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# Therapist Competency Using Transference-Focused Psychotherapy to Treat Borderline Personality Disorder.

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# THERAPIST COMPETENCY USING TRANSFERENCE-FOCUSED PSYCHOTHERAPY TO TREAT BORDERLINE PERSONALITY DISORDER

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## ABSTRACT

THERAPIST COMPETENCY USING TRANSFERENCE-FOCUSED PSYCHOTHERAPY TO TREAT BORDERLINE PERSONALITY DISORDER

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Empirical research on clinician experience of competency treating borderline personality disorder is scarce, and that which does exist focuses on the negative experiences of those who treat this population. Utilizing an interpretive phenomenological analysis approach, this qualitative research investigation explored the lived experience of feelings of competency in clinicians treating borderline personality disorder using the evidence-based model of Transference-Focused Psychotherapy. To better comprehend this phenomenon and address research questions, data were collected via one, semi-structured interview given to five different clinicians who practice Transference-Focused Psychotherapy. Four themes emerged from the researched data: Positive treatment outcomes for patients, Using negative countertransference for positive therapeutic intervention, Reliability of treatment framework, and Effectively dealing with crisis and suicidality. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).



*Keywords*: borderline personality disorders, transference-focused psychotherapy, clinician competence, transference, countertransference, suicidality, consultation, projective identification, splitting, evidence-based treatments, psychodynamic psychotherapy, psychotherapists, identity diffusion, psychiatrists

**Dedication**

This dissertation is dedicated to my beloved Grandparents:
Robert Leonard Lovett (Grandpa, Buddy Boy)
and Phyllis Arlene Goodman Lovett (Bubbe)

I know you are so proud of me.

I love you *more*.

*"This above all: To thine own self be true.*
*And it must follow,*
*As the night the day,*
*Thou canst not then be false to any man."*
*-William Shakespeare, Hamlet, c. 1601*

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# CHAPTER I: INTRODUCTION

Borderline personality disorder (BPD) is a psychiatric illness stigmatized as being one of the most difficult populations for therapists to treat because symptoms often unfold in interpersonal relationships. Because of this, treating this population often puts clinicians in complex scenarios that involve managing patient rage, devaluation, sexualization, and suicidality (Barnicot al., 2015; Bourke & Grenyer, 2013; Lee, 2017; Sulzer, 2015). Emotional dependency on the therapist can activate old relationship dynamics where the patient becomes aggressively paranoid regarding the therapist's intentions, often followed by a masochistic withdrawal; both holding potential for patient drop out. In some cases, the therapist will unintentionally say something that may hurt the patient's feelings and because the patient is highly sensitive to rejection, they respond to their hurt by becoming subtly or outwardly angry. Depending on how the therapist is trained, it may be unclear what is happening and the patient's anger will cause the clinician to become afraid and anxious. Herein lies the problem as the therapist comes to feel confused, incompetent, and trapped. If unequipped to handle these scenarios, therapists may find that these factors often impact aspects of treatment such as patient engagement, case management, treatment retention, and dropout rates (Tusiani-Eng & Yeomans, 2018).

Transference-Focused Psychotherapy (TFP) was specifically designed to address and utilize strong emotions that arise for therapeutic action (Levy et al., 2019). Therapeutic technique focuses on interpreting stormy, intense, and sometimes aggressive communication from patient to therapist through the lens of object relations. The primary technique of TFP is to allow the internal world of personality-disordered patient to unfold in context of the patient-therapist relationship so that internalized representations of self and other can be examined and

interpreted. TFP has been shown to have equal or greater benefits than other evidence-based therapies designed for individuals with BPD (Levy et al., 2019).

To date, there is no qualitative research on therapists' experience of competency when using TFP to treat individuals with BPD. This study will seek to help explore the stories of therapists, while keeping confidentiality, of how TFP has or has not helped their feelings of being an effective therapist. The study will also aim to describe what therapists define as helpful about TFP, not just in terms of its efficacy, but in helping them to feel more therapeutic and less controlled by the patient.

Initially, I will review the relevance and impact of BPD on the health care system. Then, I will outline the objectives and conceptual framework that guides the study. I will then critique the framework and provide a rationale for this study. A review of the literature on BPD, core aspects of TFP and its focus on the therapist will follow. I will conclude this section by addressing the research questions that guide the study.

**Nature of the Problem**

In the United States, the prevalence of BPD to be 1.6% of the population (Chapman et al., 2020; Yen et al., 2021). The clinical prevalence of BPD is estimated to be 20% of inpatient psychiatric population (Chapman et al., 2020). It is estimated that 73% of individuals with BPD will attempt suicide approximately three times in their life and approximately 9% will die by suicide (Yen et al., 20201. Additionally, individuals with BPD have a high lifetime risk of developing comorbid mental health disorders such as anxiety (84.5%), mood (82.7%), and substance use disorders (78.2%; Fornelos & Roque Pereira, 2019). The magnitude of the disability burden associated with BPD is also significant (Finch et al., 2019). There are several barriers associated with treating BPD such as lack of funding to maintain specialized trainings,

lack of therapist education, lack of diagnostic training, and minimal insurance coverage for evidence-based treatments (Finch et al., 2019). Because of these factors, most mental health services typically utilize short-term interventions and case management which are not likely to produce long-term sustained recovery (Lohman et al., 2017). Due to the demanding nature of treating individuals with BPD, and considering the promising use of TFP, it is important to understand the experience of therapist competency feelings while practicing this model.

## Objectives of the Study

This study will seek to understand therapists' experience of competency when using TFP to treat individuals with BPD. Feeling incompetent is a common experience for therapists, and in particular, therapeutic incompetence. The results of this study endeavor to help increase awareness of treatment modalities that enhance the feeling of technical competence of therapists treating individuals with BPD. This will allow for therapists treating individuals with BPD to better understand the nuances of support inherent in the TFP model. Furthermore, it is empirically supported that a clinician's feeling of incompetency impacts treatment outcome, premature termination, alliance ruptures, stress, and compromised personal life of the therapist (Hannigan et al., 2004; Thériault & Gazzola, 2010). In the context of treating individuals with BPD, these elements are vulnerable to vary in nature and intensity regardless of clinician competency. Therefore, there is clinical value in studying therapists' feelings of competency when treating individuals with BPD.

## Conceptual Framework

To describe the conceptual framework that will be used to guide the theoretical underpinnings of this study, Kernberg's (2018) version of object relations theory will be used. One justification for relying so heavily on Kernberg's version of object relations is that TFP

developed from Kernberg's work on the development and maintenance of borderline pathology. It should be noted though, that there are a lot of theories and evidence that support the idea that BPD is a complex developmental condition that is not only a matter of drive overload and internal conflict but also exposure to trauma and the genetic constitution of the individual (Kernberg, 2019).

An *object* is a psychic representation of an event, person, or part of a person, which takes on a life of its own in the internal world of the infant (Kernberg, 2019). According to Kernberg's object relations model, in infancy, two independent segments of the world are experienced; one in which a contented infant relates to a contented other, specifically primary caregivers, and one in which an uncontented infant relates to a depriving, unsatisfactory, agitating caregiver. In "normal" development, these two experiences of a primary caregiver become modified in such a way that the infant realizes the caregiver can be both frustrating and gratifying at the same time (Kernberg, 2019). In other words, both the good and bad experiences of the mother become integrated into neither an *all-good* or *all-bad* significant other. This is what Kernberg considers *normal identity integration*. However, if bad experiences for the infant predominate, this fusion of cannot be achieved, and the infant is stuck with the separation of these two segments of interpersonal experience (Kernberg, 2019).

Intrapsychic development of the infant is dependent on *valence* of affect. The valence of affect determines the level of integration of both positive and negative experiences (Clarkin et al., 2018). The more intense the valence of affect is, the less integration occurs. For example, the internal experience of a negative object is linked with valence of affect, such as rage towards the other. Depending on the level of affective valence, this could prohibit the integration, and therefore tolerance, of both good and bad qualities in an object. Integration is not only dependent

on valence but is seen as an amalgamation of constitutions (Clarkin et al., 2018). The infant's inability to integrate positive and negative experiences of the primary caregiver may be a result of genetics which influence temperament, hyper-reactivity, and hyper-sensitivity to the environment. It may also be attributable to the infant experiencing an overwhelming amount of negative experiences in early life such as chronic abandonment, neglect, sexual abuse, physical abuse, emotional abuse, and severe disorganization in the family structure. Ultimately, Kernberg's model of object relations conceptualizes the development of BPD as an amalgamation of genetic constitutions, temperamental dispositions, and environmental dispositions that interact to different degrees (Kernberg, 2019).

When the infant cannot fuse both good and bad experiences of a significant other, as a result of the aforementioned developmental factors, the "good" object is at risk of being contaminated with bad experiences, and the "bad" object is a risk of being contaminated with good experiences. If contamination occurs, the infant experiences uncertainty of how to conceptualize the object, which causes enormous anxiety and confusion. From this develops the defense mechanism of *splitting* and *idealization* where idealized representations of others take on internal experiences of loving, satisfying feelings, which are kept separate from negative feelings to preserve the idealization. In effort to maintain this separation, negative emotions one feels for an idealized other are projected in an attempt to control the preservation of the good object. Therein lies the development of defense mechanisms *projection*. Projection means that one is attributing emotions of their own to another person because the ownership of those emotions is too intolerable. Therefore, attributing those emotions to someone else gives the individual a way to ultimately experience the emotion vicariously, which is tolerable.

These are known as *primitive defenses* and are commonly seen in severe personality pathology, and are the underpinnings of *identity diffusion*. Identity diffusion means that the individual lacks a sense of self (e.g., lack of belief in one's self, overly critical of one's self, feeling as if one becomes a different person based on who they are with) which results in profound dependency on others for emotional security and stability (Kernberg, 2019). To not have an intact sense of self induces chronic feelings of emptiness which can be a terrifying experience. Because of this, any slight distance in close relationships may be perceived as an abandonment, which may trigger feelings of fear and isolation (Kernberg, 2019).

**Critique**

With regard to empirical research, TFP is a useful framework to use when working with individuals with BPD, yet there is room for critique. The ability to identify and interpret self and object representations as they emerge in session, even during times when therapists feel most attacked by the patient, is crucial to this framework. This places significant pressure on the therapist to make well-timed, clear, detailed, convincing and accessible transference interpretations that are devoid of retaliation or anger. This may be particularly difficult for some therapists, and it is not clear what other elements are required, other than receiving supervision and understanding the theory, would appropriately prepare a therapist for this intensive treatment (Bax & Nerantzis, 2022).

Further, the emphasis on countertransference management and interpretation serves as both a therapeutic tool and an aid to the therapist who will ostensibly be overcome by intense affect. This requires the therapist to continuously pay close attention to internal processes in both themselves and the patient. The potentially taxing nature of this work, in conjunction with likely

enduring intense countertransference, cannot be undermined and requires the use of consultation (Choi-Kain et al., 2016). However, consultation is not guaranteed after the training process.

Additionally, the emphasis on maintaining the treatment contract may be difficult for some therapists depending on the severity of patient symptoms and their personal reactions to the patient. The level to which each therapist will feel comfortable adhering to the treatment contract likely requires therapists to have some insight into their own object relations, otherwise countertransference interpretation runs the risk of being skewed by the therapist's personal blind spots (Gunderson, 2010).

## Rationale for Proposed Approach

Therapists treating individuals with BPD have reported feeling incompetent, inadequate anxious, concerned, frustrated, and confused in sessions (Tanzilli & Lingiardi, 2022). Individuals with BPD will typically experience oscillations of how they view the therapist. In one moment, the patient may feel persecuted by the therapist and experience them as sadistic. In the next moment, the patient may treat the therapist in a sadistic, controlling way (Kernberg, 2019). The therapist is always at risk of becoming someone the patient no longer desires treatment from, feels doesn't understand them, and endlessly frustrates them because they do not provide the perfect care. In some cases, this can result in patients experiencing intense, uncontrollable rage. They may resort to sexualizing the therapist or develop suspicious paranoia of the therapist's intentions, which can result in parasuicidal behaviors and threats to pursue litigation (Barnicot et al., 2015). This inevitably impacts important aspects of treatment such as patient engagement, treatment outcome, and dropout rate (Barnicot et al., 2015).

Colli and colleagues (2014) examined the relationship between psychologists' affective responses and patient diagnosis. Colli and colleagues (2014) interviewed 203 psychologists and

found that helpless, inadequate, overwhelmed, disorganized, special, and over-involved were also countertransference emotions elicited by individuals who have BPD. In other studies, therapists have reported feeling as if they are in a life-and-death struggle during session due to the intensity of affect experienced within the relationship (Bhola & Mehrotra, 2021). Therapist anxiety is almost always present in treatment with individuals with BPD (Bourke & Grenyer, 2013; McMain et al., 2015). Additionally, anxiety associated with the possibility that the patient may commit suicide or that there may be litigiousness and ethical complaints, are typically present throughout treatment (Gordon et al., 2019).

Aguirre (2015) identified feelings of dread are often common while treating individuals with BPD. This is likely due to intense displays of devaluation or idealization, unpredictable affect, and negative attitudes towards the patient. Therapists have also reported feeling more hostility towards individuals with BPD than patients with other psychiatric diagnoses such as major depressive disorder (Aguirre, 2015). Additionally, individuals with BPD present several barriers to treatment including self-mutilation, rule-breaking behaviors, rejection of care, requiring too much care, destructiveness, and attention seeking, manipulative behaviors (Aguirre, 2015; Bourke & Grenyer, 2013; Sulzer, 2015).

Because individuals with BPD have heightened sensitivity to rejection and abandonment, the slightest perception of aloofness may spark frantic efforts on behalf of the patient to re-establish security. This may come in the form of self-harm, testing boundaries of the treatment framework, intense affect dysregulation, and dropping out from treatment (Dahl et al., 2016). These factors increase therapist anxiety and may increase their chances of acting out on countertransference impulses (Dahl et al., 2016). Therapist anxiety, discomfort, and boundary transgressions may occur due to the urge to go to extraordinary lengths to demonstrate sincere

concern to the patient. This can lead to ethical issues related to practice competence (Dahl et al., 2016).

