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Behavioral Activation in TFP: The Role of the Treatment Contract in Transference-Focused Psychotherapy

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Transference-focused psychotherapy (TFP) is a manualized evidence-based treatment for borderline and other severe personality disorders that is based on psychoanalytic object relations theory. Similar to other psychodynamic psychotherapies, TFP focuses on changing psychological structures, but also focuses on symptom and behavioral change, particularly the importance of being active (e.g., obtaining a job or involvement in similar activities). In TFP, the establishment of the treatment contract, also known as the treatment frame, is where goals such as work and other activities are agreed upon. The focus on such activities is particularly relevant to the concept of behavioral activation. We provide a clinical vignette to illustrate how TFP utilizes behavioral activation in facilitating treatment outcome both at the behavioral level and at the psychological level.

Keywords: transference-focused psychotherapy, behavioral activation, treatment contracting/setting the frame

Transference-focused psychotherapy (TFP) is a manualized evidence-based treatment for borderline and other severe personality disorders that is based on psychoanalytic object relations theory. TFP developed out of the prevailing psychoanalytic treatment during the 1960s as influenced by experience and empirical research from the Menninger study (Kernberg et al., 1972; Wallerstein, 1986). Based on his experiences in the Menninger Study, the psychoanalyst Otto Kernberg (1968) began to modify classical psychoanalysis for use with patients with severe personality disorders such as borderline and narcissistic personality disorders. These changes included reducing the number of sessions from five to two per week, moving from the use of a couch to face-to-face to psychotherapy, explicit attention to the frame of the treatment, a more explicit focus on the patient's life outside of therapy, and balance between the patient's internal world and external reality (Kernberg, 1980). The emphasis on the patient's life external to the mental life and therapy, although predating the development of behavioral activation as a technique (Ferster, 1973; Lewinsohn, 1975), and carried out quite differently, is still nonetheless quite consistent with it.

Although the initial conceptualization for TFP began with modifications of classic psychoanalysis beginning in the 1960s, Kernberg and colleagues have continued to articulate and develop the treatment in a series of books (Clarkin, Yeomans, & Kernberg, 1999, 2006; Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989; Yeomans et al., 1992, 2015). Beginning in the 1980s, Kernberg, joined by John Clarkin, later Frank Yeomans and other colleagues, further elaborated TFP on the basis of experience and empirical research (Clarkin et al., 2001, 2007; Levy et al., 2006). As Kernberg and his colleagues worked to help those struggling with severe personality disorders benefit from the deep psychological exploration provided by an analytic approach, it was clear that the treatment needed to be carried out in a frame that was more structured than that of traditional psychoanalysis. Therefore, a major modification in developing TFP was the development of a detailed concept of the role of the treatment frame, conceptualized as a contract between the patient and the therapist. This central element of TFP with its focus on contingency contracting is also consistent with writings about behavioral activation (Ferster, 1973) and is the focus of this article. Similar to the model proposed by Dimaggio and colleagues (Dimaggio, Salvatore, Lysaker, Ottavi, & Popolo, 2015), from a TFP perspective, behavioral activation is not limited to the provision of environmental reinforcements and reduction of environmental punishments but also as an opportunity to rework what cognitive–behavioral therapist refer to as maladaptive interpersonal schemas or what we call, from an psychoanalytic object relations approach, object relations. These reworked schemas or object relations allow the patient to view him or herself

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differently—as efficacious and agentic (Levy & Scala, 2015). The contract or treatment frame provide opportunities to understand how these schemas/object relations, as well as related wishes, desires, and conflicts, both conscious and those not immediately in one's awareness, interfere with the patient's capacity to negotiate problems that arise in being more active (Levy & Scala, 2015).

