# The Development of Transference-Focused Psychotherapy and Its Model of Supervision

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Transference-focused psychotherapy (TFP) is an empirically based, manualized psychodynamic psychotherapy that emerged as an adaptation of psychoanalytic techniques to meet the needs of patients with personality pathology. As it became more clearly defined through a series of treatment manuals and empirical research, TFP has also come to be considered a conceptual and technical model of therapy that can be used to introduce therapists in training to the principles of psychodynamic psychotherapy in a systematic way. Advanced levels of TFP training and practice involve an emphasis on supervision that is applied in a more structured way than traditional psychodynamic supervision, while respecting the depth and subtlety of psychoanalytic exploration. This article reviews the development of the treatment model and the supervisory process that guides the therapist to carry out TFP in accordance with its proposed mechanism of change.

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To describe the teaching and supervising of transference-focused psychotherapy (TFP) requires an understanding of the development and tenets of the treatment model. Starting in the late 1960s, Otto Kernberg took on the challenge of using psychoanalytic approaches to treat patients with personality pathology (1–3). In tandem, Kernberg and his colleagues pursued the development of research on psychoanalytic treatments (4–6). This combined interest in treatment development and empirical investigation led to a focus on the clear presentation of the methodological application of psychoanalytic techniques (7), as described in a series of treatment manuals that first focused on borderline personality disorder (8–11) and then expanded to the full range of personality pathology (12) and a specific focus on narcissistic pathology (13).

Kernberg's writings (3,14,15) developed the concept of the borderline level of personality organization (BPO), a structural model of psychopathology centered on the concepts of identity diffusion, object relations (perceptions of self and others), and splitting-based defense mechanisms. As Kernberg developed the concept of BPO, which included a dimensional view of severity, the *DSM* system (16) presented a classification system of personality disorders that was descriptive and categorical. More recently, the Alternative DSM-5 Model for Personality Disorders (17) proposed a way of thinking about personality disorders that has much in common with the concept of BPO.

TFP emerged as a specific model of treatment in the 1990s. Originally an extension of the prevalent and relatively unstructured psychoanalytic method (free association, transference analysis, focus on unconscious conflicts and defenses), TFP was developed to meet the clinical needs of patients with personality disorder with a more structured and well-delineated approach that could be manualized. Embarking on a randomized controlled trial (RCT) necessitated a clear definition of the treatment method and the development of instruments to rate adherence to the method (18). The concern regarding adherence increased attention to the supervisory process as the means to teach and monitor the

**HIGHLIGHTS**

- Attempts to adapt psychoanalytic techniques to address the needs of patients with personality disorders led to the development of transference-focused psychotherapy (TFP).
- TFP involves the exploration of unconscious motivations and conflicts within a specific therapeutic structure to facilitate transforming enactments of conflicts into a conscious awareness, leading to integration of internal psychological conflicts through the process of reflection.
- Combining the general elements of psychodynamic therapy and specific elements of therapy tailored to the targeted patient population leads to a model of supervision that is more structured and detailed than traditional psychoanalytic supervision.

application of the model. Linking the supervisory process to a clearly defined model of treatment, with specific indications regarding the model's application to types and levels of pathology, resulted in a more targeted model of supervision than is generally found in the literature on supervision of psychodynamic psychotherapy (19, 20).

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## USE OF VIDEO RECORDINGS IN TFP

The research and development of TFP took place at the Personality Disorders Institute in the Department of Psychiatry of Weill Cornell Medical College. In an RCT that compared TFP with dialectical behavioral therapy and with a supportive psychodynamic therapy (21), all therapists were monitored and supervised weekly by treatment condition leaders, who observed videotaped sessions, provided feedback, and rated therapists for adherence and competence.

Video recordings of sessions were central to studying, teaching, and supervising TFP. At the time, the recording of sessions was considered to interfere with the treatment process of psychoanalytic approaches. However, observing video recordings proved crucial to understanding aspects of technique that had not been fully appreciated when supervision used only process notes. This corresponded to one of the tenets of the TFP theory: the importance of nonverbal as well as verbal communication in a therapy that emphasizes the core role of splitting defenses in personality disorders. To better understand the supervisory process described in the following text, the reader will benefit from this summary of TFP.

