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Transference-Focused Psychotherapy in Australian psychiatric training and practice

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Abstract

Objective: This article discusses Transference-Focused Psychotherapy, a contemporary evidence-based and manualised form of psychoanalytic psychotherapy for borderline personality disorder. Transference focused psychotherapy has evolved from decades of research in the object-relations approach developed by Professor Otto Kernberg and his collaborators. It is being adopted increasingly throughout North and South America and Europe, and this article explores the role its adoption might play in psychiatric training as well as public and private service provision contexts in Australia.

Conclusions: Transference focused psychotherapy is readily applicable in a range of training, research and public and private service provision contexts in Australia. A numbers of aspects of current Australian psychiatric training and practice, such as the Royal Australian and New Zealand College of Psychiatrists advanced training certificate, and the Australian medicare schedule, make it especially relevant for this purpose.

Keywords: psychotherapy, borderline personality disorder, psychiatric training, public health

Patients with borderline personality disorder (BPD) present clinicians with a challenging constellation of symptoms. At times both clinicians and patients can feel that the available treatment modalities are limited in their ability to address the patient's core issues. The prevalence of BPD in Australia is estimated to be 1–3% in the general population; however, people with BPD have been reported to account for up to 23% of psychiatric outpatients and up to 43% of psychiatric inpatients.[1] Individuals living with BPD also have a significantly higher mortality rate than the general population.[2] All of these factors highlight the need for continued training of clinicians in evidence-based treatment modalities. This is especially the case of psychiatrists and psychiatry trainees who will continue to see patients with BPD frequently regardless of their level of training.

In Australia in the past decade, public service provision to this clinical domain has been increasingly emphasised, including recently published National Health and Medical Research Council guidelines, and federal and state government policies,[1] but there continues to be great difficulty in achieving systematised services for this population, both in the public sector and in settings integrated with the private sector or research and training centres. The fundamental issue relates to the resource-rich nature of quality evidence-based care which needs to be phase specific, multimodal, individually tailored, multisite, with the longer term and intensive involvement of dedicated psychotherapists. This care extends beyond generic management approaches or the often isolated dialectical behaviour therapy groups offered by many public mental health services.

This article intends to explore the role that one contemporary evidence-based model of psychotherapy for BPD,

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Transference-Focused Psychotherapy (TFP), could increasingly have in the Australian context. What follows is a description of TFP and the role it could play increasingly in training as well as public and private service settings in Australia.

Transference-Focused Psychotherapy

TFP is a structured, manualised, twice-weekly psychodynamic evidence-based treatment for severe personality disorders, particularly BPD and narcissistic personality disorder. TFP has arisen in North America in the past 25 years as a progression of the work of Professor Otto Kernberg and his collaborators on BPD, borderline personality organisation and modified psychoanalytic psychotherapy that dates back to the 1960s. The influence of this work and TFP has now spread across North and South America and Europe and there is increasing opportunity to develop applications in the Australian context.

TFP is based on object-relations theory and has a primary focus on the exploration of the dominant affect-laden themes that emerge over the course of therapy between the patient and the therapist.[3] This exploration of transference and countertransference is done in the 'here and now' of the unfolding therapeutic relationship and enables better understanding of the patient's interaction with the world outside of therapy.[4] As the subjective and interpersonal experience of the patient with severe personality disorder is often exaggerated and distorted, the aim of TFP is to use the activation of this in the treatment relationship to frame the affects cognitively that arise in relationships in order to facilitate integration of the related conflicting internal object relations (or 'dyads') into a more cohesive and functional personality structure.[5] The therapist promotes reflective function and affect regulation by adopting a neutral stance that actively enquires about and clarifies aspects of patients thoughts, feelings and perceptions, and then confronts (invites the patient to reflect on inconsistencies related to internal splitting mechanisms) the patient with and interprets the patterns in which these relate to the transference relationship and key relationships in the individual's life.

Another key element of TFP is the initial treatment contract, developed between the patient and the therapist in the very early stages of therapy. The contract focuses on holding patients responsible for their own recovery, establishing a clear framework for how acting out behaviours (for example, self-harm) will be addressed during therapy.[6] The contract also defines the treatment relationship in a clear way that facilitates observing and interpreting any deviations from the defined relations based on the patient's distorted internal images. TFP has a growing evidence base, with studies showing that it has positive effects across a broad range of outcome domains including suicidality, anger, impulsivity and irritability. It is also being studied in specific populations (youth, for example) and settings (resident training, for example). It is worthwhile to consider how these applications could be developed in the Australian context in training as well as in public and private service provision.

Psychotherapy training for Australian psychiatrists

Training in psychotherapy is a vital part of psychiatry training; this is reflected by the college's retention of the psychotherapy written case as a mandatory training experience in the transition from the 2003 to the 2012 training curriculum. The advanced training certificate in the psychotherapies is also one of the most popular and is felt to be very relevant for the transition of senior psychiatry trainees to the role of junior consultancy.