If pervasive negative countertransference goes unaddressed, it can become detrimental to the treatment process and therapeutic outcome (Gordon et al., 2016). The TFP framework is structured around understanding therapist countertransference and utilizing these emotions to inform and deepen treatment. Therefore, there is clinical value in studying how TFP informs therapists' feelings of competency treating individuals with BPD.

# CHAPTER II: REVIEW OF THE LITERATURE

The title "borderline" can be both stigmatizing and marginalizing because there is a widely held belief that this label encompasses the entirety of who the individual is. Particularly for therapists, it is important to be educated about the diagnosis rather than simply utilizing a certain label. In many cases, there are inherent interpersonal stressors when treating individuals who have BPD, which has long posed concerns to the mental health community. The purpose of this literature review is to understand the nuances of what makes treatment complicated with these patients. Additionally, it will examine the role of the therapist in TFP to better understand how the treatment framework impacts feelings of competency on behalf of the therapist.

## Clinical Presentation of Borderline Personality Disorder

According to Kernberg (2016, 2019), personality disorders are disturbances in a person's capacity to relate harmoniously to the psychosocial environment and to his or her internal needs. This often results in abnormal behaviors and emotional dysregulation which effects one's life in the main areas of work, love, sex, social life, and creativity (Kernberg, 2016, 2019). BPD is defined as "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following" (American Psychiatric Association, 2013):

(1) Frantic efforts to avoid real or imagined abandonment.

(2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

(3) Identity disturbance: markedly and persistently unstable self-image or sense of self.

(4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).

(5) Recurrent suicidal behavior, gestures or threats, or self-mutilating behavior.

(6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

(7) Chronic feelings of emptiness.

(8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

(9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

In terms of clinical presentation, borderline symptomatology commonly presents as intense affect, rapid shifts between paranoid rage and masochistic withdrawal, idealization and then devaluation of objects, impulsivity, self-destructiveness, and aggressive dependency (Kernberg, 2019). While individuals with BPD have intact reality testing, they may experience quasi-psychotic episodes in intimate social situations. In other words, when these individuals are engaged in regular life, they may appear totally healthy, but when they become close with another person, they may appear as psychotic in the way they interpret relationships because there is a fundamental difference in the shared reality. For example, an individual with BPD may experience their partner's need for autonomy in the relationship as a form of hate-driven abandonment. Another example is their propensity to feeling attacked because they have become accustomed to being hurt, when that is not necessarily the objective interpersonal experience.

Individuals with BPD may become paranoid that their romantic partners, or even their therapists, secretly hate them or are trying to get away from them; even if someone has worked

hard to prove that they will not. Because of this, the slightest hint of rejection may trigger them into believing that their abandonment paranoia was correct all along. This turns their fear of abandonment into an active attempt to avoid being left which may manifest in seemingly controlling or manipulative behavior. If one goes through life feeling like the people closest to them are on the precipice of abandoning them at the slightest frustration, it is going to take an immense toll on their emotions and ability to regulate them. So, it is understandable why someone would turn to extreme measures to escape the pain of emotional dysregulation (e.g., cutting, substance abuse). The interpersonal consequence of feeling so hurt is that it is easy to become hostile and say hurtful things in response; not because someone with BPD is bad or malicious, but because they feel justified in how hurt they are. So to the lay person, this behavior might come across as being evil or malicious, but what's happening is that one of people in the relationship are setting boundaries and the borderline person is reacting in accordance with feeling rejected and abandoned as a result of those boundaries.

Due to this, individuals with BPD have perceptions of others that shift abruptly according to immediate circumstances and minor triggers. These abrupt shifts in perception result in a dysregulation of both cognition and affect (Gratz et al., 2019). For example, the individual does not just get angry, they often are convinced that there is a justifiable reason to be angry (Kernberg, 2019). Inherent in this is an oscillation between cognitive-affective states (Gratz et al., 2019; Kernberg, 2019). For example, the individual may experience themselves as a helpless victim in the face of aggression in one moment, and in the next moment, may behave with rageful aggression towards the self or others (Kernberg, 2019). In the face of intense affect, borderline individuals have a tendency to self-mutilate to calm themselves down as if experiencing pain gives them a sense of control. Affective dysregulation can also lead to the

individual becoming suicidal as an expression of their rage and irritation directed against the self as well as others. This chronic instability and lability of mood is problematic in their relationships. This very aspect is what has given individuals with BPD a negative stigma because their shifts in mood seriously affect the way in which they relate to important people in their lives. There's also a problem with interpersonal uncertainty, where they oscillate between love and hate of others and have difficulty assessing other people (Kernberg, 2019). There is a painful puzzlement of where they stand in relation to others, and a need to adjust their behavior to those around them to maintain a sense of internal security. This allows them to understand what is expected of them and what to expect of others. Often individuals with BPD are unable to maintain jobs and relationships because of their contradictory behaviors towards others, rage attacks, excessive demands, that end up causing others to react strongly, perhaps with anger or rejection (Kernberg, 2019). What is perhaps most painful for the individual is that their reactions form a self-fulfilling prophecy in which the individual ends up experiencing what they are most afraid of (e.g., aggression, abandonment; Kernberg, 2019).

Another core feature of BPD is affective instability as well as the inability to sustain positive affect. Affective instability is defined as a deficit in the ability to internally modulate both the experience and expression of emotions in the presence of negative affect (Gratz et al., 2019; Kernberg, 2019). Affective instability is one of the most persistent symptoms of BPD. It is also considered to be the symptom that prevents the individual from moving to remission or recovery and is one of the real challenges to treatment (Gratz et al., 2019; Scott et al., 2017). Intense affective instability is usually comprised of paranoid reactions that manifest in rage, withdrawal, seething hostility, or painful despondency. Intense affective instability is frequently experienced by individuals with BPD and often leads to drop out (Desrosiers et al., 2015).

In terms of how these elements manifest in the therapy relationship, there is repetition in this relationship as there is in all other relationships. In cases of primitive idealization, patients are desperate to maintain an ideal view of the therapist because they are so afraid of a horrible view of the therapist. So they divide the therapist into either all good or all bad, and they oscillate their views of the therapist, and of themselves. This chain of events contributes to borderline individuals receiving labels with negative connotations such as manipulative or controlling. However, the more justified way of viewing controlling or manipulative behavior is seeing it as a desperate request for security (Kernberg, 2019). It is important to note that not all borderline individuals have the same degree of sense of self. It may be that an individual has more sense of self in particular situations while others may not.

**Diversity and Culture**

BPD manifests in different ways depending on a variety of factors, two of which are culture and gender. In terms of gender, BPD is more commonly diagnosed in women than men (Scheiderer et al., 2015). However, there is evidence to suggest that BPD is equally as prevalent in men as it is in women (Grant et al., 2012). Sansone and Sansone (2011) propose that the perception of a female predominance may be due to the varied expression of BPD. This gender bias may come from the fact that many BPD diagnoses are given in psychiatric settings, which may not reflect the true gender distribution of BPD (Sansone & Sansone, 2011). Moreover, women are more likely to seek mental health treatment, which may account for the overreport of BPD in women (Scheiderer et al., 2015). Men are more likely to endorse the DSM criteria of "intense and inappropriate anger" and "impulsivity." Women, however, were more likely to endorse DSM criteria of "chronic feelings of emptiness," "affective instability," and "suicidal/self-harm behavior" (Bozzatello et al., 2024). Women who are diagnosed with BPD

may exhibit more dependent and submissive interpersonal behaviors, whereas men with BPD may display more controlling or dominant behaviors, which can lead to different types of boundary violations in therapy. In terms of sexual boundary violations, male therapists working with female patients may be more cautious about potential allegations of sexual misconduct, whereas female therapists may face increased sexualized transference or countertransference with male patients (Hook & Devereux, 2018).

In terms of treatment utilization, there are notable differences between genders. Men with BPD have higher rates of drug and alcohol rehabilitation service utilization, whereas women with BPD have higher utilization rates of mental health services (Goodman et al., 2010). It is important to consider that borderline symptomatology in men may manifest in antisocial behaviors and substance abuse. This would account for greater male presence in rehab and prisons, and under-representations in mental health settings (Bayes & Parker, 2017). Research also suggests that women are more likely to display help-seeking attitudes, such as the utilization of mental health care services, when compared to men (Scheiderer et al., 2015).

In terms of culture, De Genna and Feske (2013) studied a sample of Black female psychiatric outpatients with BPD. De Genna and Feske (2013) found that Black participants reported low levels of suicidal behaviors and self-injurious behaviors, and high levels of expressed anger and aggressive behaviors. Newhill et al. (2009) looked at the affective and behavioral differences of BPD in 17 Black women and 27 White women. Newhill and colleagues (2009) found that Black women in the sample endorsed greater affective intensity, interpersonal violence, and affective instability. It was also found that Black women were significantly less likely to be forthcoming about self-harming behaviors. Consistent with these findings, Garlow et al. (2005) reported significantly lower rates of suicidal ideation and attempts among Black

individuals in both clinical and non-clinical samples. These are only some examples of how BPD symptomatology presents differently in terms of diversity.

## Transference-Focused Psychotherapy

This next section will focus on a broad description of TFP. First, I will discuss the use of contracting in treatment. Second, I will discuss the mechanisms of working in the transference. Third, I will address the technical implications of working with the patient's internalized object relations. Lastly, I will elaborate on the mechanism of working with countertransference.

### Contracting

Contracting with the patient is an essential part of TFP. The act of establishing a treatment contract asserts to the patient that they take responsibility for their treatment. The patient is responsible for attendance and participation, paying their fee, and making the effort to report feelings freely without censoring them (Yeomans et al., 2017). It also sets clear, firm boundaries from the beginning of treatment to help increase the comfort and technical confidence of the therapist, such as establishing therapist and patient responsibilities, terms of extra-therapy contact, and hierarchy of what should be discussed in treatment. In terms of therapist responsibilities, therapists should attend to the schedule, help the patient gain understanding about themselves and gain deeper insight into the difficulties of their personality (Yeomans et al., 2017). In addition, therapists should, when appropriate, clarify the limits of the therapist and their involvement with the patient. In terms of attending to the schedule, the therapist should be clear and unapologetic about the intended behavior behind needing to cancel an appointment (Yeomans et al., 2017). The rationale behind this is that the absence of clarification for a cancellation allows the patient to have a fantasy of what the therapist's intentions might be. For example, if a patient were to react to the therapist's cancellation by

imagining the therapist was sadistically abandoning them, this presents the therapist with valuable information about the patient's internal world that should be explored therapeutically. This includes making the attempt to reschedule the appointment and reaffirm the commitment to the patient to working with them on a one to two time per week basis (Clarkin et al., 2018). Therapists are expected to be clear to the patient that the only compensation they expect from treatment is in the form of payment, and that nothing else is required from the patient to receive those services. The fee is for the time and effort, not for the outcome, and any subsequent feelings that arise about the attitude about the therapist's investment in outcome should be analyzed for transference implications (Clarkin et al., 2018).

**Working in the Transference**

Kernberg (2019) conceptualizes transference as the process by which affective energy, typically originating from early childhood attachment relationships, is displaced onto the therapist (Kernberg, 2019). The type of transference changes depending on the situation, who the individual is relating to at the time, and valence of affect associated with the initial object (Kernberg, 2019). Transference processes take place unconsciously and very often do not reflect real elements of what is occurring in the present. Often times it is based on real elements of the relationship, but then takes those as representing the whole of the relationship. This is the nature of part-objects and splitting. Inherent in the TFP model is the therapist's ability to work in the transference (Kernberg, 2019). There is typically an immediate activation of the transference during psychotherapy with individuals with BPD due to the sheer power of the primitive object representations projected into the therapist (Kernberg, 2019). The therapist must be able to work with all negative feelings that arise as a result of the relationship, which may be difficult. Interpretations should point out discrepancies between what is actually occurring in the

relationship and what is a projection. In addition, it should also be pointed out how aspects of the relationship are handled through splitting (Levy et al., 2017).

According to TFP framework, the therapist observes, and communicates, the dynamics of the projections and how they are experienced in the immediacy of the relationship with the therapist (Kernberg, 2019). When the therapist observes these oscillations, or perceptions that are distorted, they must be able to actively challenge the patient's view of the experience in order to establish a common, shared reality (Clarkin et al., 2018). Interpretations should point out discrepancies between what is actually occurring in the relationship and what is a projection. In addition, it should also be pointed out how aspects of the relationship are handled through splitting (Levy et al., 2017). The therapist should also bring attention to relational dyads that emerge, how they oscillate in the treatment process, and what defensive function they serve. To be able to do this, the therapist must be able to work with the negative emotions that transpire within themselves. The therapist must also have intention to allow for total exploration of all affects that arise in session including sexual feelings. The therapist is expected to explore all affect without arousing or shaming the patient (Clarkin et al., 2018). This requires a high level of skill and competence for it to be therapeutic. If handled incompetently, the therapist risks attacking the patient's projections, which can be a detriment to the therapy (Clarkin et al., 2018). This highlights the need for therapists to feel competent in their ability to practice this model.

**Addressing Internalized Object Relations**

The foundation of TFP is centered around helping patients understand both the affect and the role that is projected onto others, such as how the patient experiences the therapist (Kernberg, 2019). In TFP, patients are encouraged to speak freely about whatever comes to mind, especially if it is related to problems they identify at the beginning of treatment or that arise in the context

of the therapy relationship. The therapist listens for three major communications from the patient (1) verbal; (2) nonverbal; (3) the therapist's countertransference to the patient (Kernberg, 2016). Crucial therapeutic information is seen to be conveyed through tone, body posture, or via projective identification (Clarkin et al., 2018). The therapist is encouraged to communicate how the patient appears to be experiencing themselves and the therapists, and to draw attention to shifts in affect (Yeomans et al., 2017). If the patient does not spontaneously talk about what is going on in their life, the therapist would instead explore the avoidance of talking about important issues (Clarkin et al., 2018). The therapist is not there to correct the patients' experience, but rather to encourage them to explore the affects in their entirety (Yeomans et al., 2017).