## TFP PROCESS

TFP starts with precise diagnostic assessment (22, 23) to allow the therapist to make the appropriate treatment recommendations, both in terms of the range of possible treatments and the specifics of TFP, and to frame the treatment in a way that corresponds to the level of the patient's pathology. The assessment determines the presence or absence of personality pathology and of symptom disorders (formerly referred to as axis I disorders), including posttraumatic stress disorder. TFP is deemed appropriate for diagnoses of any level of personality disorder, with the exceptions of antisocial personality disorder and psychotic-level personality pathology, in the absence of an active symptom disorder such as major depression, bipolar disorder, schizophrenia, or substance use disorder. Having established an appropriate diagnosis, the therapist proposes a clear frame of treatment, through discussion of the treatment contract, to channel the patient's affects into the therapy sessions rather than having them expressed through acting out.

During the psychodynamic exploration phase of TFP, the work is guided by a focus on splitting, which is understood to be the radical separation of all-positive affects and all-negative affects in the mind. The polarized affects are associated with extreme internal images of the self and of others. Abrupt shifts from one extreme to the other underlie the affective instability; relational problems; acting-out behaviors; and vague, ill-defined sense of self of those with borderline personality disorder. The therapy is based on creating a safe context within which the disparate, polarized experiences of self and of others can instead be experiences in relation to the therapist, whose role is to engage the patient in reflecting on the patient's unquestioned and often rigid and caricatured experiences. Over time, observing the patient's various intense experiences of self in relation to the therapist (the transference) provides awareness of the patient's disconnected internal affective states and helps the patient overcome the anxieties that prevented the integration of those disparate experiences of self in relation to others into a coherent whole.

Because of the focus on creating awareness of dissociated (split-off) emotional states that may not be communicated through the patient's verbal expressions, but that can be accessed through attention to the patient's nonverbal communication and the therapist's countertransference, the therapist is encouraged to read all three channels of communication (verbal, nonverbal, and countertransference) simultaneously in each session. The therapist uses these data to follow the basic strategies of TFP, starting with formulating in his mind the interactional dyad that seems to be active in the moment, with attention to possible role reversals within the dyad that could shed light on split-off aspects of the patient's internal world. The therapist uses the techniques of TFP (maintaining therapeutic neutrality; utilizing countertransference; and following the process of transference analysis through cycles of clarification, confrontation of inconstancy, and interpretation) in the service of helping the patient move from a split internal psychological structure to an integrated one, as demonstrated by the following dialogue.

> Therapist: You're talking about possibly killing yourself, but it might help us to think about what your facial expression seems to be communicating.
> Patient: What do you mean?
> Therapist: You're looking at me with intense scrutiny, implying that the deeper issue might not be suicidal thoughts but, rather, interest in how I respond to them. This would fit with your doubts about whether I, or anybody, cares about you. But it seems hard to discuss that concern directly for fear of being disappointed.

Given the emphasis on nonverbal communication in TFP, switching to teletherapy during the COVID-19 pandemic posed a challenge. However, experience showed that recorded teletherapy sessions provide sufficient data on nonverbal communications to permit adequate supervision.

TFP became a more clearly defined model of treatment throughout the 1990s (8, 10). Although a core didactic curriculum was established, supervision is the central element in learning the model of therapy, as reflected in the International Society of Transference-Focused Psychotherapy criteria for certification as a TFP therapist (24). The supervisory experience has been enriched by reflection on the process of supervision itself and the development of a clinical adherence-rating instrument that can be used as a guide during supervision (24).

The supervisory process, like TFP itself, combines an emphasis on structure and limit setting with careful exploration of unconscious processes. Supervision in TFP goes beyond some of the basic elements of supervision described in recent texts on the subject (19, 20) to focus on the specific object relations understanding of personality pathology and the therapeutic process on which TFP is based and to relate the supervisory process to the mechanisms of change, particularly transference interpretation and reflective function, posited in TFP (25).

## DEVELOPMENT OF A TFP CHECKLIST

To aid the supervisor in attending to the multiple aspects of the treatment, a checklist has been developed (O.F. Kernberg and F.E. Yeomans, unpublished manuscript, September 15, 2021) that covers all necessary aspects of supervision. When it has been established that the fundamental elements of supervision reviewed in the checklist are in place, a further refinement in the supervision process in TFP may be used that emphasizes group and parallel process analysis in the supervision group to deepen the understanding of the patient's dynamics and the therapist's work in the session (S. Doering, A. Schneider-Heine, and M. Lohmer, unpublished manuscript, August 30, 2021). The checklist both ensures that all necessary conditions are present for meaningful therapy to take place and monitors the therapist's basic adherence in attending to the TFP exploratory process. This list can be summarized as follows.