Setting the frame of treatment is the first of a series of tactics in TFP and is the most crucial one that most directly involves behavioral activation (Yeomans et al., 1992). Treatment contracting is carried out by the negotiation of a verbal treatment contract or understanding between the therapist and patient. A treatment contract establishes the frame of the treatment, defines the responsibilities of each of the participants, and sets the stage for observing the patient's dynamics in a defined "space." Among other purposes it serves, the contract defines what the reality of the therapeutic relationship is. As the therapy moves forward, the clear definition of that relationship—the patient speaks freely about his or her problems and the therapist intervenes to help further deep understanding but not to give direct advice—advances the exploration of the internal workings of the patient's mind, as important elements of the patient's personality structure/way of relating to others will be evident in the ways the patient responds to the therapy relation as defined. Beyond this level of helping explore personality structure, on the level of behavioral activation, the contract details the *least restrictive* set of conditions that will allow: (a) the therapy to continue without undue interruptions from acting out behaviors, and (b) the patient to engage in some life activity that will activate their potential to function in world while simultaneously activating the difficulties the patient has interacting with others in a way that will provide important material to reflect on in the therapy—material that would not be available without this level of engagement in the world.

Essential points are as follows:

(1) Exploration of the patient's mind cannot take place in the context of repeated crises that distract attention from the exploratory endeavor. Therefore, behavioral parameters must be established to contain and limit the pattern of crises.

The therapist might say to a patient whose wrist cutting had led to repeatedly calling her therapist late in the evening, going to the ER, and getting hospitalized: *There are probably a number of reasons that lead to your cutting yourself. The one that's most clear so far is that it's a way to try to get intense and seemingly unbearable emotions. However, doing that makes it difficult to carry out the kind of therapy I'm proposing—a therapy that's aimed at getting to know and understand those intense emotions—in two ways. First, it "short-circuits" the emotions—temporarily discharging them so that we do not have the chance to fully know and explore them in therapy. Second, it has put your prior therapists more in the role of a case manager dealing with how to manage symptoms than of a therapist who can help explore your deep feeling states and conflicts. To use a metaphor, as a therapist I could either try to help you put out the brush fires you create or try to help you understand what's behind them. Which type of therapy you choose is up to you, but I recommend, and would only engage with you, in the type that seeks to focus on exploration and understanding of your emotions.*

(2) Clinical experience has shown that psychotherapy that is carried out with a person who has no active engagement in life is generally a fruitless endeavor. Therefore, the patient must agree to engage in some form of productive life activity.

The therapist might say: *I understand that getting involved in activities with others causes a lot of anxiety and distress for you and so you've been staying at home and have no job or plan to study. However, in my experience as a therapist, people who come to therapy without some involvement in life have a hard time making real progress. Understanding things here needs to be accompanied by seeing how you feel and react out in the world. I know going out and doing something creates a lot of anxiety in you, but it can become a positive feedback cycle where what you're doing 'out there' can provide us with a lot of material for understanding 'in here' and then what we learn 'in here' can help you with how you experience interactions and react 'out there.'*

The therapy that I think would help you the most is one where your role is to let me know everything that comes to your mind about the problems that brought you here—without censoring or holding back. That could include thoughts that emerge about me. This may sound easy but it can be tough to do. My role is to make every effort to understand things that go on in your mind that you're not aware but that have an impact on what you feel, what you think and what you do. In this type of therapy, my role is not to give you advice because my view of you is that you have the potential to grow in autonomy and it would tend to leave you in a more dependent position if my role were to give advice.

Creating conditions in which a psychodynamic exploration can take place involves—

(1) Agreeing that the patient's difficulties may benefit from deeper understanding of the self (in contrast to a purely biological view of the problems). An example of this is found in the clinical vignette below.

(2) Containing acting out behaviors so that the exploratory work is not interrupted repeatedly by "putting out fires," as discussed above. The therapist might add: *Many people with borderline personality disorder assume that they have no control over their impulses. However, clinical experience, as well as some scientific studies, have shown that people with this disorder can often find some level of control if they make the effort. This could include being explicit about steps one might take to control impulses. In addition, our understanding that working with the emotions behind the impulses and agreeing that there is a meaning we can find in them can help put an end to acting out and focus on our joint work toward understanding here.*

(3) Defining what the treatment and treatment relationship are, as discussed above.