Nevertheless, psychotherapy training, especially in the field of psychodynamic methods, can be particularly challenging for trainees given the complexity and sheer amount of theory on which it is based; the lack of a clear procedure in some treatment modalities and the challenges of managing transference and countertransference.[7] There also seems to be a commonly held bias that patients with BPD are unsuitable for trainees to see for long-term psychotherapy due to their intensity and high risk; this deprives trainees of a vital learning opportunity and is seemingly at odds with the reality that trainees are already treating patients with BPD in other treatment settings (inpatient wards, community settings). Psychotherapy influenced by the principles of TFP is a way for trainees to offer psychotherapy to these patients by providing a treatment model that is both engaging and practical. It offers a unified psychodynamic theory within a manualised therapy with a clear practice framework. As recognising and managing countertransference is central to the therapy, trainees begin knowing that managing this is vital, and instead of feeling anxious about it, they welcome the emergence of transference/countertransference as a core aspect of the therapeutic intervention.

Interestingly, in addition to the use of TFP with patients who have severe personality disorders, trainees have found that the skills learnt in TFP have applications that extend to a vast cohort of their patient populations. The ability to understand psychodynamic theory better and how it applies to patients, in addition to feeling much more comfortable with managing difficult interactions in which transference and countertransference are prominent, better equips trainees in all of their rotations – be that in an acute inpatient ward, a community mental health team or in a busy emergency department.

Furthermore, TFP lends itself well to advanced training in psychotherapy, as 12 trainees in South Australia who are currently undertaking the advanced certificate have found. In addition to the benefits outlined above, supervision options exist both locally and internationally via online video-conferencing, increasing the accessibility

of expertise in this area. The trainees have found that this training is not only beneficial for their learning and the provision of psychotherapy to their patients, but it can also be disseminated within their services to instigate changes in their service culture.

Private practice in Australian psychiatry

TFP is an ideal modality for private practice. The robust training benefits and supervision options discussed above also apply to the private practice setting. TFP's principles that inherently encourage liaison with other parties (family, carers, general practitioners, other mental health services) ensure a supported, transparent framework from which to provide care. The clearly defined roles in this structure assist in overcoming biases of polypharmacy, misdiagnosis and the avoidance of otherwise complex and treatment-resistant patients. Although Medicare data illustrate that item numbers applicable to psychotherapy sessions have been increasingly less employed,[8] rebate number 306 (and for attendances greater than 50 per year, item 319) is ideally suited to provide affordable treatment in the TFP format of twice-weekly 50-minute sessions. Given that the Australian psychiatric community is historically influenced by psychodynamic, and specifically object-relations, approaches, this is an ideal modality to be adopted into the future by private practitioners. Also, training in this modality of psychotherapy can be easily incorporated into private practice, where training cases and supervision can enhance day to day private practice and provide further opportunities for peer and supervisor contact, and further professional development.

Public sector psychiatry in Australia

Certain regions and leaders in Australia have developed approaches to training, research and limited service provision for BPD, for example: the Westmead Psychotherapy Unit;[9] Spectrum;[10] the Hype Service at Orygen;[11] and Project Air.[12] These centres, in different ways, address issues of training, research, consultation and service provision in innovative and unique ways. Some are wedded to a specific modality of psychotherapy, some are multimodal, and some attempt to generalise accepted approaches from a range of psychotherapies into a more generic and adaptable approach.

TFP has been formulated not only to be a structured treatment offered by a trained and supervised practitioner, but also to have principles that can be translated into a range of settings to influence very practical approaches to BPD treatment within general mental health services and dedicated centres in the public sector.[13] TFP encourages safe and structured contracting of treatment, and a coherent and collaborative approach with the suffering individual and their family, and between care providers. Paying attention to the field of relationships in the suffering individual's life can avoid problems that have been typically associated with BPD sufferers, including splitting within teams and services, as well as inconsistent and fragmented care. These principles clearly delineate the roles of the therapist and service provision offered by the community mental health service, emergency departments and the patient's general practitioner.

As such, public services have the potential not only to emphasise further training in this modality of psychotherapy, but also to adopt its broader principles in structuring and integrating the services it provides to these populations. There is the opportunity for TFP to provide a specialised form of psychotherapy treatment for BPD sufferers, as well as guide the structure of broader systems of service.

Conclusions

TFP is increasingly adoptable in the Australian context for a high risk, high needs population that is currently underserviced and continues to have poor outcomes despite sophisticated manualised, evidence-based modes such as TFP potentially being available. TFP lends itself well to psychiatric training, complementing the current Royal Australian and New Zealand College of Psychiatrists general curriculum as well as psychotherapy advanced training requirements. Furthermore, TFP is well-suited to the public and private sectors more broadly; it can be adapted to these settings and accommodated by broader services, and existing Medicare rebates should render it an affordable, accessible treatment.

Disclosure

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