The main concern, both at the beginning of a new case and sometimes as the supervision progresses, is to have an accurate diagnostic assessment, combining descriptive and structural elements of a case and clarifying any differential diagnostic questions that remain. An accurate diagnosis is essential to the management of a case, and reconsideration of the diagnostic question is always an option as a case proceeds.

The second focus is on the indications and contraindications for treatment, confirming that a case is appropriate for TFP and spelling out the major objectives that the patient has for his or her treatment and whether a sufficient concordance exists between the patient's and the therapist's objectives to warrant embarking on the treatment. The emphasis on clear goals of therapy is different from the traditional psychodynamic view that understanding, per se, is the goal of therapy. The discussion of treatment goals also provides the frame for future transference analysis if conflicting views of the treatment objectives or how to achieve them arise as therapy proceeds.

As part of the initial discussion of a case, the supervisor makes sure that the therapist has discussed his diagnostic impression with the patient to provide some basic psychoeducation about how to understand the condition; reviewed the nature of the recommended treatment with the patient and explained its exploratory nature, in contrast to an overtly supportive therapeutic approach; and clarified the central role of free association in relation to the problems that brought the patient to therapy.

Next comes a review of any special elements of the treatment frame or contract that had been included because of the risk of acting-out behaviors that could challenge the exploratory process. As the therapy moves forward, the supervisor will be careful to help the therapist note any deviations from the agreed-on conditions of treatment that may occur.

Having clarified the diagnosis, treatment goals, description of the therapeutic method, and treatment frame, the supervisor next observes how the therapist deals with the exploration of the patient's internal world as it unfolds in the transference or in extratransferential relationships. The supervisor ensures that the therapist is adequately informed about the patient's "outside life" in a way that is foreign to much psychoanalytic work. This is done both to look for transference and relational patterns in interpersonal interactions outside the therapy and to stay informed about the patient's present real-world functioning.

Supervisory work focuses most closely on the proposed process of change in TFP during transference analysis (25). The establishment of the treatment frame creates a setting in which the intense affects that characterize the patient's split internal psychological organization emerge. These affects are linked to paired internal images of self in relation to an other (object relations dyads) that are activated in the therapeutic setting. The supervisor helps the therapist remain faithful to the exploratory work, even when doing so increases the emotional intensity in the session. This is in contrast to the therapist's provision of cognitive corrections of an inaccurate perception of the therapist. The goal is to identify and interpret the affectively charged, maladaptive representations of self and others in the patient's mind.

For example, if a patient responds to the therapist's glancing at the clock by saying, "It's obvious you can't stand me and want to get rid of me," the supervisor helps the therapist avoid reassuring the patient (e.g., "I'm actually very committed to you and your therapy") and supports the therapist in the more arduous task of entering into the negative transference triggered by the glance at the clock. Using the technique of seeking clarification of the images in the patient's mind, the therapist engages the patient in becoming more aware of the specific internal representations of self and other from which the affect emerges. The supervisor often helps the therapist deal with intense countertransference reactions at such moments. Then, by using the technique

of confrontation, the therapist helps the patient become aware of affective and perceptual contradictions related to his split internal psychological structure. This work involves helping the patient become aware both of denied aspects of the self that are projected onto others and of radically different experiences of self and others that emerge sequentially (not simultaneously). The technique of interpretation helps the patient understand the anxieties that perpetuate his split internal state and then helps the patient develop an integrated sense of self and others that permits the modulation of affects, because they are now experienced in the context of the broader and richer foundation of an integrated sense of self and others.

## STRUCTURE OF SUPERVISORY SESSIONS

With regard to the structure of the supervisory sessions, the supervisor should begin by asking about the patient's external reality (e.g., Is there anything new or relevant going on in the patient's life?) before proceeding to exploration of the dynamics in the session. The supervisor helps the therapist determine where the patient's affect is strongest—whether in the transference or in relation to outside life—and define the dyad that underlies the affect.

The supervisor regularly reminds the therapist of the principle that any distortion of the "normal" relation in the therapeutic interaction (interested and committed patient and therapist joined in collaborative exploration) provides information about dyads in the patient's mind that determine his experience of others in ways that he does not question. For example, a patient who feels that the therapist is more interested in showing how smart he is than in helping the patient harbors both paranoid and narcissistic concerns in relation to others.