The TFP framework directs the therapist to empathize with the patient's negative affect, which may be a complex and difficult task depending on the therapist. Therapists are expected to contain the patient's negative feelings and work to identify the dominant object relation that is activated. In these conditions, the therapist must have tactful yet honest communication with the patient (Kernberg, 2019). It is proposed that the experience of being empathically understood is essential in reducing the intensity of affect. The therapist must have the technical confidence to execute this process in order have the resumption of a collaborative relationship (Yeomans et al., 2017).

**Working with Countertransference**

TFP outlines the use of *countertransference* as being an essential guide to understanding the patient's internal experience, particularly via projective identification (Carsky, 2020). Through the perspective of TFP, countertransference is viewed as the total emotional reaction of the therapist to the patient in the treatment situation; this includes the therapists' reactions to the

patient's reality as well as their own neurotic needs and unresolved emotional conflicts. An important aspect of working with countertransference is understanding the patient's projective identification. According to TFP framework, the therapist should be able to acknowledge and use their countertransference to identify projections (Kernberg, 2019). When feelings of idealization, devaluation, or sexualization are activated between patient and therapist, the TFP model instructs the therapist to utilize these emotions to respond in a therapeutic and specific way (Kernberg, 2019). The therapist's objective is to maintain an accepting and reflective stance in the face of negative or idealizing affect. This requires the therapist to refrain from resorting to denial or action. It is essential the therapist rely on their ability to remain neutral, observant, and empathic regardless of content or level of affect in the countertransference (Kernberg, 2019). Because there is such importance placed on the therapist's ability to formulate reality-based transference interpretations in the face of intense, negative affect, it is important to understand what this process is like to execute.

**Current Research**

To date, there is no qualitative research on therapists' experiences of competency when using TFP to treat individuals with BPD. Previous literature on the usability of TFP has predominantly centered around the usefulness of the model rather than the experience of using it. Bernstein et al. (2015) studied how TFP can be helpful to psychiatry residents in addressing challenges faced by while learning psychodynamic psychotherapy. Residents reported that TFP increased their confidence and comfort even when the patient was distressed or in a suicidal crisis (Bernstein et al., 2015). Psychiatry residents reported that when sadomasochistic transferences occur, the therapist had not done something uncaring or cruel, and that it is even expected. When these feelings were activated, TFP showed residents how to understand them as

representing underlying self-object dyads which helped preserve the safety and humanity of such a distressing experience (Bernstein et al., 2015). This also contributed to the residents' ability to manage feelings of ineffectiveness and helplessness. Psychiatry residents found TFP's coherent theory of mind and psychopathology to be useful in managing difficult transference and countertransference experiences. It also helped residents gain useful ways to address difficulties when practicing psychodynamic psychotherapy with difficult patients (Bernstein et al., 2015).

A study done in the United Kingdom looked at ways in which TFP helped trainee psychiatrists working with individuals with BPD in National Health System hospitals (Bax & Nerantzis, 2022). Trainees interviewed in this study reported that TFP played a part in reducing their levels of anxiety doing psychotherapy with individuals with BPD on inpatient units. It was also found that TFP helped residents reduce feelings of overwhelm and defeat when treating challenging patients in an acute treatment setting (Bax & Nerantzis, 2022). Moreover, residents reported feeling more skilled and capable as therapists in terms of managing risk and acting out after being trained in the TFP model.

Zerbo and colleagues (2013) looked at ways in which psychiatry residents found the TFP model useful when treating personality pathology in a variety of settings. Psychiatry residents found that Kernberg's model of personality organization was easily applicable to many of the patients. Residents reported that core principles of TFP such as managing countertransference, making use of it, and understanding the patient's internal situation, is valuable in both acute and long-term therapy settings (Zerbo et al., 2013). While it is important that therapists experience the model as being helpful in the treatment and management of patients, there is no research on how TFP enhances the competency of therapists.

## Research Questions

The research question that guided this study was concerned with how TFP is experienced by therapists with regard to competency feelings; something that is usually attacked by the patient. Feelings of envy and inherent power differentials also often trigger the patient into actively creating feelings of incompetence in the therapist; this can be conceptualized as resistance to the treatment process. There is clearly a need to understand therapist experience of competency when using TFP to treat individuals with BPD because these individuals are notorious for being difficult to engage and retain in treatment. It is hypothesized that therapists feel an increased sense of competency while treating individuals with BPD through this model.

There was one primary question for this study and five sub-questions, totaling six questions. Research questions were open-ended and aimed to explore how therapists describe, and make meaning of, their experience using TFP to treat BPD with an emphasis on feelings of competency. The primary research question asked participants to describe their experience using TFP to treat BPD. The sub-questions ask about feelings of competency, their experience using TFP compared to other treatment modalities, management of countertransference, overall helpfulness of the TFP model, and the participant's personal experience of managing suicidality with TFP (See Appendix C).

# CHAPTER III: METHODS

A qualitative research framework was used for this study because it allows the researcher to gain an in-depth understanding of a particular lived experience (Stahl & King, 2020). Qualitative research has been widely used by healthcare professionals to understand the lived experience of both providers and patients (Stahl & King, 2020). This approach allowed me to gain an understanding of the complexities that inform clinical practice (Stahl & King, 2020).

## Phenomenological Method

This study used phenomenology as the guiding framework of research (Giorgi, 2012). One of the pioneers of phenomenological inquiry is German philosopher Edmund Husserl. Husserl's motivation to start the phenomenological movement was derived from the belief that experimental research is not a sufficient enough way to study various aspects of human phenomena. Phenomenology aims to identify detailed aspects of a phenomena or experience which make them unique and distinguishable from other experiences (Creswell, 2013). Because this study requires the description of an in-depth, lived experience of therapists, the phenomenological method is most appropriate for this study. The framework was used to create space for therapists to talk about their feelings of competency in-depth while expanding on personal and clinical examples to provide additional context.

## Interpretive Phenomenological Analysis

This study used the Interpretive Phenomenological Analysis (IPA) research paradigm to interpret and analyze data collected. The process of IPA provides a framework for subjective exploration of therapists' personal perspectives and lived experience, making it phenomenological method at its core (Smith, 2017). This requires the researcher to take an active role by gaining access to the participant's experience and then interpreting the experience

(Pietkiewicz & Smith, 2014). This analysis is otherwise known as a *double hermeneutic*, or dual interpretation process, by which the participant makes meaning of their experience and then the researcher makes meaning of that experience (Smith, 2017). This framework was chosen for this study because looking at the experience of therapists practicing TFP is more important than the phenomena of how TFP works. This method will allow myself, as the researcher, to understand the quality of experience and competency of therapists practicing TFP. Therefore, this makes IPA a rich and comprehensive means for analyzing the experience of TFP therapists.

**Data Sample**

Phenomenological research approaches typically prescribe a small sample size as the goal is to gain a deep appreciation for each participant's account of their experience (Smith, 2017). Using a small sample size allows the researcher to focus on the participant's individualistic experiences rather than having a larger sample size which may prompt the account of a specific group or population (Smith, 2017). It also allows the researcher to investigate themes surrounding personal details of lived experience (Pietkiewicz & Smith, 2014). A homogenous sample is necessary for this research paradigm so the common themes, and differences, from people who share common experiences, can be realized (Pietkiewicz & Smith, 2014). The primary criterion for participation in a phenomenological study is ensuring that all individuals studied represent people who have experienced the phenomenon (Creswell, 2013).

Therefore, criterion for this study required the participants to be doctoral-level and licensed therapists practicing Transference-Focused Psychotherapy, twice-weekly, with patients who have borderline personality disorder. Five therapists were recruited to participate in this study. Participants were asked to participate in this research study via email (See Appendix A).

### Collection Strategy

The most appropriate means for gathering data through the IPA framework is through semi-structured, in-depth, one-to-one, interviews (Pietkiewicz & Smith, 2014). Participants received informed consent at the beginning of the interview (see Appendix A). The participants were encouraged to talk at length about their experience treating individuals with BPD through TFP and were asked to be detailed and personal in their response. This allowed for participants to provide the most uncensored, unfiltered account of their experience, therefore increasing the validity of the data. Interviews lasted approximately one hour which is per the IPA framework, which allowed for me to collect sufficient data to robustly answer each research question (Smith, 2017). I audio recorded interviews to allow for verbatim transcription (Smith, 2017).

Pietkiewicz and Smith (2014) recommended that researchers use one or two central questions followed by no more than five to seven sub-questions. Therefore, questions started more open-ended in order to generate categories and understand the way therapists describe their experience of competency through the TFP model. Then, questions became more specific in order to gain more clarity or information in order to paint a full picture of their experience. The sub-questions followed the general question and helped narrow in on the focus of the study (Pietkiewicz & Smith, 2014). I initially asked each participant to talk about how they experience using TFP. If further exploration was required in order to gain understanding of competency, I followed up by asking therapists more specific questions to understand what effect TFP has on their feelings of competency.

## Ethical Considerations

IPA studies often draw in personal, and therefore existential, topics. According to this paradigm, it was my responsibility to maintain awareness of how the interviewing process was

impacting the participant (Pietkiewicz & Smith, 2014). A participant may have felt judgment or shame during the interview as this study explores personal feelings of competency. In line with the IPA framework, I used clinical skills in order to help contain the experience of each participant (Pietkiewicz & Smith, 2014).

Additionally, during data analysis, I remained mindful when applying theories developed specifically for western culture to explain a certain phenomenon (Pietkiewicz & Smith, 2014). IPA framework indicates that if unexpected issues arise during the interview, the researcher should investigate further with additional questions, which I ultimately asked throughout each interview (Smith, 2017).

## Methods of Analyzing Information

I used NVivo, a Qualitative Data Analysis software, to sort, structure, and analyze collected data (Pietkiewicz & Smith, 2014). Initially, I listened to the audio recording of each interview several times (Pietkiewicz & Smith, 2014). Each time I reviewed the data, new insights, reflections, and observations about the therapist's experience were noticed and noted. I focused on language use, repetitions, pauses, distinctive phrases, and emotional responses that reflected the core of the material. I then compiled notes after a comprehensive data review (Pietkiewicz & Smith, 2014). Next, I worked with my notes surrounding therapist experience as much, if not more, than with the transcription itself to reduce misinterpretation or researcher bias. These notes were then formed into emerging themes (Pietkiewicz & Smith, 2014). These themes were conceptualized on a psychological level whereby themes reflected a high level of abstraction but were not far removed from the participant's account of their experience (Pietkiewicz & Smith, 2014).

The final stage of analysis required me to identify emerging themes from each participant's account of their experience. These themes were then grouped together based on conceptual similarities (Pietkiewicz & Smith, 2014). Following this, each cluster of themes were given a descriptive label. Once themes were clustered, they were appraised to determine whether or not they met the research aims. Themes that did not meet the research aims were discarded. This was determined by seeking out whether or not they fit well with the emerging themes of participants' experiences (Pietkiewicz & Smith, 2014).

## Synthesizing and Writing Results

In order to synthesize data, I identified and described emergent themes while being mindful to retain the voice and nuances of the therapists' inside perspective by using their own words (Smith, 2017). I then created a narrative that integrates therapist account of their experience using TFP to treat BPD (Pietkiewicz & Smith, 2014). The narrative is then followed by a discussion section that connects identified themes with existing literature and the conceptual framework of TFP (Pietkiewicz & Smith, 2014). Implications of the study, its limitations, and ideas for the future were also addressed (Pietkiewicz & Smith, 2014).

Using IPA for data analysis yielded rich, in-depth insight into each participant's experience, which will help to fill the gap in the existing literature on the lived experiences specific to TFP and its impact on clinician feelings of competency.

## Researcher Bias

The prevalence of individuals with BPD in mental health settings is significant. My initial experience working with a borderline patient was an anxiety-producing and confusing experience, as I felt fundamentally unequipped to address the intensity of my patient's rage that arose in session. Since then, I have been working with several other individuals with BPD and

have found that the use of transference and countertransference interpretation has enhanced my technical and personal competency. Additionally, I have had relationships with individuals who have BPD on a personal level which, at times, left me questioning my own sense of reality. During the research process, I will be mindful of biases that arise which were not previously known.

# CHAPTER IV: RESULTS

The purpose of this study was to understand how TFP impacts clinicians' feelings of competency when treating BPD. In addition, this study was designed to examine how clinicians experience the management of negative countertransference, the overall usefulness of the therapy model, utilization of TFP compared to other treatment modalities, and the experience of managing suicidal behaviors using TFP. The analysis was conducted based on researcher interpretation using the guidelines of IPA outlined by Pietkiewicz and Smith (2014).

This section will discuss the data gathered from six semi-structured interview questions and then will outline the findings based on the results from the data collection and analysis process. This section will also provide a brief description of the five participants which will allow the reader to obtain a more holistic view of each clinician's perspective and will provide the opportunity to acknowledge the clinician's contribution to this research as indicated by phenomenological work. After the description of the participants, I will outline the emergent themes and discuss them in detail using extractions from the participants' interviews and relevant pre-established research on TFP to support the justification for each theme. Lastly, a summary of the key points will be outlined to conclude the research findings.

## The Participants

A sample of five clinicians trained in TFP was used for this study. The following background information on the participants are intended to provide the reader with greater insight into who these clinicians are as individuals and professionals.

### Participant #1- Dr. John

Dr. John is a certified TFP therapist and psychiatrist. Dr. John is trained in the following evidence-based treatment modalities for BPD: TFP, DBT, and Mentalization-Based Treatment.

Dr. John completed the Transference-Focused Psychotherapy Program through the Columbia University Center for Psychoanalytic Training and Research.

**Participant #2- Dr. Smith**

Dr. Smith is a board-certified psychiatrist and a certified TFP therapist. Dr. Smith uses TFP and TFP-informed therapy. Dr. Smith also has training in DBT. She completed the Transference-Focused Psychotherapy Program through the Columbia University Center for Psychoanalytic Training and Research.

**Participant #3- Dr. Henry**

Dr. Henry is a board-certified psychiatrist and training and supervising analyst with a private practice combining therapy and psychopharmacology. Dr. Henry is an assistant clinical professor for psychiatry residents and psychologists. Dr. Henry is a TFP therapist and supervisor.

**Participant #4- Dr. Cooper**

Dr. Cooper is a licensed clinical psychologist in full-time private practice. Dr. Cooper practices several modes of treatment, including DBT. Dr. Cooper was a supervising psychologist at the Personality Studies Institute.