A guiding principle in setting up the conditions of treatment is that the therapist must feel comfortable and safe enough to think clearly. This is no small matter in the treatment of patients who often create a level of anxiety that can lead the therapist either to

abandon psychodynamic techniques in favor of whatever measures seem to meet the need of the moment or, much worse, abandon the case. In so doing, therapists usually participate in acting out the primitive dynamics of the patient rather than helping the patient understand and resolve them.

In discussing the treatment contract, the therapist must address: (a) universal and essential parameters of treatment which apply to all cases in psychodynamic therapy; and (b) resistances that can appear in the form of specific behaviors that could threaten the treatment that the therapist learned of during the assessment. These behavioral resistances stem from the fact that exploratory therapy threatens the patient's fragile homeostasis.

Although the patient must make a commitment to try from the start to work within the parameters of treatment, the therapist should understand that difficulty following the contract may constitute a primary topic in therapy before full adherence is achieved. The contracting process is not a unilateral statement by the therapist, but a dialogue in which the therapist pays careful attention to the patient's reaction to the statement of the conditions of treatment. As discussed by Dimaggio and his coauthors (Dimaggio et al., 2015), the contracting process may vary according to the patient's specific pathology. For example, we have noted (Caligor, Levy, & Yeomans, 2015; Diamond et al., 2011; Levy, 2012) the therapist may have to be particularly patient and flexible with patients presenting with narcissistic personality disorder (NPD), as they may experience the discussion of necessary conditions of treatment at a challenge to their (fragile) grandiosity and their need to control.

The areas of patient responsibility that should be routinely discussed include attendance, participation, fees, the patient's role in the therapy, and the patient's engagement in life activities. The idea of having responsibilities in treatment may be foreign to some borderline patients who feel that they have no control over their actions and that the therapist's role is to take care of them. Our clinical experience is that these patients are generally capable of both a higher level of control and a higher level of activity than is often assumed, and that to approach them with this understanding is beneficial for progress in therapy and appeals to the patient's potential. It can be helpful for the therapist to explain that he or she does not see the patient's acting out behaviors as the essence of her illness, but rather as a manifestation of underlying psychological difficulties that can be understood and changed.

Given the choice of therapies for borderline personality, patients sometimes ask why a psychodynamic approach would be preferable to other approaches. The recommendation for TFP is based on the therapist's clinical impression, after a thorough evaluation, that the most complete resolution of the patient's problems will come from addressing the psychological make-up that underlies the patient's specific symptoms and that work on this level is most likely to lead to achieving normal functioning in the areas of work, love, interpersonal relations, and creative and leisure activities.

In addition to the general arrangements required for any patient to engage in TFP, a major goal of setting up the contract is to anticipate which forms of resistance to exploration a particular patient is likely to create that could threaten the continuation of the treatment and to devise parameters to address and reduce that threat. This process is individualized for each patient and can be subtle and complex and is elaborated elsewhere (Yeomans et al., 1992).

Resistances to the treatment can result from primitive defense mechanisms working to maintain a brittle status quo (projection of affects the patient is not comfortable with) and/or from efforts to maintain the secondary gain of illness (e.g., support from parents, unwarranted medical disability payments). The elimination of secondary gain is enhanced by the behavioral activation aspects of the contract and generally leads to the patient engaging more fully in treatment. Not all threats to effective treatment are active behaviors. If the patient's lifestyle is so chronically passive or socially withdrawn that the treatment is the patient's only activity in life, the therapist may discuss with the patient the need for some form of work or study as a condition of treatment. A therapist who accepts that the patient will go on indefinitely doing nothing except attending treatment may be colluding with a view that the patient is helpless and must continue in the role of a passive, dependent recipient of caregiving. Our experience is that it is very rare that a borderline patient is not able to improve and achieve a level of independent functioning.

