A Psychodynamic Approach for the General Psychiatrist

Using Transference-Focused Psychotherapy Principles in Acute Care Settings

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KEYWORDS

• Personality disorders • Transference • Psychodynamic psychotherapy
• General psychiatry • Psychopharmacology

KEY POINTS

- Psychiatrists in acute care settings routinely see a significant number of patients with personality disorder pathology.
- Failure to recognize primary or co-occurring personality disorder pathology can be problematic and complicating.
- Central tenets of this evidence-based treatment (transference-focused psychotherapy [TFP]) for borderline personality disorder can be useful for clinicians in acute care settings, even when those clinicians are not acting as the primary psychotherapist.
- Utilization of fundamental principles of TFP can help improve outcomes and also serve as an effective risk management strategy.

INTRODUCTION

Transference-focused psychotherapy (TFP), one of the evidence-based treatments for patients with borderline personality disorder (BPD), was developed by clinicians steeped in psychoanalytically informed psychotherapy who recognized that their standard treatment approach required significant adjustment to be of use to patients with moderate to severe personality pathology.[1] Although TFP research has focused thus far exclusively on individual psychotherapy with those individuals meeting *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) criteria for BPD, its central principles may have utility for clinicians treating a broader group of patients and in a variety of settings including those in acute care psychiatry.[2,3] It might

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seem, on the surface, counterintuitive to suggest using psychoanalytically informed interventions in the world of contemporary acute care psychiatry, now dominated by pharmacotherapy and cognitive-behavioral interventions. That said, numerous studies have concluded that patients with personality disorder (PD) pathology, and in particular those with BPD, are significantly represented in psychiatric emergency departments, inpatient psychiatric settings, and general outpatient psychiatric clinics.[4,5] (Although this article refers to patients with moderate to severe PD generally, because the vast majority of PD research has been on patients with BPD, most of the references relate to findings on that particular subgroup of patients.) What is the general psychiatrist's likely present-day accommodation? Some clinicians might ignore PD symptoms completely, focusing exclusively on mood, anxiety, eating, or substance use disorders, which are comorbidities frequently seen in BPD.[6] (This conjecture is supported by research examining rates of PD diagnosis in outpatient clinics; when clinicians use semistructured interviews they are much more likely to make a PD diagnosis than when assessing the same patient without such prompts.[7]) Others may try to direct patients to specialized care, although such opportunities may be rare, or prohibitively expensive, or both.[8] Applications of TFP principles, although not a panacea, can provide clinicians with a way to assess PD pathology by category and by level of severity, and to help them manage common clinical situations.

As noted, TFP was originally developed as an individual psychotherapy for patients with BPD. Since its inception, academic leaders have proposed adapting TFP concepts and techniques for patients with higher-level personality pathology, with adolescents, and with a group treatment format.[9–11] More recently, psychiatry residencies have introduced TFP teaching as a tool to enhance trainees' introduction to conducting individual psychotherapy, and as a tool to help manage patients with PD pathology in the acute care settings where residents practice.[12,13] Psychiatry residents will generally see patients in situations marked by relatively high acuity, such as emergency departments, inpatient units, and tertiary-care outpatient clinics; this acuity is associated with high rates of patients with primary PD presentations or PD symptoms co-occurring with other disorders.[14,15] In general, psychiatry residents get relatively little training about working with patients with PDs and the exposure to treatments for patients with PDs tends to be focused on dialectical behavioral therapy (DBT).[16] Although learning about DBT will certainly have utility for psychiatric trainees and assist them in considering referral options, the pilot programs introducing TFP training to residents have a broader overarching goal of integrating TFP concepts into the trainees' daily work with patients in multiple spheres.

TFP as an individual psychotherapy has a distinct way of unfolding, marked by a specific order and critical essential elements required even before the therapy begins. Once the individual psychotherapy is started, the TFP therapist will use a defined set of interventions. In this respect, TFP is unlike many "free-form" supportive or expressive psychotherapies as they are widely practiced. The notion that TFP principles can be "applied" in settings other than an extended individual psychotherapy echoes the longstanding tradition of "applied psychoanalysis" or the use of psychoanalytic theory and technique in situations outside of the individual psychotherapy dyad.[17]

THE ESSENTIAL ELEMENTS OF TRANSFERENCE-FOCUSED PSYCHOTHERAPY AS AN INDIVIDUAL PSYCHOTHERAPY

Before discussion of applications of TFP principles in acute care settings, it is useful to review the essential elements of TFP as an extended individual psychotherapy. As noted, TFP was developed by clinicians working in a psychoanalytic mode,