**Participant #5- Dr. Brown**

Dr. Brown is a member of TFP-NY and has published numerous articles on TFP in clinical practice. Dr. Brown has specific expertise in TFP; however, has extensive experience practicing other treatment modalities such as DBT. Dr. Brown is affiliated with several hospitals and institutions where she teaches and supervises TFP.

**Table 4.1**

*Participant Demographic Information*

| Name* | Gender | Degree | Area of Clinical Practice | Approximate Years of Experience |
|---|---|---|---|---|
| **Dr. John** | Male | MD | Psychiatry, psychotherapy | ~10 |
| **Dr. Smith** | Female | MD | Psychiatry, psychotherapy | ~20 |
| **Dr. Henry** | Female | MD | Psychiatry, psychotherapy | ~25 |
| **Dr. Cooper** | Male | PhD | Psychotherapy | ~20 |
| **Dr. Brown** | Female | PhD | Psychotherapy | ~45 |

**Pseudonyms are used in place of participants' actual names to protect their identity and privacy.*

## Results

This research study was guided by one central research question and five sub-questions. These questions were designed to elicit subjective responses from the clinicians who were interviewed. As the researcher, I performed all data analysis with the exception of transcribing the interviews. After four rounds of reviewing interview transcriptions, I used NVivo software to help me develop themes which allowed me to see and quantify which codes were the most prevalent per each participant. In accordance with Pietkiewicz and Smith's (2014) guideline for data analysis, codes were developed through a thorough review of each participant's transcripts of their experiences. This allowed me, as the researcher, to gain an in-depth understanding of the participant's experiences and perspectives. It also allowed me to interpret the meaning of their experiences. I repeated this step for each of the participants' responses followed by an analysis of the codes to identify identical or similar codes across all responses (see Appendix D) for the table of presentation of codes. Of the 13 codes derived as a

result of the analysis, four themes emerged as most indicative of the participants' experiences as well as addressing the research questions.

## Themes

After analyzing the data, four themes emerged that were related to the research questions and the areas of focus for this study. The four themes were derived from the interpretation of the data, the transcription of the participant interviews, and pertinent literature are listed below:

1. Positive Treatment Outcomes for Patients
2. Using Negative Countertransference for Positive Therapeutic Intervention
3. Reliability of Treatment Framework
4. Effectively Dealing with Crisis and Suicidality

Following this, contextual information to support these four themes will be provided and will include excerpts from participant interviews. I will present a detailed description of the thematic findings which have been determined through an in-depth analysis of participant interviews. The general coding was derived from direct quotes from the participants, and I will highlight those quotes to support each of the four themes.

### Theme One: Positive Treatment Outcomes for Patients

Perhaps the greatest pressure put on clinicians is helping their patients achieve symptom reduction and lead healthier, better lives. Participants in the study are faced with treating one of the most challenging clinical populations, which can be both challenging and rewarding. With high rates of patient suicidality, affectivity, and self-destructive behavior, clinicians are required to be highly skilled and effective in their intervention. A core characteristic of BPD is a rigid set of dysfunctional beliefs about themselves and others, which is almost certain to manifest in the

context of a negative attitude towards treatment. Clinicians treating this population will almost certainly face patient devaluation of both the treatment and the efforts of the therapist. Clinicians treating this population are at an increased risk of losing patients due to drop-out, rupture in the therapeutic alliance, and suicide.

*Positive treatment outcomes for patients* came up repeatedly for the participants when asked about their experience using TFP to treat BPD. When discussing their experience using the treatment framework, participants all commented on how they witnessed better treatment outcome with TFP than other treatment modalities. It is important to note that all participants have extensive experience practicing other treatment modalities to treat BPD including DBT, supportive psychotherapy, and psychodynamic psychotherapy. Dr. Smith felt that other treatments made her feel more "incompetent" as she found them to be more "cyclical and not as helpful." Dr. Smith felt people were "not getting better with other treatments," but she has seen "patients get better with TFP quickly." Dr. Henry explained that when she "didn't use TFP, treatment outcomes were not nearly as good." Dr. John felt other treatments were "too passive and not a lot of progress was made," and said other treatments felt more "inefficient." Dr. Cooper felt other treatments did not "go beyond the surface level communication." Lastly, Dr. Brown commented on how the patient is "better able to absorb" the treatment because TFP interventions are "close enough to the surface of what is going on in the patient's mind," and compared to other treatments, TFP "always seemed that it was much better."

**Theme Two: Using Negative Countertransference for Positive Therapeutic Intervention**

The participants of this study expressed the helpfulness of the TFP framework to diffuse negative countertransference. On a personal level, it is extremely beneficial for clinicians treating BPD to have a systematic, clear way to relieve negative feelings toward their patients that risk

jeopardizing the clinician's technical neutrality. Professionally, countertransference can be used for positive therapeutic intervention. The clinicians interviewed for this study shared how their experiences working with their negative countertransference benefit both themselves and their patients. Participants found that conceptualizing their countertransference allows them to gain better insight into the patient's unspoken internal world, which, in turn, allows them to ask questions that are closer to the patient's experience of themselves and others. Dr. John comments on how he is able to "take a step back and think about what's happening interpersonally... and having that pause between action and thinking is very helpful." Dr. Cooper said,

> There may be an enactment going on that I was totally unaware of. And TFP allows you to pull back and step outside... I can take a step back and look at what I'm feeling and say, okay, so what information is this giving me? What is happening between me and this person? What potential information is that giving me about how this person is experiencing me or how they're tending to treat other people in their life outside of the treatment relationship?

Dr. Henry commented, "You monitor what is going on in you as well, which is very helpful. It just gives you a much better handle on things." Dr. Smith stated, "to have the experience of using [countertransference] and putting that into words in order to ask better questions that are more attuned with the patient's affect really gets to more of what is driving their reactions and behaviors." Dr. Brown elaborated on her experience utilizing countertransference by stating,

> So, there are steps to take instead of feeling like I can't stand this anymore and I want to leave the session... One of the things I find extremely valuable is that [understanding negative countertransference] is a way to detoxify whatever anxiety I might have.

**Theme Three: Reliability of Treatment Framework**

The clinicians in this study expressed how contracting at the onset of treatment provides them with a sense of security and reliability. They also shared that ongoing supervision and a deep understanding of borderline pathology increase their feelings of competency. Dr. Brown

spoke about how contracting is just as much for the therapist as it is for the patient and that there is a clear outline of what she should and should not do by stating,

> The contract is for the therapist as well as the patient. It tells me there are things I'm supposed to do or not to do. TFP tends to work very strongly to get us to not even be in a situation where we're in a bind.

Dr. John expressed that contracting gives him something to refer back to if he gets confused or is in a bind with a patient, and that it is one of the most useful aspects of TFP by stating, "Contracting and talking about goals explicitly always gives you something to refer back to when you get really confused, which I think is one of the most useful things that TFP offers." In terms of supervision, participants, like Dr. Smith, see it as an ongoing opportunity to talk about her reactions to cases and speak with peers about next steps in treatment. Having the opportunity to discuss cases in supervision seems to give clinicians, no matter their years of clinical practice, an increased sense of competency. Participants also felt more competent entering the treatment arena with BPD patients because of the comprehensive understanding they have of patient pathology.

**Theme Four: Effectively Dealing with Crisis and Suicidality**

When describing their experience managing patient crises and suicidality, participants in the research felt competent and secure. Participants felt as if they had a clear, reliable plan on how to approach high-risk situations, and, moreover, felt supported by the treatment framework. Dr. Henry explained, "You have a contract on parasuicidal behaviors and on suicidal threats. You have a very firm contract and that's very helpful." Participants had a deep understanding of the relational component of patient suicidality and reported feeling at ease about managing these situations because TFP has provided them with a clear understanding of how to both understand and approach the patient when they are in despair. Dr. Brown stated, "[TFP] is very supportive

of therapists." As highlighted by Dr. Cooper, suicidality in BPD patients is often object-related, meaning that patients are often trying to act out the hurt and pain they may have experienced in the context of close interpersonal relationships. He reported,

> TFP is incredibly effective around dealing with suicidality in the context of the therapeutic frame. The contract and interpretation around that frame really help patients to reduce suicidality and become more stable because they're talking about the interpersonal tension and the instability within themselves in a relational matrix so that they don't have to go act it out.

Tolerating feelings of rejection, abandonment, or emptiness as a result of loneliness are all elements that may lead to suicidal behavior. The TFP framework pre-emptively educated participants on the intrapsychic intricacies of suicidality, providing guidance during patient crisis.

## Summary

This chapter provided detailed excerpts from the interviews of all five participants. These excerpts were provided to allow the reader to become familiar with the clinician's experience of competency using TFP, as well as the distinct perspectives of their experience treating individuals with BPD. Additionally, this section highlighted the thematic findings that were developed as a result of the data collection and subsequent analysis outlined in Chapter IV. The responses from participant's interviews yielded the following four themes: Positive treatment outcomes for patients, Using negative countertransference for positive therapeutic intervention, Reliability of treatment framework, and Effectively dealing with crisis and suicidality. Each of the themes was supported by excerpts directly from collected data from participants.

Chapter V provides a discussion of the findings as they pertain to the research questions and research connected to the topic of this study. Additionally, recommendations will be offered

to clinicians treating BPD as a result of this study's findings. Suggestions for future research will also be presented and discussed.

# CHAPTER V: DISCUSSION, RECOMMENDATIONS, AND CONCLUSION

This chapter presents a discussion of the research study and the conclusions drawn from the findings presented in Chapter IV. Specifically, it will expand on the findings of participant interviews and how they connect to the conceptual framework. I will then explore the implications for practice, limitations, and recommendations for future research. The participants in this study, with robust clinical backgrounds, shared their experience of competency treating individuals with BPD using TFP. This research delved into other domains of clinical practice that were pertinent to their overall experiences treating BPD with TFP. For more complete examples of participant responses see Appendix D.

## Treatment Outcome

All participants reported a positive experience using TFP, with four participants answering this question by speaking about their observation of patient treatment outcome. Derived from these reports is the theme, *Positive treatment outcomes for patients*. Participants shared the experience of seeing patients with BPD become markedly better and referring to the treatment framework as very useful for patients, seeing better treatment outcomes, and an overall positive experience using the framework. Dr. Cooper talked about how TFP has engaged him in the treatment process as he was "drawn to the intensity of the work." Following this, he commented on how his patients experience an "intense responsiveness" to the treatment. Participants went into detail about how they achieved positive patient outcome by speaking about how TFP techniques speak directly to the patient's internalized object relations as they manifest in the therapy relationship. It can be inferred that seeing better treatment outcomes for patients has an impact on clinician feelings of competency. Following this initial research question, I asked five sub-questions in order to elicit more specific responses from participants.

The participants provided unfiltered accounts of how TFP is different from other treatment modalities in terms of treatment outcome. The participants described their experiences using other treatment modalities as inferior to TFP, particularly when compared to DBT. Participants, who all have experience practicing TFP and DBT described that they were ultimately more supported by the TFP framework and felt that they were speaking more directly to the core of the patient's difficulties through TFP techniques. These reports from participants added value to the thematic finding, Positive treatment outcomes for patients. This is an important finding as more support to the clinician and greater belief in the efficacy of treatment all contribute to overall competency. This, in turn, reduces turmoil in the therapy relationship (e.g., acting out, threats of suicide, self-harm, devaluation of the therapist), which participants felt decreased their anxiety with patients. Throughout the interview process, each of the participants talked about the positive treatment outcome they often experience as clinicians treating BPD. The participants spoke about better treatment outcomes using TFP as compared to DBT, how TFP shifts and interacts with the subjectivity and internalized object relations of the patient, the patient's ability to absorb interpretations, and how quickly treatment progression occurs.

The participants noted how TFP interventions got to the core of the patient's symptomatology rather than just addressing the symptoms. Participants also spoke about how addressing core, internalized representational dyads of self and other reduces patient affectivity, particularly aggression which is supported by relevant research on the efficacy of TFP when compared to other evidence-based treatments for BPD (Choi-Kain et al., 2016).

**Connection to the Literature**

TFP has been shown to have equal or greater benefits than DBT treatment for individuals with BPD. In clinical trials, TFP has been shown to be more effective than DBT with regard to improving temperamental symptoms of BPD (Levy et al., 2019; Zanarini, 2009). There are also areas of interpersonal functioning that are not usually addressed in DBT but are central to the TFP framework, such as the explicit discussion and interpretation of emotional aspects of the therapeutic relationship. Clarkin and colleagues (2007) examined three year-long treatments for BPD which included TFP, DBT, and supportive psychotherapy. Patients who were diagnosed with BPD were randomly assigned to receive treatment from different therapeutic orientations. During the course of therapy, suicidal ideation, aggression, impulsivity, anxiety, depression, and social adjustment were assessed. While all three treatments yielded significant improvement in patients after one year, only TFP and supportive psychotherapy were associated with improvement in anger and facets of impulsivity (Clarkin et al., 2007). However, only TFP was effective in the sustained reduction of irritability and aggression (Choi-Kain et al., 2010; Clarkin et al., 2007).

These findings are also consistent with a former study by Levy et al. (2019) which showed a notable increase in reflective function with TFP, but not with DBT. In another study done by Fischer-Kern and colleagues (2015), patients with borderline personality disorder in TFP and community psychotherapy were assessed for changes in reflective functioning after one year of treatment. Findings revealed significant improvements with regard to reflective functioning in the TFP group, but not in the community psychotherapy group (Fischer-Kern et al., 2015). Results showed that after one year of TFP, patients averaged 3.31 out of a possible 5 on the Reflective Functioning Scale, where scores above 3 indicate a gradual development of the

ability for mentalization. Conversely, no changes in reflective function were noted in the community psychotherapy group. When compared with DBT, mentalization-based treatment, and schema-focused psychotherapy, there were two major findings in favor of TFP. Zanarini (2009) identified that TFP was the only treatment significantly associated with improvement in irritability, verbal assault, and direct assault. TFP influences important treatment variables such as emotion modulation and attachment style.