Contracting around specific threats call on the therapist's judgment, as it requires the therapist to decide (a) which aspects of a particular patient's behavior and history may present a threat to the treatment and (b) if the threat is so serious that a strict parameter must be in place before therapy can begin (e.g., "You will have to stop all drug use and regularly attend a 12-step meeting for therapy to begin") or if the therapy can begin while the threatening behavior is being worked on (e.g., "I know you are still struggling with your anorexic behaviors, but as long as you agree to meet regularly with the dietician and stay above the minimum weight, we will be able to proceed with our treatment"). Contracting around specific elements often elicits resistance from the patient. Patients may feel that the behaviors designated by the therapist as threats to the treatment are precisely those coping mechanisms that help them find relief or even survive. They may, therefore, be reluctant to give them up. Plans for contracting around substance abuse, eating disordered behaviors, and other harmful behaviors that take the treatment focus away from psychological exploration are discussed in the TFP manual (Yeomans et al., 2015)

We chose contracting around issues of inactivity/social dependency as the focus of this paper, as they best illustrate the behavioral activation aspects of TFP. Many borderline patients are deemed to be disabled, unable to work, and, therefore, entitled to public assistance or family support. In cases where the patient is receiving disability payments, the question arises as to: (a) the assessment of whether or not the patient is able to engage in some productive activity, and (b) evaluation of the patient's willingness to act on her capacity to work versus resistance to do so because of psychological and financial secondary gain.

The considerations we discuss here do not apply to all BPD patients, as many are in school or have a job or career at the point of beginning therapy. And those who are living a dependent life often experience ambivalence and internal conflict around their passive, dependent status. However, patients come for treatment manifesting different sides of the conflict. Although on the one hand, some patients leave therapy when it is made clear that functioning at an appropriate level is an expectation of the treatment, on the other hand, this expectation may appeal to the side of patients that is frustrated with their nonfunctioning and experiences an urge to take on a more active role. There is a certain irony that some patients whose illness is expressed primarily as an

immature dependency and pursuit of secondary gain, and who do not appear "as sick" as patients who manifest severe self-destructive behaviors, do not do as well as this latter group because it is easier for them to be comfortable in their pathology. It is more difficult for the patient with severe self-destructive behaviors to deny the severity of her illness. The pathologically dependent patient is more likely to avoid or drop out of a treatment that tries to get at the root of her illness and attempts to effect fundamental change. This type of patient is more likely to settle into the status of chronic patient, especially in social settings where alternate treatments and social benefit systems support this status. The best strategy for the TFP therapist is to question this choice of chronic dependency and to support the part of the patient that has strivings for more autonomous functioning.

In establishing the conditions of treatment, the therapist should always consider the patient's current level of day-to-day functioning and discuss a realistic level of structured activity. This could range from attending a day program to obtaining meaningful employment. The therapist may encounter any of the following.

(1) Patients who are not working, and for whom there are no clear psychological nor physical reasons why they cannot work. With these patients, the goal of obtaining work within a specified period of time must be negotiated in the contract setting phase of treatment. Patients with BPO generally are capable of functioning either at a job or at school. Nevertheless, BPO patients with passive, infantile, dependent, and/or antisocial traits often avoid the challenge of work despite the potential for functioning and exploit the social system, either government aid or family aid. This may stem from the combination of an internal conflict around functioning (a patient's internal world often includes a defective, incompetent self-representation subjected to merciless harsh criticism from an object representation), emotionally reactivity to others (generally based on the internal representations), and a wish to have the external world compensate for a history of real or perceived neglect or mistreatment. Although these problems may be present, our experience is that most patients are capable of functioning and that functioning is essential to any real improvement and has important psychological benefits (such as helping the person address choices in life and thus be a step in resolving identity diffusion and supporting the patient's being in an interpersonal situation where stresses can be experienced, discussed, and understood.)

