non-neutral intervention of the therapist, for example, in the case of suicide risk. After an intervention involving a temporary deviation from neutrality, an analysis of the transferential consequences of neutrality is carried out, until it can be resolved, and then continue with the analysis of the transference of the reasons that forced the neutrality to be interrupted.

On the other hand, transference analysis is closely linked to the analysis of the patient's problems in external reality, to avoid the dissociation of psychotherapy sessions from the patient's external life. The use of counter-transference is an important therapeutic tool and source of information on dominant themes at the time, "allowing an analysis in terms of the nature of the self-representation or the representation of the object that is being projected onto the therapist at that point, facilitating the complete interpretation of the dyadic relationship in the transference" (Kernberg et al., 2008, p 610), in this way, the analysis of counter-transference

is used by the therapist to clarify transference, incorporating them into the interpretations of the latter.

Empirical evidence

It is important to review the existing empirical evidence on this therapeutic model for the treatment of BPD. The results reported by Clarkin et al. (2007) from an RCT and a meta-analysis by Stoffers-Winterling et al. (2012), suggest that TFP contributed to the improvement of depression, anxiety, global functioning, and interpersonal adjustment in participants. TFP was also associated with significant reductions in suicidal and anger, according to Clarkin and colleagues, irritability, physical and verbal aggression, and impulsivity only changed in TFP, compared to other therapeutic models such as DBT.

CONCLUSIONS

In conclusion, TFP is a contemporary psycho-dynamic therapy designed to support people with personality disorders, including BPD; has a robust and consistent theoretical framework that describes and explains the psychopathology of the disorder; The methodology focuses on the analysis of transference in the psycho-therapeutic relationship and has as its general objective, to achieve the structural change of personality, that is, to move from functioning and level of borderline organization of personality, to a level of neurotic organization, which implies the integration of identity, an improvement in acute symptoms, the strengthening of the ego and ego functions such as the reduction of impulsivity and the reduction of emotional dysregulation.

Finally, it should be emphasized that it is a psychotherapy that has empirical support and, together with DBT, MBT, and GPM, is one of the most recognized therapeutic approaches to address this problem.

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