Levy and colleagues (2006) analyzed changes in both reflective functioning and attachment organization during year-long intensive psychotherapy treatment for individuals with BPD. Patients were enrolled in either TFP, DBT, or supportive psychotherapy. Patients in TFP evidenced a greater increase in reflective functioning, sense of self, and secure attachment when compared to DBT and supportive psychotherapy. These changes are hypothesized to modulate one's ability to form a more coherent sense of identity, greater capacity for intimacy, reduction in self-destructive behaviors, and general improvement in functioning (Levy et al., 2006).

## Managing and Using Countertransference

The participants of this study expressed the helpfulness of the TFP framework to diffuse negative countertransference. On a personal level, it is extremely beneficial for clinicians treating BPD to have a systematic, clear way to relieve negative feelings toward their patients that risk jeopardizing the clinician's technical neutrality. Professionally, countertransference can be used for positive therapeutic intervention. The clinicians interviewed for this study shared how their experiences working with their negative countertransference benefit both themselves and their patients. Participants found that conceptualizing their countertransference allows them to gain better insight into the patient's unspoken internal world, which, in turn, allows them to ask questions that are closer to the patient's experience of themselves and others. Dr. John comments

on how he is able to “take a step back and think about what’s happening interpersonally... and having that pause between action and thinking is very helpful.” Dr. Cooper said,

> There may be an enactment going on that I was totally unaware of. And TFP allows you to pull back and step outside... I can take a step back and look at what I’m feeling and say, okay, so what information is this giving me? What is happening between me and this person? What potential information is that giving me about how this person is experiencing me or how they’re tending to treat other people in their life outside of the treatment relationship?

Dr. Henry commented, “You monitor what is going on in you as well, which is very helpful. It just gives you a much better handle on things.” Dr. Smith stated, “to have the experience of using [countertransference] and putting that into words in order to ask better questions that are more attuned with the patient's affect really gets to more of what is driving their reactions and behaviors.” Dr. Brown elaborated on her experience utilizing countertransference by stating,

> So, there are steps to take instead of feeling like I can’t stand this anymore and I want to leave the session... One of the things I find extremely valuable is that [understanding negative countertransference] is a way to detoxify whatever anxiety I might have.

**Connection to the Literature**

Clinicians trained in TFP identify the predominant affect present in the session and explore the dynamics of how that emotion is expressed and experienced in the here and now with the therapist (Kernberg, 2019). The therapist is not there to correct these emotions per se, but rather to allow the patient space to explore them fully (Yeomans et al., 2017). Therapists are encouraged to draw correlations between past relational patterns and how they are reenacted in the transference relationship (Kernberg et al., 2008). This technique brings attention to how the patient relates to others, themselves, and their relationships. Moreover, it allows the patient to develop insight and an ability to think about how they relate to others (Kernberg et al., 2008). TFP is designed to explore anger as it comes up in the context of the therapeutic relationship

(Kernberg, 2019). Reenactments of aggression and rage that arise in the therapeutic relationship present the therapist with an opportunity to examine and interpret transference and countertransference material. Over time, this process reduces the intensity of affect, and emotions begin to feel more tolerable. This approach is theorized to help integrate contradictory aspects of self and others (Clarkin et al., 2018). The interpretation of intense affects as they arise in the session allows the patient to gain awareness to the unconscious processes that precipitate them.

## Treatment Framework Elements Influencing Feelings of Competency

The research aim of this study was to understand clinicians' feelings of competency treating BPD through TFP. Throughout the interview, this was the first time feelings of competency were mentioned by participants. Consultation with fellow TFP practitioners showed to be an important aspect of feeling competent in treating individuals with BPD. Not only did this aspect of TFP prove to help clinicians manage their cases, but also helped them manage their personal experiences of working with the TFP modality. Participants unanimously reported that TFP markedly increased their feelings of competency compared to other treatment modalities for BPD and other treatment modalities in general, which is where the theme *Increased feelings of competency* was derived. Dr. John stated, "Another important part of TFP is consultation, certainly while you're learning it." Supervision and consultation with peers enhanced feelings of competency for participants as this element of support provided them with an opportunity to process their feelings about patients and receive validation and guidance on how to progress with cases. This aspect increased participants' confidence in managing individuals with BPD. Additionally, participants reported increased feelings of competency due to the comprehensive nature of the theory behind the treatment framework. Dr. Brown reports, "TFP tends to work

very strongly to get us to not even be in a situation where we're in a bind." Participants attributed their feelings of competency to the in-depth understanding of borderline pathology that is taught as part of the TFP framework. This increased clinician feeling of competency because participants rarely felt thrown off by what was happening with their patient. Dr. Henry reported, "If a patient threatens to end treatment, or do something crazy, I feel like I can take a step back and I have some things to rely on and I know what to do." Clinicians in this study reported an increased amount of empathy for patients because the nature of their illness is so clearly defined by the framework. Dr. Smith stated,

> It really helped me hold on to more empathy for these patients because the understanding of their illness is so clearly defined. It actually makes me a little more objective as to why they're behaving the way that they are, so that is very helpful.

This study focuses on how TFP impacts feelings of competency in clinicians, which means clinicians should ostensibly feel supported by the treatment model in a range of clinical situations. Participants reported a deep trust in the framework, particularly through supervision and theory.

Contracting in TFP was an aspect of the framework that participants found most helpful. From this, the theme *Reliability of treatment framework* was created. The contractual agreement that takes place before therapy begins provides participants with direction and security. Contracting gave participants a clear road map of what to do in situations where they were in a bind, felt the need to overextend themselves for a patient, and in cases where patients were putting themselves, or the treatment, in danger. Participants discussed how important it is for them to have the direction provided by contracting in order to contain both themselves and their patients. The other positive aspect provided by contracting is the benefit it has to the patient. Participants expressed that the contractual agreement between themselves and the patient helped

the patient take responsibility for their treatment and provided them with a sense of trustworthiness. Contracting with a patient prior to engaging in therapy is an essential part of TFP. The contract addresses acting-out behaviors (e.g., substance use, non-suicidal self-injury, and suicidal behaviors) and avoidant behaviors (e.g., threats to leave treatment, masochistic withdrawal from relationships, missing sessions). TFP requires the patient to agree to the contract before engaging in treatment (Radcliffe & Yeomans, 2019). Contracting was an important part of participants' experiences of competency, and participants generally felt less anxious when managing affectively charged issues. The usefulness of having a treatment contract remains pertinent throughout the treatment and has been particularly useful to clinicians in critical situations.

**Connection to the Literature**

In terms of contracting, there are specific steps the clinician must take to thoroughly establish a treatment agreement with the patient. These steps include (1) the clinician identifying and assessing a personality disorder diagnosis with attention to level of severity, (2) the clinician sharing the patient's diagnostic impression and providing relevant, germane, psychoeducation, (3) contact information of family members, members of the patient support system, and prior providers, and (4) the development and maintenance of the treatment frame (Hersh, 2021). The initial phase of contracting consists of an extensive evaluation of patient symptomatology. This allows the therapist to determine the level of functioning and suitability for TFP. When the clinician contacts prior treatment providers, the clinician can feel confident that the information provided by the patient is accurate and in order for the clinician to make an accurate assessment of whether or not the individual is an appropriate case to take on (Carsky, 2020). The idea behind this step is to provide the clinician with relevant information that may pose challenges to the

treatment and to help the clinician decide what arrangements will be supportive to both the patient and the clinician (Carsky, 2020). If the patient agrees to engage in TFP, the therapist establishes the treatment framework with the patient which consists of clear responsibilities of both the patient and therapist, including payment, scheduling, protocol for threats of suicide or self-destructive behavior, intruding into the therapist's personal life, lying or censoring information, and engagement in work and day-to-day life activities (Carsky, 2020).

In terms of supervision, TFP requires the modality of supervision to integrate psychoanalysis and psychoanalytic psychotherapy. TFP supervision is anchored to the treatment manual and follows similar guidelines such as moment-to-moment interventions between the supervisor and supervisee. Supervision of clinicians, particularly trainees, often requires the supervisor to contain the anxieties of the clinician due to the challenging nature of treating this population. Yeomans and colleagues (2023) explain the importance of providing treatment under the supervision of a senior clinician. The supervisory process consists of reviewing video-taped sessions to better allow for the supervisor to observe an unfiltered portrayal of the therapist-patient dynamic. It also allows for the supervisor to understand the patient's verbal and non-verbal communication which is the most accurate way of understanding in-session dynamics (Topor et al., 2017).

### Competency Managing Crisis and Suicidality

Participants unanimously expressed feelings of competency in handling patient suicidality because there is a clear plan about what to do in the event of suicidality or self-harm. Feelings of competency in this area trickle back to the contractual agreement established at the onset of treatment surrounding patient responsibility to contain their self-destructive impulses and talk about it in session, and clear limitations of therapist involvement in threats of suicide.

The clear set of principles, agreements, and strategies outlined by TFP were all factors that contributed to participants' competency and effectiveness in addressing suicidality and suicidal behaviors. Contracting with a patient prior to engaging in therapy is an essential part of TFP. The contract addresses acting-out behaviors (e.g., substance use, non-suicidal self-injury, and suicidal behaviors) and avoidant behaviors (e.g., threats to leave treatment, masochistic withdrawal from relationships, missing sessions). TFP requires the patient to agree to the contract before engaging in treatment (Radcliffe & Yeomans, 2019). Contracting was an important part of participants' experience of competency, and participants generally felt less anxious when managing affectively charged issues. Dr. Brown shared, "I think another thing that helps me feel competent is that there's a very clear plan at all times about what to do in the event of suicidality or self-harm." TFP reduces patient irritability and aggression as compared to DBT, MBT, and general psychiatric management (Choi-Kane et al., 2016). All participants reported feeling equipped to handle patient suicidality, self-injury, and crisis. In fact, some participants reported a reduction of anxiety related to patient suicidality as a result of TFP's comprehensive, supportive framework. This was corroborated by participant reports. Dr. Henry reported, "You have a contract on parasuicidal behaviors and on suicidal threats. You have a very firm contract and that's very helpful... And it really is amazingly good to contain the patient."

Participants all endorsed having a clear plan of how to handle suicidal behaviors and feeling competent and supported in doing so. Dr. John spoke to this point directly in saying, "These principles are enormously helpful in feeling more secure and confident in what you're doing." Dr. Cooper similarly stated,

> TFP is incredibly effective around dealing with suicidality in the context of the therapeutic frame. The contract and interpretation around that frame really help patients to reduce suicidality and become more stable because they're talking about the

> interpersonal tension and the instability within themselves in a relational matrix so that they don't have to go act it out.

This is a particularly important result as clinicians treating BPD will most certainly need to effectively manage either self-injury or suicidality.

**Connection to the Literature**

A major finding in the clinical studies of TFP was that patients showed a marked reduction in the following domains: emotion regulation presentations, psychiatric hospitalizations, and day hospitalization (Levy et al., 2019). There was also an increase in global functioning when compared to a treatment-as-usual cohort (Levy et al., 2019). Additionally, there is empirical evidence to support neurological shifts in functioning following TFP (Perez et al., 2016). Perez et al. (2016) found that TFP was shown to reduce activation in brain regions associated with emotion regulation, impulsivity, and aggression. TFP was also associated with a decrease in emotional reactivity and semantic-based memory retrieval. There was a reduction in amygdala activation, which demonstrates the ability of TFP to reduce negative emotional interference post-treatment. Results of this study suggest that TFP may precipitate the improvement of borderline symptomatology associated with specific parts of the brain related to cognitive-emotional control. Secondly, TFP was associated with significant improvement in two crucial areas of functioning: reflective capacity and increased secure attachment (Zanarini, 2009). TFP treatment was also shown to reduce suicidality, anger, and facets of impulsivity (Zanarini, 2009). TFP reduces patient irritability and aggression as compared to DBT, MBT, and general psychiatric management (Choi-Kane et al., 2016). All participants reported feeling equipped to handle patient suicidality, self-injury, and crisis. In fact, some participants reported a reduction of anxiety related to patient suicidality as a result of TFP's comprehensive, supportive framework.

## Unexpected Findings

The focus of this study was to understand the relationship between TFP and clinician feelings of competency in treating BPD. While the thematic finding *Positive treatment outcomes for patients* was derived from the analysis of the data, it was surprising to find that participants initially focused on the experience of the patients rather than their personal experience when asked about their experience using TFP. It seemed that participants needed prompting to talk about their personal experiences further into the interview.

It was also interesting to learn that all participants who had training in DBT or other treatment modalities found that TFP was the most effective, supportive, and comprehensive treatment framework for both themselves and their patients. While this finding is likely not unique, it is enlightening to have qualitative data from TFP clinicians to support the quantitative data on treatment outcome of TFP.

## Limitations

There are four limitations to this dissertation research. The first limitation is that the participant sample was very specific in terms of level of training, therapeutic modality practiced, and population treated. Therefore, the recruitment for this study was not random, instead, certain clinicians with specific credentials were contacted directly. While I do not know participants on a personal level, there is an element of researcher bias due to the intentional recruitment of participants. The rationale behind contacting specific individuals to participate in this study are the following: (1) In order to collect valid data, participants needed to be trained in TFP, (2) participants needed to specialize in treating borderline personality disorder, and (3) participants needed to have sufficient clinical experience in order to reflect on their personal experience using TFP.

The second limitation to the study may be that participants could have, or could not have been, influenced by the expectations of the study (e.g., needing to report increased feelings of competency using TFP as per the nature of the study's intention). It is also possible that participants had their own biases about TFP or other treatments for BPD that influenced their responses. In order to reduce this potential, I was careful to build rapport with participants and ensure their confidentiality throughout the data collection and analysis process. The third limitation of this study is the process of data analysis was subjected to my own perspective and unconscious biases (e.g., creating meaning out of participant experiences, patterns, and themes). To help mitigate the subjective nature of qualitative data analysis, I utilized NVivo software to accurately transcribe and assist in coding the data provided by participants. The fourth limitation of the study is that I was the only individual who reviewed the data of this research. Therefore, the creation of the aforementioned four themes is exclusively a result of my personal, subjective process of interpreting and synthesizing the data.