(2) For those patients not working because of symptoms such as depression and anxiety, an assessment must be made of the nature of the symptoms. If the patient is experiencing a major depressive episode, treatment with antidepressant medication may be necessary before the patient is able to start increasing her level of functioning. With regard to anxiety, some patients are helped by low doses of atypical antipsychotic medication. However, it is also helpful to address the nature of the anxiety that interferes with functioning. We have found that it often involves a paranoid position in relation to others—the expectation that others in the school or work setting will be critical of the patient, resent her, talk behind her back, and so on. Discussion of such fears, and of the fact that this usually corresponds to a harsh internal object representation that is being projected, can help the patient begin to take on a functioning role. However, this discussion often becomes meaningful when those dynamics have been experienced and explored in the relation with the therapist.

(3) For patients who are working below their potential, the therapist should explain that this issue would be addressed in therapy both to understand why this is the case and, if the patient is interested, with the concrete expectation that the patient would take action to improve her level of functioning.

(4) A variant of problems with level of functioning involves patients who are active but who are involved in activities with dangerous or antisocial aspects (e.g., working as a prostitute). In such cases, the therapist should take the position that progression to work of a less dangerous and/or less antisocial nature would be a goal of treatment.

It is important to keep in mind that the treatment plan is predicated on an adequate diagnostic impression. *Before* setting up the contract, the therapist should be comfortable that the patient is organized at a borderline level and is not currently experiencing another major pathology, such as a major depressive episode or psychotic illness.

Clinical Vignette[1]—Client Background and History

At the time treatment began, the patient, Sophie, was an unemployed 32-year old never married woman living alone and having few friends. The patient grew up as the second of four children in an upper-middle class family. Her father, a successful professional, seemed to value academic and professional success above all else. Her mother was emotional unstable and made at least one suicide attempt in the course of the patient's growing up but she never received psychiatric care. The patient described herself as "a loner" in school. Her depressive symptoms and self-cutting led to psychiatric consultation at age 18. She was diagnosed as bipolar and received years of treatment that combined medication and supportive psychotherapy. She completed two years of college and then went on to training in a paraprofessional field. She had a number of jobs throughout her 20's but was fired from each one of them. She attributed this to people's irrational dislike of her. By the time she entered therapy, she had given up on working.

Presenting Problem

Sophie presented for treatment with a years-long diagnosis of bipolar illness and "treatment-refractory depression". Her specific

[1] The clinical vignette is disguised by changes in all possible identifying facts and details describing the patient. Session notes were used retrospectively best approximate these interactions.

presenting problems were (a) chronic depressed mood with frequent suicidal ideation, (b) poor interpersonal relations (she had no friends and had never had a romantic or sexual relationship), and (c) poor functioning in life (she had been fired from many jobs and had unemployed for the past year, receiving financial assistance from her parents). In addition, Sophie had a history self-injury (wrist-cutting) in the past.

Case Formulation

The therapist based his diagnosis of BPD/NPD on a careful diagnostic assessment called the structural interview (Kernberg, 1984). His formulation of the case was that the patient's difficulties were rooted in a psychological structure based on splitting. The structural interview had provided evidence of a lack of integration of her self-view and her view of others, with radical shifts from positive to negative experiences of both self and others. For example, at one point she said she knew she was always the smartest person at any job she had, while later she said she was a useless person who had no reason to live. As an example in her describing someone else was saying that her father was a highly successful professional who she admired for his accomplishments and later saying he was a tyrannical despot who was "worse than Stalin." The therapist hypothesized that this was the main contributing factor, along with a temperamental intensity, to her rapidly shifting moods and to her lack of a solid sense of herself in the world. In addition, he hypothesized that the Sophie's difficult relations with others and repeated terminations of employment were related to externalizing defenses which led to her experiencing a hostility in others that it was difficult to recognize in herself. The structural interview included moments when the therapist experienced an aggressive "edge" in Sophie when she vociferously accused others of mistreating her and indicated that she believed the therapist was prejudiced against her without any evidence to that effect.