The final focus is on the therapist's skill in applying technical interventions: maintenance of technical neutrality, use of countertransference reactions, and application of interpretive interventions. Helping the therapist to be more fully aware of countertransference is the most important role of the supervisor, who relates the therapist's communication of his countertransference in supervision to what is observed in the video and to the therapist's affect and manner in communicating the clinical material.

In addition to attending to the nature of the therapist's interventions in supervision, it is important that the supervisor engage the therapist in reflecting on the nature of the patient's discourse. This is done to avoid the therapist's overemphasis on the content of the patient's verbal communication versus the form of the discourse. Attention should be paid to whether there is a connection between the patient's discourse and a goal of therapy or whether the discourse tends to avoid underlying affects and conflicts, the nature of the patient's discourse (e.g., whether the patient is having trouble with free association or flooding the session with material in a way that makes it hard for the therapist to intervene), and presence or absence of narrative coherence (the extent to which the patient creates a narrative that is organized, credible, and authentic vs. disjointed, disorganized, and discontinuous) (26). These questions are related to the fragmentation versus integration of the patient's internal world. The nature of the patient's discourse may be a way of putting a dyad into action (e.g., control of the therapist by flooding the session with words). Changes in the quality of the patient's narrative coherence in TFP have been found to be an indication of structural change (27).

An additional supervisory task is to ensure that the therapist is respecting the concept of priorities of intervention described in the TFP manuals (8–12). This concept contrasts with the privileging of the process of free association that is typical of classical analytic technique. It calls for the therapist to prioritize and actively address any evidence of a threat to the safety of the patient (or of anyone else) or of threats to the continuation of the treatment.

An important part of the supervisory process is to convey to the therapist how to explain interventions in an accessible, patient-friendly, relatable way. Supervision often develops jargon-laden formulations that do not make a dent in the patient's defensive system; verbal expressions need to be worded in a way that connects to the patient's subjective experience and tactfully helps him see what he has been defending against. For example, if the formulation is, "It seems that the patient's anxiety about libidinal longings is leading to defensive anger and hostility," the challenge is how to translate that concept into an intervention that can engage the patient's reflective capacities. It is useful to name the present affect first (e.g., anger) and then make note of other data (e.g., a look or feeling of fearful longing) to consider what might motivate the affect, staying close to the patient's words and descriptions.

Parallel process can be both a problem in supervision and an opportunity to further understanding. It is usually an indication of resistance in the therapist or of difficulty seeing an emergent object relational scenario. For example, in discussing a session in which the patient seemed to ignore the therapist's interventions and the therapist did not comment on this inattentiveness, the supervisor began to bring the therapist's attention to the patient's dismissiveness. At that point, the therapist seemed to pay little attention to the supervisor's comments. The supervisor proposed that the therapist may be defending against the painful experience of being devalued by a patient and then discussed how the patient may have, by projective mechanisms, defended against a painful sense of humiliation in himself by inducing it in the therapist—who, in turn, brought it into the supervisory process. Parallel process enactments may stem from material in the session that has activated an unconscious conflict within the supervisee. Open discussion of countertransference, of both the supervisee and the supervisor and, if relevant, of others in a group setting, is essential.

Finally, the supervisor pays careful attention to the patient's response to the therapist's interventions and how the therapist works with that response. Such moments can

represent a sudden shift in the internal dyad that is active. Therapists often miss the shift, for example, from an anxious paranoid transference to a devaluing narcissistic transference and continue to work with the former when the latter has become more relevant. The supervisor's role includes helping the therapist to be aware of these shifts.

## CONCLUSIONS

The teaching and supervising of TFP are intimately linked to the object relations understanding of personality pathology that underlies the treatment model. In supervision, as in TFP itself, there is careful attention to diagnostic assessment and the framing of the treatment before the exploratory work can become the focus. Supervision involves monitoring adherence to the multiple aspects of the treatment model and evaluating the therapist's use of the techniques of TFP. The supervision process supports the fundamental mechanism of action of TFP: to identify the split-off internal experiences of self and others that are associated with intense, unintegrated affects and to help the patient achieve an integrated internal world that allows for the modulation of immediate affects in the broader context of an integrated self.