## Engaging in IPA Methodology

IPA was selected for this study because it allowed me to gain insight into the experiences of clinicians' feelings of competency treating BPD using TFP. By utilizing IPA, I was able to gather in-depth accounts of each participant's interpretation of their professional and personal experiences using TFP. I found that using IPA was an informative, in-depth way to conduct and analyze data for my dissertation research. This is the first time I have used IPA and have come to learn that it is an intensive, time-consuming process to carefully analyze data through this methodology. One of the helpful aspects of my data collection process was that my sample size was relatively small and only one interview was conducted per participant. However, each participant's interview lasted approximately 60 minutes which meant that the transcription of the

data was also a time-consuming process. I found the use of NVivo software was helpful in the transcription process, although there were parts in each interview where the transcription was incorrect. Therefore, it required me to go back to the interview and correct the transcription, which was somewhat of an intricate process.

However, I found the IPA methodology of data analysis and interpretation to be engaging and thoughtful. There is a lot of autonomy prescribed to the researcher in that I was able to ask questions and engage with participants in a way that was both structured yet spontaneous. I also felt that asking participants very open-ended questions about their experience allowed the participants to engage with the research study in a way that felt close to their experience, which enhanced the validity of the study. Moreover, the IPA approach to interviewing allowed me to meet and engage with professionals whose stories were inspiring, educational, and intriguing to me. Overall, utilizing IPA was both a time-consuming and intellectually gratifying methodology to engage with for my dissertation research.

## Implications for Practice

Individuals with BPD are often difficult patients to treat due to the intense countertransference they elicit. The inherent difficulty in engaging and managing individuals with BPD has an impact on patient retention and dropout rates (Barnicot et al., 2015). Mental health services typically utilize short-term interventions or case management, which are not likely to produce long-term recovery among people with BPD (Lohman et al., 2017). It has also been widely documented that there is resistance in the mental health community to treat individuals with BPD due to the negative countertransference and stigma associated with engaging in treatment (Tusiani-Eng & Yeomans, 2018). Therefore, considering the results of this study indicate that TFP is helpful to the clinician in managing their countertransference, feeling

effective in treatment, and feeling supported by TFP, there is reason to bring more attention to this treatment framework which has been underutilized and understudied compared to other gold-standard treatments for BPD such as DBT.

## Recommendations for Clinicians Treating BPD

Clinicians treating BPD, and all other clinical populations, have a responsibility to have awareness of their own countertransference. Failure to address countertransference while working with BPD may constitute an ethical issue related to practice competence (Clark, 2007). If pervasive negative countertransference goes unaddressed, it can become detrimental to the treatment process and therapeutic outcome. It seems the most ethical approach to the treatment of difficult patients is for clinicians to understand and address their own countertransference so they can provide ethical and informed care for this clinical population. Regardless of therapeutic orientation, clinician countertransference should be assessed and monitored throughout treatment to both provide optimal care to the patient and to consider the comfort and feelings of competency of the clinician.

It also seems appropriate to recommend a paradigm shift in terms of the way clinicians think about and choose treatment for individuals with BPD. While DBT is effective in reducing suicidal and self-injurious behaviors, not all individuals with BPD will benefit from the skill-based interventions that are central to the DBT framework (Rizvi, 2011). While DBT is a highly-utilized treatment for BPD, clinicians should consider the benefits of utilizing TFP before making the presumption that DBT is the "gold-standard" treatment for all individuals with BPD. This alternative, more dynamic, way of approaching treatment for individuals with BPD is not solely for the benefit of the patient, but the findings of this study suggest that there are treatment

modalities, such as TFP, work to support the clinician's negative countertransference which is the primary reasons there is such a resistance to treat this population.

## Directions for Future Research

Due to the limited number of studies related to the experiences of clinicians using TFP, the following recommendations for future research will hopefully add to the necessary scholarship on this topic. To expand on the research body of feelings of competency in clinicians treating BPD with TFP, non-phenomenological qualitative approaches, quantitative approaches, or mixed methodology would need to gather data under the same, or similar, research question as this study. It would be useful to use varying sample sizes and populations, particularly recruiting less experienced clinicians and perhaps even trainees. This would not only increase the degree of scholarship on this topic but would diversify the findings. It may also be beneficial to study feelings of clinician feelings of competency pre-TFP and post-TFP training compared to non-TFP treatment modalities. This would provide scholarship on treatment modalities that consider how treatment modality influences clinician countertransference, particularly feelings of competency and incompetence in treating BPD. Furthermore, it would add to the scholarship of TFP research to study the patient's lived experience of receiving TFP.

## Conclusion

Individuals with BPD are known for being difficult to engage and retain in treatment. During the course of treatment, these individuals typically produce frequent and intense transference and countertransference patterns which impact many clinicians' willingness to engage with this treatment population.

The purpose of this study was to capture the true and lived experience of clinicians' feelings of competency when treating BPD with TFP. Specifically, clinicians were asked about

their experience with clinical domains related to both the treatment framework and treating BPD. Through this investigation, I was able to capture the experience of five clinicians who treat BPD with TFP. These clinicians shared what it is like to treat BPD with TFP and now there is new knowledge to be added to the TFP literature about clinician experience using the treatment framework. Through this investigation by way of a semi-structured interview, the clinicians in the study were given an opportunity to have their voices heard as a contribution to the TFP research and to the field of psychology. This study provides a perspective that is not typically acknowledged in research which is the experience of the clinician as opposed to the experience of the patient.

It is my hope that the outcome of this dissertation research will initiate conversations on both an educational and professional level regarding optimal treatment options for individuals with BPD based on both the benefit of the clinician and the patient. More importantly, the shared goal of both the patient and clinician is positive treatment outcome, and considering the severity, potential lethality, and debilitating symptomatology of BPD, it is important to bring awareness to treatment modalities that promote long-term change.

## References


Aguirre, B. (2015). Handbook of good psychiatric management for borderline personality disorder. *Journal of Psychiatric Practice*, *21*(4), 313–314. https://doi.org/10.1097/pra.0000000000000086

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

Barnicot, K., Couldrey, L., Sandhu, S., & Priebe, S. (2015). Overcoming barriers to skills training in borderline personality disorder: A qualitative interview study. *PloS One, 10*(10), e0140635. https://doi.org/10.1371/journal.pone.0140635

Bayes, A., & Parker, G. (2017). Borderline personality disorder in men: A literature review and illustrative case vignettes. *Psychiatry Research*, *257*, 197–202. https://doi.org/10.1016/j.psychres.2017.07.047

Bax, O. K., & Nerantzis, G. (2022). Transference focused psychotherapy and mentalization based treatment. Evidence based psychotherapies for borderline personality disorder. *Psychiatriki, 34*(2), 143–154. https://doi.org/10.22365/jpsych.2022.066]

Bernstein, J., Zimmerman, M., & Auchincloss, E. L. (2015). Transference-focused psychotherapy training during residency: An aide to learning psychodynamic psychotherapy. *Psychodynamic Psychiatry, 43*(2), 201–221. https://doi.org/10.1521/pdps.2015.43.2.201

Bhola, P., & Mehrotra, K. (2021). Associations between countertransference reactions towards patients with borderline personality disorder and therapist experience levels and mentalization ability. *Trends in Psychiatry and Psychotherapy*, *43*(2). https://doi.org/10.47626/2237-6089-2020-0025

Bourke, M. E., & Grenyer, B. F. S. (2013). Therapists' accounts of psychotherapy process associated with treating patients with borderline personality disorder. *Journal of Personality Disorders*, *27*(6), 735–745. https://doi.org/10.1521/pedi_2013_27_108

Bozzatello, P., Blua, C., Brandellero, D., Baldassarri, L., Brasso, C., Rocca, P., & Bellino, S. (2024). Gender differences in borderline personality disorder: A narrative review. *Frontiers in Psychiatry, 15*. https://doi.org/10.3389/fpsyt.2024.1320546

Carsky, M. (2020). How treatment arrangements enhance transference analysis in transference-focused psychotherapy. *Psychoanalytic Psychology*, *37*(4), 335–343. https://doi.org/10.1037/pap0000313

Chapman, A. L., Hope, N. H., & Turner, B. J. (2020). Borderline personality disorder. In C. W. Lejuez & K. L. Gratz (Eds.), *The Cambridge handbook of personality disorders* (pp. 223–241). Cambridge University Press. https://doi.org/10.1017/9781108333931.041

Choi-Kain, L. W., Albert, E. B., & Gunderson, J. G. (2016). Evidence-based treatments for borderline personality disorder: Implementation, integration, and stepped care. *Harvard Review of Psychiatry*, *24*(5), 342–356. https://doi.org/10.1097/hrp.0000000000000113

Choi-Kain, L. W., Zanarini, M. C., Frankenburg, F. R., Fitzmaurice, G. M., & Reich, D. B. (2010). A longitudinal study of the 10-year course of interpersonal features in borderline personality disorder. *Journal of Personality Disorders*, *24*(3), 365–376. https://doi.org/10.1521/pedi.2010.24.3.36

Clark, A. (2007). The analyst's self-interest: Coasting in the countertransference. *The American Journal of Psychoanalysis, 67*(1), 103–105. https://doi.org/10.1057/palgrave.ajp.3350006

Clarkin, J. F., Cain, N. M., & Lenzenweger, M. F. (2018). Advances in transference-focused psychotherapy derived from the study of borderline personality disorder: Clinical insights with a focus on mechanism. *Current Opinion in Psychology*, *21*, 80–85. https://doi.org/10.1016/j.copsyc.2017.09.008

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry*, *164*(6), 922–928. https://doi.org/10.1176/ajp.2007.164.6.922

Colli, A., Tanzilli, A., Dimaggio, G., & Lingiardi, V. (2014). Patient personality and therapist response: An empirical investigation. *The American Journal of Psychiatry*, *171*(1), 102–108. https://doi.org/10.1176/appi.ajp.2013.13020224

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). SAGE.

Dahl, H. J., Høglend, P., Ulberg, R., Amlo, S., Gabbard, G. O., Perry, J. C., & Christoph, P. C. (2016). Does therapists' disengaged feelings influence the effect of transference work? A study on countertransference. *Clinical Psychology & Psychotherapy*, *24*(2), 462–474. https://doi.org/10.1002/cpp.2015

De Genna, N. M., & Feske, U. (2013). Phenomenology of borderline personality disorder and the role of race and socioeconomic status. *The Journal of Nervous & Mental Disease*, *201*(12), 1027–1034. https://doi.org/10.1097/nmd.0000000000000053

Desrosiers, L., Saint-Jean, M., & Breton, J.-J. (2015). Treatment planning: A key milestone to prevent treatment dropout in adolescents with borderline personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(2), 178–196. https://doi.org/10.1111/papt.12033

Finch, E. F., Iliakis, E. A., Masland, S. R., & Choi-Kain, L. W. (2019). A meta-analysis of treatment as usual for borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment*, *10*(6), 491–499. https://doi.org/10.1037/per0000353

Fischer-Kern, M., Doering, S., Taubner, S., Hörz, S., Zimmermann, J., Rentrop, M., Schuster, P., Buchheim, P., & Buchheim, A. (2015). Transference-focused psychotherapy for borderline personality disorder: Change in reflective function. *The British Journal of Psychiatry*, *207*(2), 173–174. https://doi.org/10.1192/bjp.bp.113.143842

Fornelos, A., & Roque Pereira, M. (2019). Bipolar disorder and borderline personality disorder: What is the relationship? Morressier. https://doi.org/10.26226/morressier.5d1a036357558b317a13f8e8

Garlow, S. J., Purselle, D., & Heninger, M. (2005). Ethnic differences in patterns of suicide across the life cycle. *The American Journal of Psychiatry*, *162*(2), 319–323. https://doi.org/10.1176/appi.ajp.162.2.319

Giorgi, A. (2012). The descriptive phenomenological psychological method. *Journal of Phenomenological Psychology*, *43*(1), 3–12. https://doi.org/10.1163/156916212x632934

Goodman, M., Patil, U., Steffel, L., Avedon, J., Sasso, S., Triebwasser, J., & Stanley, B. (2010). Treatment utilization by gender in patients with borderline personality disorder. *Journal of Psychiatric Practice*, *16*(3), 155–163. https://doi.org/10.1097/01.pra.0000375711.47337.27

Gordon, R. M., Gazzillo, F., Blake, A., Bornstein, R. F., Etzi, J., Lingiardi, V., McWilliams, N., Rothery, C., & Tasso, A. F. (2016). The relationship between theoretical orientation and countertransference expectations: Implications for ethical dilemmas and risk management. *Clinical Psychology & Psychotherapy*, *23*(3), 236–245. https://doi.org/10.1002/cpp.1951

Gordon, R. M., Spektor, V., & Luu, L. (2019). Personality organization traits and expected Countertransference and treatment interventions. *International Journal of Psychology and Psychoanalysis*, *5*(1), 1–7. https://doi.org/10.23937/2572-4037.1510039

Grant, J. E., Mooney, M. E., & Kushner, M. G. (2012). Prevalence, correlates, and comorbidity of DSM-IV obsessive-compulsive personality disorder: Results from the national epidemiologic survey on alcohol and related conditions. *Journal of Psychiatric Research*, *46*(4), 469–475. https://doi.org/10.1016/j.jpsychires.2012.01.009

Gratz, K. L., Richmond, J. R., Dixon-Gordon, K. L., Chapman, A. L., & Tull, M. T. (2019). Multimodal assessment of emotional reactivity and regulation in response to social rejection among self-harming adults with and without borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment*, *10*(5), 395–405. https://doi.org/10.1037/per0000334

Gunderson, J. G. (2010). Borderline personality disorder: Ontogeny of a diagnosis. *American Journal of Psychiatry*, *8*(2), 230–239. https://doi.org/10.1176/foc.8.2.foc230

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology: Findings from a systematic review. *Journal of Mental Health, 13*(3), 235–245. https://doi.org/10.1080/09638230410001700871

Hersh, R. G. (2021). Applied transference-focused psychotherapy: An overview and update. *Psychodynamic Psychiatry*, *49*(2), 273–295. https://doi.org/10.1521/pdps.2021.49.2.273

Hook, J., & Devereux, D. (2018). Sexual boundary violations: Victims, perpetrators and risk reduction. *BJPsych Advances, 24*(6), 374–383. https://doi.org/10.1192/bja.2018.27

Kernberg, O. F. (2010). Transference focused psychotherapy (TFP). In P. Williams (Ed.)*, The Psychoanalytic therapy of severe disturbance* (pp. 21–34). https://doi.org/10.4324/9780429482885-2