The therapist recommended treatment with TFP because of its combined focus on a patient's functioning in the world and the resolution of the internal psychological conflicts (inability to integrate extreme positive and negative affects) that underlie emotional instability and interpersonal difficulties. A summary of his discussion of his diagnostic impression is as follows: *I don't doubt that you experience depression a great deal of the time. However, depression can stem from a number of different sources. So far, yours has been considered as primarily rooted in the biology of your nervous system. Yet in listening to you, it seems important to consider a psychological root of your depression. For example, you told me that if your musical talent had gotten the recognition it deserves, you would have become the next Whitney Houston and that you have fantasies of success and wealth even in your depressive states. This suggests that there is a big gap in your mind between what you feel you should be and what you are—experiencing that gap could lead to feeling bad about yourself, about your life, and about the world. This is just one example of how ways your mind work that you may not have reflected upon can have a provide impact on your mood and functioning.*

Sophie was willing to consider the new diagnosis of personality disorder and readily agreed to the general conditions of treatment (attending, speaking without censoring, etc.). However, when the therapist discussed the need to engage in some form of work or study, the patient responded by saying: *You do not know me. Making me getting involved in any kind of, activity would make me relapse into a state of total depression.*

The therapist was concerned about this and even wondered if he might be harming patient with his treatment plan. However, as he internally reviewed the basis for his diagnosis, he proceeded with the discussion of the need to work: *I understand your fear. However, I'm basing my recommendation on a combination of faith in the diagnostic impression I have of you and a body of clinical experience that shows that, with the support of therapy sessions where you can discuss the anxieties and fears, as well as the frustrations and anger you might experience in an activity with others, people with your kind of difficulties can begin to be more productive and get a sense of achievement. Of course, it requires looking at the reactions you'd be having there in our work here, so it's also a means of providing important material for the therapy. Of course, the choice is up to you. I'm suggesting what I think would be the most beneficial treatment for you. We might have an honest difference of opinion and you might feel a more supportive or more biologically oriented therapy is what you need.* Sophie listened with a look that suggested a combination of reflection and annoyance. She said she would think about it and left that session saying under her breath that the therapist could take his idea about work and "shove it." However, she came to the next session with the news that she had obtained a part time job in a field that interested her. This was an important indication of positive, health-seeking element in her internal world that was usually concealed by challenging and hostile affects on the surface. Sophie was able to do the work at this volunteer job, which involved teaching skills to underprivileged young adults. It was very beneficial that she could discuss the stress she experienced on the job with her boss, who appeared supportive and psychologically minded, as well as with her therapist. Nonetheless, she reported in therapy that her boss did not understand the reality of the situation. For example, Sophie said: *My boss thinks I'm getting along with the other employers and the students. . . . She said 'I see you talking and laughing with them', but she doesn't understand I'm convinced they all hate me.*

This is where the essence of TFP comes into play. That essence is the belief that in patients with serious personality disorders, the internal mental images that the patient has of self and others is stronger than the data the patient receives from her real-life experience. This is why the work must ultimately focus on how the patient experiences herself in relation to the therapist since that is where the difference between internal images and external reality can be explored most closely. In the course of the first year of therapy, some crucial moments were the following.

(1) Two months into the therapy, the therapist shifted attention away from the content of what Sophie had been saying to her manner of speaking with him. Her content in every session was about how others mistreated her ("they all hate me"). The therapist shifted attention to the patient's interactional style with him, which was to talk in a nonstop and somewhat pressured monologue. After very tactfully suggesting that there was something controlling about the patient's way of talking to him, which she could agree with, he wondered with her about why she would interact with that style. Sophie eventu-

ally communicated that she felt that if she was not in control, the therapist would react negatively to her and possibly even end the treatment. This opened up an important avenue for exploration.

(2) Six months into the treatment, Sophie, who had been doing better in the therapy and at her job, began to take a negative turn. She reported a resurgence of suicidal ideation and the view that the therapist and therapy had been useless. Exploration of this led to an understanding that she was becoming attached to him and that this made her anxious, since she could not imagine reciprocal warm feelings, and she became defensively antagonistic. This "here-and-now" understanding of her discomfort feeling close to others, and its roots in the anticipation of rejection that was partly based on her projection of angry feelings, led to improved relations on the job and the possibility of moving on to paid employment.