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### REFERENCES

1. Kernberg O: The treatment of patients with borderline personality organization. Int J Psychoanal 1968; 49:600–619
2. Kernberg OF: Factors in the psychoanalytic treatment of narcissistic personalities. J Am Psychoanal Assoc 1970; 18:51–85
3. Kernberg OF: Borderline Conditions and Pathological Narcissism. New York, Aronson, 1975
4. Kernberg OF, Burstein ED, Coyne L, et al: Psychotherapy and psychoanalysis: final report of the Menninger Foundation's psychotherapy research project. Bull Menninger Clin 1972; 36:1–277
5. Koenigsberg HW, Kernberg OF, Haas G, et al: Development of a scale for measuring techniques in the psychotherapy of borderline patients. J Nerv Ment Dis 1985; 173:424–431
6. Koenigsberg HW, Kernberg OF, Appelbaum AH, et al: A method for analyzing therapist interventions in the psychotherapy of borderline patients. J Psychother Pract Res 1993; 2:119–134
7. Kernberg OF, Clarkin JF: Developing a disorder-specific manual: the treatment of borderline character disorder; in Psychodynamic Treatment Research: A Handbook for Clinical Practice. Edited by Miller NE, Luborsky L, Barber JP, et al. New York, Basic, 2013
8. Clarkin JF, Yeomans FE, Kernberg OF: Psychotherapy for Borderline Personality. New York, Wiley, 1999
9. Clarkin JF, Yeomans FE, Kernberg OF: Psychotherapy for Borderline Personality: Focusing on Object Relations. Arlington, VA, American Psychiatric Publishing, 2006
10. Kernberg OF, Selzer MA, Koenigsberg HW, et al: Psychodynamic Psychotherapy of Borderline Patients. New York, Basic, 1989
11. Yeomans FE, Clarkin JF, Kernberg OF: Transference-Focused Psychotherapy for Borderline Personality Disorder: A Clinical Guide. Arlington, VA, American Psychiatric Publishing, 2015
12. Caligor E, Kernberg OF, Clarkin JF, et al: Psychodynamic Therapy for Personality Pathology: Treating Self and Interpersonal Functioning. Washington, DC, American Psychiatric Association Publishing, 2018
13. Diamond D, Yeomans FE, Stern BL, et al: Treating Pathological Narcissism With Transference-Focused Psychotherapy. New York, Guilford, 2021
14. Kernberg OK: Internal World and External Reality: Object Relations Theory Applied. New York, Aronson, 1980
15. Kernberg OF: Severe Personality Disorders. New York, Aronson, 1984
16. Diagnostic and Statistical Manual of Mental Disorders, 3rd ed. Washington, DC, American Psychiatric Association, 1980
17. Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Arlington, VA, American Psychiatric Association, 2013
18. Clarkin JF, Foelsch PA, Levy KN, et al: The development of a psychodynamic treatment for patients with borderline personality disorder: a preliminary study of behavioral change. J Pers Disord 2001; 15:487–495
19. Kennedy KG, Welton R, Yeomans FE (eds): Supervising Individual Psychotherapy: The Guide to "Good Enough." Washington, DC, American Psychiatric Association Publishing, in press
20. McWilliams N: Psychoanalytic Supervision. New York, Guilford, 2021
21. Clarkin JF, Levy KN, Lenzenweger MF, et al: Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry 2007; 164:922–928
22. Kernberg OF: Severe Personality Disorders: Psychotherapeutic Strategies. New Haven, CT, Yale University Press, 1984
23. Clarkin JF, Caligor E, Stern BL, et al: Structured Interview of Personality Organization–Revised (STIPO-R). New York, Weill Medical College of Cornell University, Personality Disorders Institute, 2016. https://borderlinedisorders.com/assets/STIPO-R.pdf
24. Levels of Certification in TFP. New York, International Society of Transference-Focused Psychotherapy, 2022. https://istfp.org/training/levels-of-certification-in-tfp. Accessed May 1, 2022
25. Levy KN, Clarkin JF, Yeomans FE, et al: The mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy. J Clin Psychol 2006; 62: 481–501
26. Stern BL, Yeomans FE: The psychodynamic treatment of borderline personality disorder: an introduction to transference-focused psychotherapy. Psychiatr Clin North Am 2018; 41:207–223
27. Levy KN, Meehan KB, Kelly KM, et al: Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. J Consult Clin Psychol 2006; 74:1027–1040