Kernberg, O. F. (2016). New developments in transference focused psychotherapy. *The International Journal of Psychoanalysis*, *97*(2), 385–407. https://doi.org/10.1111/1745-8315.12289

Kernberg, O. F. (2019). Therapeutic implications of transference structures in various personality pathologies. *Journal of the American Psychoanalytic Association*, *67*(6), 951–986. https://doi.org/10.1177/0003065119898190

Kernberg, O. F., Yeomans, F. E., Clarkin, J. F., & Levy, K. N. (2008). Transference focused psychotherapy: Overview and update. *The International Journal of Psychoanalysis*, *89*(3), 601–620. https://doi.org/10.1111/j.1745-8315.2008.00046.x

Lee, E. (2017). Working through countertransference: Navigating between safety and paranoia for a client with complex trauma history and borderline personality organization. *Psychoanalytic Social Work*, *24*(2), 75–95. https://doi.org/10.1080/15228878.2017.1336104

Levy, K. N., Draijer, N., Kivity, Y., Yeomans, F. E., & Rosenstein, L. K. (2019). Transference focused psychotherapy (TFP). *Current Treatment Options in Psychiatry*, *6*(4), 312–324. https://doi.org/10.1007/s40501-019-00193-9

Levy, K. N., Meehan, K. B., Clouthier, T. L., Yeomans, F. E., Lenzenweger, M. F., Clarkin, J. F., & Kernberg, O. F. (2017). Transference-focused psychotherapy for adult borderline personality disorder. In D. B. Fishman, S. B. Messer, D. J. A. Edwards, & F. M. Dattilio (Eds.), *Case studies within psychotherapy trials: Integrating qualitative and quantitative methods* (pp. 190–245). Oxford University Press. https://doi.org/10.1093/med:psych/9780199344635.003.0007

Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Weber, M., Clarkin, J. F., & Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, *74*(6), 1027–1040. https://doi.org/10.1037/0022-006x.74.6.1027

Lohman, M. C., Whiteman, K. L., Yeomans, F. E., Cherico, S. A., & Christ, W. R. (2017). Qualitative analysis of resources and barriers related to treatment of borderline personality disorder in the United States. *Psychiatric Services*, *68*(2), 167–172. https://doi.org/10.1176/appi.ps.201600108

McMain, S. F., Boritz, T. Z., & Leybman, M. J. (2015). Common strategies for cultivating a positive therapy relationship in the treatment of borderline personality disorder. *Journal of Psychotherapy Integration*, *25*(1), 20–29. https://doi.org/10.1037/a0038768

Newhill, C. E., Eack, S. M., & Conner, K. O. (2009). Racial differences between African and white Americans in the presentation of borderline personality disorder. *Race and Social Problems*, *1*(2), 87–96. https://doi.org/10.1007/s12552-009-9006-2

Perez, D. L., Vago, D. R., Pan, H., Root, J., Tuescher, O., Fuchs, B. H., Leung, L., Epstein, J., Cain, N. M., Clarkin, J. F., Lenzenweger, M. F., Kernberg, O. F., Levy, K. N., Silbersweig, D. A., & Stern, E. (2016). Frontolimbic neural circuit changes in emotional processing and inhibitory control associated with clinical improvement following transference-focused psychotherapy in borderline personality disorder. *Psychiatry and Clinical Neurosciences*, *70*(1), 51–61. https://doi.org/10.1111/pcn.12357

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Czasopismo Psychologiczne*, *18*(2), 361–369. https://doi.org/10.14691/CPPJ.20.1.7

Radcliffe, J., & Yeomans, F. (2019). Transference-focused psychotherapy for patients with personality disorders: Overview and case example with a focus on the use of contracting. *British Journal of Psychotherapy, 35*(1), 4–23. https://doi.org/10.1111/bjp.12421

Rizvi, S. L. (2011). Treatment failure in dialectical behavior therapy. *Cognitive and Behavioral Practice*, *18*(3), 403–412. https://doi.org/10.1016/j.cbpra.2010.05.003

Sansone, R. A., & Sansone, L. A. (2011). Gender patterns in borderline personality disorder. *Innovations in Clinical Neuroscience*, *8*(5), 16–20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3115767/

Scott, L. N., Wright, A. G., Beeney, J. E., Lazarus, S. A., Pilkonis, P. A., & Stepp, S. D. (2017). Supplemental material for borderline personality disorder symptoms and aggression: A within-person process model. *Journal of Abnormal Psychology, 126*(4), 429–440. https://doi.org/10.1037/abn0000272.supp

Scheiderer, E. M., Wood, P. K., & Trull, T. J. (2015). The comorbidity of borderline personality disorder and posttraumatic stress disorder: Revisiting the prevalence and associations in a general population sample. *Borderline Personality Disorder and Emotion Dysregulation*, *2*(1). https://doi.org/10.1186/s40479-015-0032-y

Smith, J. A. (2017). Interpretative phenomenological analysis: Getting at lived experience. *The Journal of Positive Psychology*, *12*(3), 303–304. https://doi.org/10.1080/17439760.2016.1262622

Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education, 44*(1), 26–28. https://doi.org/10.1177/08903344221116620

Sulzer, S. H. (2015). Does "difficult patient" status contribute to de facto demedicalization? The case of borderline personality disorder. *Social Science & Medicine*, *142*, 82–89. https://doi.org/10.1016/j.socscimed.2015.08.008

Tanzilli, A., & Lingiardi, V. (2022). The diagnostic use of countertransference in psychodynamic practice. In M. Biondi, A. Picardi, M. Pallagrosi, & L. Fonzi (Eds.), *The clinician in the psychiatric diagnostic process* (pp. 151–163). Springer. https://doi.org/10.1007/978-3-030-90431-9_10

Thériault, A., & Gazzola, N. (2010). Therapist feelings of incompetence and suboptimal processes in psychotherapy. *Journal of Contemporary Psychotherapy, 40*(4), 233–243. https://doi.org/10.1007/s10879-010-9147-z

Topor, D. R., AhnAllen, C. G., Mulligan, E. A., & Dickey, C. C. (2017). Using video recordings of psychotherapy sessions in supervision: Strategies to reduce learner anxiety. *Academic Psychiatry*, *41*(1), 40–43. https://doi.org/10.1007/s40596-016-0605-0

Tusiani-Eng, P., & Yeomans, F. (2018). Borderline personality disorder: Barriers to borderline personality disorder treatment and opportunities for advocacy. *Psychiatric Clinics of North America, 41*(4), 695–709. https://doi.org/10.1016/j.psc.2018.07.006

Yen, S., Peters, J. R., Nishar, S., Grilo, C. M., Sanislow, C. A., Shea, M. T., Zanarini, M. C., McGlashan, T. H., Morey, L. C., & Skodol, A. E. (2021). Association of borderline personality disorder criteria with suicide attempts. *JAMA Psychiatry*, *78*(2), 187. https://doi.org/10.1001/jamapsychiatry.2020.3598

Yeomans, F. E., Clarkin, J. F., & Kernberg, O. F. (2015). *Transference-focused psychotherapy for borderline personality disorder: A clinical guide*. American Psychiatric Assocation Publishing.

Yeomans, F. E., Delaney, J. C., & Levy, K. N. (2017). Behavioral activation in TFP: The role of the treatment contract in transference-focused psychotherapy. *Psychotherapy*, *54*(3), 260–266. https://doi.org/10.1037/pst0000118

Yeomans, F., Caligor, E., & Diamond, D. (2023). The development of transference-focused psychotherapy and its model of supervision. *American Journal of Psychotherapy, 76*(1), 46–50. https://doi.org/10.1176/appi.psychotherapy.20220019

Zanarini, M. C. (2009). Psychotherapy of borderline personality disorder. *Acta Psychiatrica Scandinavica*, *120*(5), 373–377. https://doi.org/10.1111/j.1600-0447.2009.01448.x

Zerbo, E., Cohen, S., Bielska, W., & Caligor, E. (2013). Transference-focused psychotherapy in the general psychiatry residency: A useful and applicable model for residents in acute clinical settings. *Psychodynamic Psychiatry, 41*(1), 163–181. https://doi.org/10.1521/pdps.2013.41.1.163

## APPENDIX A: LETTER TO PARTICIPANTS

Dear [institution],

My name is Rachel Altman, and I am a doctoral candidate in clinical psychology at Antioch University New England. I am seeking participants for my dissertation study, which has been approved by Antioch's institutional review board. The study will aim to understand therapists' experience of competency when using Transference-Focused Psychotherapy to treat individuals with borderline personality disorder. In particular, I am hoping to increase awareness of treatment modalities that enhance the technical competence of therapists treating individuals with borderline personality disorder.

As a [therapist] at an institution that trains clinicians in Transference-Focused Psychotherapy, please consider participating in my study, which will consist of an individual interview. As a note, throughout the data collection and analysis processes, participant data, including interview recordings, will be stored in a password-protected computer within a locked office inside a locked building. While your name and the name of your institution, provided in the survey, will be used to connect your responses to the interview, only the information about your professional status will be included in data analyses and the subsequent publication.

The interview may take approximately 60 minutes to complete. Thank you in advance for your time and consideration.

Sincerely,

Rachel Altman M.A., M.S.

## APPENDIX B: CONSENT FORM

**Project Title:** Therapist Competency Using Transference-Focused Psychotherapy to Treat Borderline Personality Disorder
**Project Investigator:** Rachel Altman, M.A., M.S.
**Dissertation Chair:** Theodore Ellenhorn, Ph.D., ABPP

1. I understand that this study is of a research nature. It may offer no direct benefit to me.
2. Participation in this study is voluntary. I may refuse to enter it or may withdraw at any time without creating any harmful consequences to myself. I understand also that the investigator may drop me at any time from the study.
3. The purpose of this study is: To gain a deeper, finer understanding of how the Transference-Focused Psychotherapy model has impacted their personal competency treating individuals with borderline personality disorder.
4. As a participant in the study, I will be asked to take part in the following procedures: To describe
    1. Participants in the study will take 1-2 hours of my time and will take place virtually over a HIPPA compliant Zoom platform.
5. The risks, discomforts and inconveniences of the above procedures might be: No study is completely risk free. However, I do not anticipate that you will be harmed or distressed during this study. You may stop being in the study at any time if you become uncomfortable.
6. The possible benefits of the procedure might be:
    1. Direct benefit to me: There will be no direct benefit to you, but your participation may help others in the future.
    2. Benefits to others: This information will allow us to better understand how Transference-Focused Psychotherapy enhances the technical and personal confidence of therapists treating individual with borderline personality disorder.
7. Your information will not be used or distributed for future research. Audio recordings of your responses will be taped. The only person who will have access to these recordings is the researcher. If you leave the study early, the researcher will not use your data.
8. Information about the study was discussed with me by Rachel Altman. If I have further questions, I can call her at (XX-XX-XXX).
9. Though the purpose of this study is primarily to fulfill my requirement to complete a formal research project as a dissertation at Antioch University, I also intend to include the data and results of the study in future scholarly publications and presentations. Our confidentiality agreement, as articulated above, will be effective in all cases of data sharing.

If you have any questions about the study, you may contact Rachel Altman, at telephone # (XX-XXX-XXX) or via email at (XXXXXX@XXXXXXX.XXX). If you have any questions about your rights as a research participant, you may contact Kevin Lyness (XXXXXXX@XXXXXXX.XXX).

Date:_____ Signed:_____

## APPENDIX C: RESEARCH QUESTIONS

Central Research Question:

1. What has your experience been like using TFP to treat BPD?

Sub-questions:

2. In what ways does TFP affect your feelings of competency in treating BPD?
3. How do you experience using TFP compared to other treatment modalities for BPD?
4. In what ways does TFP support and inform your countertransference?
5. What do you find most helpful about using TFP?
6. What has your experience been addressing suicidality and self-harm using TFP?

# APPENDIX D: PRESENTATION OF CODES

| Initial Codes | Categories | | Themes |
|---|---|---|---|
| | Emergent Codes | Category Name | |
| Less affective instability in patients | Less affective instability in patients | Positive treatment outcomes for patients | Positive treatment outcomes for patients |
| Clear plan of how to handle suicidality and self-harı | Interventions interact with internal subjectivity of patients | | |
| Clinician feelings of competency managing suicidal behavior | Compared to other treatment modalities | | |
| Compared to other treatment modalities | Preparedness to monitor and conceptualize clinician's emotional reaction | Ability to manage and utilize countertransference | Using negative countertransference for positive therapeutic intervention |
| Conceptualization and interpretation relieves negative countertransference | Negative countertransference is viewed as a source of information about the patient | | |
| Contract contains the patient | Framework teaches clinican how to think about their reactions | | |
| Contract provides a reference point during times of confusion and helplessness | Conceptualization and interpretation relieves negative countertransference | | |
| Framework teaches clinican how to think about their reactions | Supervision increases feelings of competency | Support and competency through treatment framework | Realiability of treatment framework |
| Interventions interact with internal subjectivity of patients | Treatment framework helps clinician understand pathology | | |
| Negative countertransference is viewed as a source of information about the patient | Contract provides a reference point during times of confusion and helplessness | Security and reliabilty of contracting | |
| Preparedness to monitor and conceptualize countertransference | Contract contains the patient | | |
| Supervision increases feelings of competency | Clear plan of how to handle suicidality and self-harm | Efficacy managing suicidlaity and self-harm behaviors | Effectively dealing with crisis and suicidality |
| Treatment framework helps clinician understand pathology | Clinician feelings of competency managing suicidal behavior | | |

## APPENDIX E: PERTINENT PARTICIPANT TRANSCRIPTION OF EMERGENT THEMES

### Theme One: Positive Treatment Outcomes or Patients

*It's a lot of work to sell [DBT] skills and to get [patients] to buy in. I think that [DBT] is harder to sustain because it goes back to the same skills and [patients] were not invested and they saw me as they see many people, as either less than, or incompetent, or against them. I just didn't see people getting better with it. But, I have seen patients get better with TFP quickly. When I would get a borderline patient, I felt even more anxious when I was using DBT. I actually felt like I was working harder than the patient [when using DBT] (Dr. Smith, personal communication, June 21, 2023).*