(3) A session 11 months into treatment included an example of the intimate interaction between behavioral activation and work in the transference. The practical situation was that Sophie had to move on to paid employment to continue the therapy. Her father said he would stop paying after one year.

She began a session saying:	*Forget about continuing therapy. It's hopeless. I'll never get paid work.*
Therapist (surprised):	*But just last week you were saying that prospects were looking good.*
Sophie:	*You'll never understand. I'm just too sick. I'll never be able to function like a normal person.*
Therapist:	*We've been working on your sickness and you seem to have been making progress. Just last week you were talking about the interview you had. . . .*
Sophie:	*Forget about it. I'm sick. I can't function. I'm not going to get a paid job. Therapy will be over.*

At this point the therapist reflected on his countertransference (the set of feelings he was having in response to the patient interaction). Countertransference feelings are an important source of information in BPD patients, as they evoke in the therapist affects and images that exist in the patient's internal world but that the patient either cannot feel or cannot express directly. At this moment the therapist noticed (a) that he had begun to vigorously pursue Sophie to stay in therapy, and (b) that he felt the urge to offer her free treatment so that she could continue the treatment.

With this understanding, he said: *I have a thought about what's been going on here the past few minutes.*

Sophie:	*What?*
Therapist:	*I've noticed how hard I'm trying to talk you into staying in therapy. Given the issues we've discussed in your therapy, I'm thinking that might feel good.*
Sophie:	*You caught me.*
Therapist:	*What?*
Sophie:	*I actually got a job—but it did feel good to have you chasing after me.*

This exchange demonstrated both the Sophie's ability to function better and to reflect better, including the ability to use humor.

In this example, we see talk of going against the treatment agreement without the patient actually having done so. In TFP, if there is a violation of the contract, the approach is to explore the meaning of it with the hope that understanding will lead to getting back on track. However, if that does not come about, the therapist may have to set a limit. For example, if Sophie had come into to a session in the middle of the first year of therapy and said: *I've had it. I'm quitting my job,* the therapist would have explored differently possibilities of how to understand that. These might include seeing it Sophie was making a last-ditch effort to maintain a system of secondary gain of illness and dependency or if she was challenging the therapist to see if he cared enough about her to hold on to his convictions of what he felt was best for her. If the exploration did not result in the patient's returning to the parameters of treatment, the therapist might suggest they stop the exploratory therapy they were engaged in and change to a more supportive form of therapy that could either by carried out by the same therapist or could be dealt with by referral to a colleague. The therapist would indicate his recommendation that the patient return a more exploratory and autonomy-seeking form of therapy in the future.

Sophie's therapy lasted a number of years. In the second year of therapy, she decided to enter a master's program. The stress of doing so revived some of her anxieties about others not liking her. As before, work in therapy revealed a projective element in this. She did not fully recognize her own competiveness and imagined others resenting her the way that she actually resented them. The work in therapy helped her complete her masters. She then worked regularly and met a man who she eventually married. The therapy ended with her expressing deep gratitude to the therapist for having, in her words, "saved her life" and with her acknowledging that she had more work to do to achieve all her personal goals in life, especially in the realm of intimacy and sexual satisfaction. Her more integrated appreciation of others as she ended therapy was reflected in the following comment about her father: *He wasn't perfect and I wish he'd done a better job parenting, but he had to deal with major challenges in his life and he did the best he could.* At the time of termination, she was dealing with some conflicts in her marriage and a difficulty feeling fully comfortable with sex. She chose to use the gains she had made in therapy to work on those issues on her own, with the understanding that she could return to therapy in the future if she felt it were necessary.