*It was evident through the interviews and reflective notes that the observation of positive treatment outcomes was particularly notable when compared to other evidence-based treatments for BPD that participants have utilized. Dr. Cooper talked about the benefits of TFP when compared to DBT. When using DBT, I didn't feel like something was really going on beyond surface-level communication. I always felt like it didn't resonate that much with the patients and it didn't resonate with me. I didn't feel like I was getting under the hood and really interacting with the internal subjectivity of the patients. [With DBT], I was moreso telling them what to do, eventually, and a lot of them resent that. But like a lot of people [with BPD] feel insulted and talked down to and patronized by DBT (Dr. Cooper, personal communication, August 11, 2023).*

*I think it's the best psychodynamic treatment out there, sort of unparalleled in my opinion for treating this patient population because it has structure and specific techniques tailored to working with these people that other treatments don't do (Dr. John, personal communication, July 14, 2023).*

*It takes a lot of discipline to really stick to the TFP model. And earlier on when I didn't use it, the outcomes were nearly as good, In this treatment, one thing that happens is that patients really, really develop better tolerance for intense affect. And you notice that TFP also results in increased reflective functioning, just like MBT. Although increased [reflective functioning] is not part of the modality, it has that impact and also focuses on aggression and negative control. For borderline patients, it really, really helps them. So, over the course of the second or third year of treatment, there is much less affective instability and they are more able to step back and reflect. If a patient is in the middle of an affect storm, then it's not useful to interpret. You need to contain, and then later on, you can say "I would like to share something with you, but I think it might upset you, do you think you can hear me right now or not" and the patient typically becomes curious, so that's very helpful and a helpful too. The other thing we are taught is that you can say anything to the patient as long as it comes from a deep respect of the patient ...Once you start working [with TFP], it really helps to cut through the chaos of the patient. It really helps you pick up the main affective themes and the transformational figure that you are (Dr. Henry, personal communication, June 2, 2023).*

*We look at the dyads that are being activated. Patients gain an intellectual understanding of these dyads through interpretation of the transference. And those interpretations will be close*

*enough to what's on the surface of the patient's mind so that he or she will be able to absorb it. You're also working on the internalized bad object as well and they're learning more about how it's internal, the dyad of victim and victimizer. And in this dynamic, you will see how they avoid being [the victimizer]. It starts to be pretty clear that this is all going on in their mind and not going on in the outside world (Dr. Brown, personal communication, July 21, 2023).*

**Theme Two: Using Negative Countertransference for Positive Therapeutic Intervention**

*TFP teaches you how to think about countertransference and what it's about. So it brings me back to the frame and how to think about things. I think the other piece of this is that I often reflect on a session even outside of session or when I'm writing my notes. I think, what was that feeling, and it's helpful being able to bring that back into the next session... I'm mindful of what my feelings are and I'm able to sit with them and tolerate them and think about what's triggering them and what it's about. It's a pretty active treatment. So being able then, over time, to have the experience of using [countertransference] and putting that into words in order to ask better questions that are more attuned with the patient's affect really gets to more of what is driving their reactions and behaviors (Dr. Smith, personal communication, June 21, 2023).*

*If you feel like a really horrible and depriving asshole for not prescribing medicine for this person, instead of immediately giving into that, thinking I should probably just give them something, you can take a step back and think about what's happening interpersonally and this might relate to their kind of core difficulties. So just having that pause between action and thinking is very helpful. I think TFP helps people be a little more assertive in their approach, you know, in the service of helping the patient and not being afraid to talk about aggression openly... You're going to feel things really intensely and that is actually good news because it's really often and important source of information. When I notice myself feeling something intensely rather than feeling overwhelmed or bad or confused by that, I can take a step back and look at what I'm feeling and say, okay, so what information is this giving me? What is happening between me and this person? What potential information is that giving me about how this person is experiencing me or how they're tending to treat other people in their life outside of the treatment relationship? (Dr. John, personal communication, July 14, 2023).*

*There may be an enactment going on that I was totally unaware of. And TFP allows you to pull back and step outside. There's no way to not get pulled into enactments, it's just about what happens when you find yourself in them and how to walk yourself out of them...You can be with this incredibly anti-reflective patient who is attacking you, accusing you, and you're not going to own these things. It's your job to maintain reflective functioning with an incredibly anti-reflective person which is a really hard thing to do. Being attacked and accused by a patient who is engaging in primitive defense structures and denial, you still have to maintain a curiosity and reflection about what's going on and understand, and not be thrown off by it (Dr. Cooper, personal communication, August 11, 2023).*

*And we all know that the patients will test the limits all of the time, at least for quite some time in the treatment. So, then you monitor what is going on in you as well, which is very helpful. It just gives you a much better handle on things (Dr. Henry, personal communication, June 2, 2023).*

*[TFP] gives us a series of questions if we have a big reaction. And then my thinking goes in a particular direction, like, 'Why am I thinking or feeling that?', 'What is he or she doing to me that makes me feel that way or what's triggering that feeling?', 'Why are they doing that?', 'How are they seeing me that makes them treat me this way?' And then, 'What are they doing?', 'What exactly are they doing concretely that comes from experiencing me in a certain way?' So, there are steps to take instead of feeling like I can't stand this anymore and I want to leave the session. If she's looking at me with such contempt, why is she looking at me with contempt? Because we have to agree on some kind of reality first so at that point, at least, we're not butting heads and I'm no longer feeling attacked. And hopefully, the patient feels less attacked because I'm trying very obviously to not treat her with contempt because I'm interested in what she has to say. They can see that I'm perfectly comfortable hearing about this and talking about this. I think this is a really crucial aspect. One of the things I find extremely valuable is that [understanding negative countertransference] is a way to detoxify whatever anxiety I might have (Dr. Brown, personal communication, July 21, 2023).*

*If somebody is yelling at me and telling me I'm a terrible doctor, I know that instead of being totally overwhelmed and confused, I know there is something really important to do which is to really elaborate with them about what their full experience of me is. So instead of firing the person, you can take a step back and try to reorient yourself to a position of technical neutrality and observe what's going on. It's easier said than done, but knowing that's something you can and should be doing is stabilizing when things feel really chaotic (Dr. John, personal communication, July 14, 2023).*

*TFP helps a great deal to help therapists process feelings within themselves when it's being intensely forced into you. Like, I'm being seen as this terrible exploitative asshole, but having the language for that and understanding how it reflects the split off parts of the patient and being able to talk about it, elucidating the dyad, encourages the patient to have their feelings around that and it also helps [the clinician] conceptualize the dyads. This process helps me digest those feelings and see them as between us rather than swallowing them and having them stuck in me. The conceptualization and interpretation aspect really helps me deal with my negative countertransference (Dr. Cooper, personal communication, August 11, 2023).*

**Theme Three: Reliability of Treatment Framework**

*Having group supervision with colleagues of mine that I've trained with and have TFP knowledge helps me process these feelings when we do it together. I can process the primitive emotional experience that we go through with the patients. That's very helpful in digesting my own experience (Dr. Cooper, personal communication, August 11, 2023).*

*Supervision is incredibly helpful to talk about what I'm feeling and thinking about doing. And it's incredibly helpful because every patient is different and it's hard to maintain perspective, even with your best effort and a lot of experience. And so, it's really useful to be able to talk with someone who can be more objective and validate and help formulate what the next steps should be (Dr. Smith, personal communication, June 21, 2023).*

*Another important part of TFP is consultation, certainly while you're learning it. It helps me feel more competent when I meet with someone else and see the things I've been doing well and also see some things I haven't been doing well and learn and build my competence that way (Dr. John, personal communication, July 14, 2023).*

*It really helped me hold on to more empathy for these patients because the understanding of their illness is so clearly defined. It actually makes me a little more objective as to why they're behaving the way that they are, so that is very helpful (Dr. Smith, personal communication, June 21, 2023).*

*The structural interview is extremely helpful. It helps you place the patient [on the spectrum of diagnosis]. So, you distinguish this early on which is hugely helpful. And then the other thing that is very helpful is to get as much information from the outside as possible. So, we speak with the prior therapist and ask the patient how prior treatments went and what they think of [the previous treatments]. And, it's very helpful to get the formal training and do the coursework. When I started out as a therapist, I was working more in a psychoanalytic psychodynamic treatment with the TFP framework in my head, but not the systematic use of the methods. But now using TFP, I feel more competent than I was back then (Dr. Henry, personal communication, June 2, 2023).*

*The contract helps me not go out of my way to rescue somebody. I know when I feel that way, that's a huge red flag. It means I stop and analyze what is being acted out. The contract is for the therapist as well as the patient. It tells me there are things I'm supposed to do or not to do. TFP tends to work very strongly to get us to not even be in a situation where we're in a bind (Dr. Brown, personal communication, July 21, 2023).*

*Contracting and talking about goals explicitly always gives you something to refer back to when you get really confused, which I think is one of the most useful things that TFP offers. So if the patient is saying "I don't have any problems, I don't want to be in treatment anymore, so I'm not showing up tomorrow", we've already had a discussion about exactly why they're in treatment, what their goals are, and they've made an agreement with you not to abruptly end treatment without talking about it with you first. So, you can always refer back to that and say, wait a second, something has changed, so we got to figure out what has changed here instead of feeling helpless and confused. You have a kind of North Star or lighthouse to refer back to. That's something else that's different about TFP that I find helpful (Dr. John, personal communication, July 14, 2023).*

*If a patient threatens to end treatment, or do something crazy, I feel like I can take a step back and I have some things to rely on and I know what to do (Dr. John, personal communication, July 14, 2023).*

*The boundaries set by the therapist enable the patient to feel competent because the message to them is that they're capable of keeping those boundaries. And I think many people in a borderline's life don't experience them as incapable. They might feel intimidated or bullied by them in such a way that they have to bend the rules constantly for them which ultimately, I think, leaves the patient feeling that they are not capable. Yes, it's gratifying to get the rules bent [for*

*them] but, in the end, the message is that [they're] not capable of adhering to the rules. They don't have the ability and they don't have the strength. And I think when it's relayed in a caring, thoughtful way, which is the frame of TFP, it instills some authority and confidence that they can do this. And I think many of them do not feel that way at all (Dr. Smith, personal communication, June 21, 2023).*

*The contract helps the patient see that having no limits is not good for them. They want some kind of structure, otherwise, they're anxious and all over the place until [they] fire me. So, it actually helps them as well (Dr. Cooper, personal communication, August 11, 2023).*

**Theme Four: Effectively Dealing with Crisis and Suicidality**

*I think another thing that helps me feel competent is that there's a very clear plan at all times about what to do in the event of suicidality or self-harm. And you've discussed that explicitly with the patient at the beginning and the patient has either agreed to it, in which case that is the plan, or they don't agree to it, and you don't start treatment. If they say, "I'm going to kill myself, I'm actually going to do it", then you call 911 or they go to the emergency room and you then figure out if treatment is viable. If they are feeling suicidal but they don't want to actually kill themselves and they can contain those urges, then they come to talk to you about it next session as a priority (Dr. John, personal communication, July 14, 2023).*

*You have a contract on parasuicidal behaviors and on suicidal threats. You have a very firm contract and that's very helpful. And it really is amazingly good to contain the patient, if the patient storms, for instance. It's very helpful that you are not hostage to the patient or suicidal behavior, not hostage to the patient's acting out because you have a firm agreement. And if you cannot have the agreement, then there is no treatment (Dr. Henry, personal communication, June 2, 2023).*

*I don't feel a lot of anxiety about suicidality in part because I feel like there's a plan that I know how to follow. I obviously don't feel unfazed by it, but I mean, generally, when people bring up suicide, I'm like okay, I know what to do because there's a whole set of principles and agreements and strategies and tactics about how to handle this kind of thing that I've learned from TFP and can lean on. So I guess I don't feel all that frazzled. These principles are enormously helpful in feeling more secure and confident in what you're doing (Dr. John, personal communication, July 14, 2023).*

*I find that with suicidal patients, I am more at ease when I feel that I am on the same page as the people who are closest to them (Dr. Smith, personal communication, June 21, 2023).*

*[TFP] is very supportive of therapists, so you don't have to treat somebody if you just feel too uncomfortable for whatever reason. But also, if you're treating someone who is a high risk for suicide, you should see the family and document that you explained the diagnosis and the risks that the person has a potentially life-threatening illness. You can say that you will do your best, but you cannot promise they won't commit suicide. If a person is determined, they will find a way. If there's a concern about this, we spend time talking about it and clearly distinguishing*

*between suicidal impulses, ideas, feelings, and urges. This is why the diagnostic evaluation is so important (Dr. Brown, personal communication, July 21, 2023).*

*TFP is incredibly effective around dealing with suicidality in the context of the therapeutic frame. The contract and interpretation around that frame really help patients to reduce suicidality and become more stable because they're talking about the interpersonal tension and the instability within themselves in a relational matrix so that they don't have to go act it out. We explore the plan, we talk about the voyeuristic quality around talking about jumping off a bridge, and that in itself reduces the power struggle, internal power struggle, a relational power struggle that drives the suicidal impulses in the first place. Taking the power struggle out of it really disarms the patients in ways where they don't feel like they have to hold on to their suicidality. The suicidality is their only tool of self-expression. But often [BPD] personalities... around suicidality are very object-related. They're feeling very abandoned, very empty. They need to connect around that. They need to talk about how enraged they are and how they're going to take that out on themselves [with self-harm or suicide]. And when they do that, their suicidality goes down. They were so overwhelmed with their negative emotion, their abandonment, their rage, their aloneness, and they are trying to soothe themselves in some way and act out these intense negative emotions that [they feel]. They end up killing themselves or severely maiming themselves with impulsivity, with going just a little bit too far, taking just a few too many pills. That's usually how personality disordered people really seriously damage or destroy themselves. And sitting with these very disturbing topics [with the patient] and taking the power struggle out of this by saying, 'I can't stop you from doing this. I could put you in a hospital for two days, then you leave, and you'd be pissed off at me, and you wouldn't want to work with me anymore. If you really want to die, you can find a ledge to jump off. But, I'm here to try to figure out if this relationship can be healing enough that you may reconsider your destructive impulses.' (Dr. Cooper, personal communication, August 11, 2023).*