Conclusions

In concluding this discussion of behavioral activation as it is used in the contracting process in TFP, it is important to emphasize that the contract is "a living document." If patients break their

contract, we give them a second chance. Our therapeutic stance is at this point is to emphasize to the patient the risk that persistence of noncompliance would make it impossible to carry out an effective treatment. The meaning of such a risk, particularly the patient's severe self-defeating tendencies and/or impulse to challenge the therapist, needs to be integrated into the interpretive work. Otherwise, there could be a cycle of repeated acting out of unexamined maladaptive impulses. This may appear obvious. However, in clinical practice the therapist may join with the patient in avoiding full exploration of episodes of acting out and may abruptly end the therapy; this would be a form of collusion with dissociative defenses that protect against conscious awareness of the disturbing and uncomfortable affects underlying severe acting out that need to be unpacked and explored in the course of the therapy.

References

Caligor, E., Levy, K. N., & Yeomans, F. E. (2015). Treatment in psychiatry: Narcissistic personality disorder. *American Journal of Psychiatry, 172,* 415–422.

Clarkin, J. F., Foelsch, P. A., Levy, K. N., Hull, J., Delaney, J. C., & Kernberg, O. F. (2001). The development of a psychodynamic treatment for patients with borderline personality disorder: A preliminary study of behavioral change. *Journal of Personality Disorders, 15,* 487–495.

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

Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (1999). *Psychotherapy for borderline patients*. New York, NY: Wiley.

Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2006). *Psychotherapy for borderline patients: An object relations approach*. Washington, DC: American Psychiatric Press.

Diamond, D., Yeomans, F. E., & Levy, K. N. (2011). Psychodynamic psychotherapy for narcissistic personality. In W. K. Campbell & J. D. Miller (Eds.), *The handbook of narcissism and narcissistic personality disorder: Theoretical approaches, empirical findings, and treatments* (pp. 423–433). Hoboken, NJ: Wiley.

Dimaggio, G., Salvatore, G., Lysaker, P. H., Ottavi, P., & Popolo, R. (2015). Behavioral activation revisited as a key principle of change in personality disorders psychotherapy. *Journal of Psychotherapy Integration, 25,* 30–38. http://dx.doi.org/10.1037/a0038769

Ferster, C. B. (1973). A functional anlysis of depression. *American Psychologist, 28,* 857–870. http://dx.doi.org/10.1037/h0035605.PMID 4753644

Kernberg, O. F. (1968). The treatment of patients with borderline personality organization. *International Journal of Psycho-Analysis, 49,* 600–6l9.

Kernberg, O. F. (1980). *Internal world, external reality*. New York, NY: Aronson.

Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies*. New Haven, CT: Yale University Press.

Kernberg, O. F., Burnstein, E., Coyne, L., Appelbaum, A., Horowitz, L., & Voth, H. (1972). Psychotherapy and psychoanalysis: Final report of the Menninger Foundation's Psychotherapy Research Project. *Bulletin of the Menninger Clinic, 36,* 1–275.

Kernberg, O. F., Selzer, M., Koenigsberg, H., Carr, A., & Appelbaum, A. H. (1989). *Psychotherapy for borderline patients*. New York, NY: Basic Books.

Levy, K. N. (2012). Subtypes, dimensions, levels, and mental states in narcissism and narcissistic personality disorder. *Journal of Clinical Psychology: In Session, 68,* 886–896.

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,* 1027–1040. http://dx.doi.org/10.1037/0022-006X.74.6.1027

Levy, K. N., & Scala, J. W. (2015). Psychotherapy integration for personality disorders. *Journal of Psychotherapy Integration, 25,* 49–57. http://dx.doi.org/10.1037/a0038771

Lewinsohn, P. M. (1975). The behavioral study and treatment of depression. In M. Hersen, R. M. Eisler, & P. M. Miller (Eds.), *Progress in behavioral modification* (Vol. 1, pp. 19–65). New York, NY: Academic. http://dx.doi.org/10.1016/B978-0-12-535601-5.50009-3

Wallerstein, R. (1986). *Forty-two lives in treatment–a study of psychoanalysis and psychotherapy*. New York, NY: Guilford Press.

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

Yeomans, F. E., Selzer, M. A., & Clarkin, J. F. (1992). *Treating the borderline patient: A contract-based approach*. New York, NY: Basic Books.

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