JPS. Volume 10 No 2. November 2021
e-ISSN:2716-358X; p-ISSN:2355-2409
DOI=10.20473/jps.v10i2.22396
Available online at https://e-journal.unair.ac.id/JPS/index

Articles

Application of Transference Focused Psychotherapy in Borderline Personality Disorders

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OPEN ACCESS

ARTICLE INFO

Received: October 2, 2020
Revised: December 27, 2020
Accepted: December 29, 2020
Published: September 1, 2021

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Keywords: Borderline Personality Disorder, Psychodynamic Psychotherapy, Transference Focused Psychotherapy.

Abstract

Borderline Personality Disorder (BPD) is a condition that is currently commonly found in daily psychiatric practice, and causes serious psychiatric disorders because it has an impact on the emergence of various other comorbid psychiatric disorders. The management of BPD is a challenge, because it is quite difficult and complex. Psychotherapy is an effective first-line therapy for BPD. Transference Focused Psychotherapy (TFP) is psychodynamic based psychotherapy that is specifically designed for BPD and is considered effective based on the specific psychopathology of BPD, namely the lack of identity integration. TFP focuses on the relationship between patient and therapist in sessions which have the aim of facilitating better behavioral control and increasing reflection and influencing regulation so as to produce identity integration that leads to a more coherent identity, better regulatory abilities, less self-destructive behavior. forming a more balanced and constant relationship, and increasing overall functioning.

Cite this as: Ardiyani, I. D., Karimah, A. "Application of Tranference Focused Psychotherapy in Borderline Personality Disorders". *Jurnal Psikiatri Surabaya*, vol. 10, no. 1, pp. 66-73, 2021, doi: 10.20473/jps.v10i2.22396.

INTRODUCTION

Borderline Personality Disorders (BPD) are often found in daily psychiatric practice, both in outpatient and inpatient visits as well as in the emergency department. The prevalence of BPD in the community is around 1% of the general population, about 12% in psychiatric outpatient visits and 22% in psychiatric inpatients [1]. The prevalence of BPD in adolescent psychiatric inpatients is about 43%, while the prevalence of BPD in adolescents and adults has a similar average of 0.9% to 3.0% in the general population and about 11% in psychiatric outpatients. Studies show that BPD ranks fourth of personality disorders that exist in society after schizoid, narcissitic, and paranoid personality disorders [2].

Patients with BPD have clinical symptoms that are characterized by a dysregulation of mood, negative emotions and thoughts, unnatural anger, impulsivity, identity problems, self-destructive behavior, so that they have difficulty adapting to the environment and difficulty having stable interpersonal relationships. This has an impact on the emergence of various other comorbid psychiatric disorders such as mood disorders, anxiety disorders, substance abuse and eating disorders [3]. The behavior of self-injury in patients with BPD is a common thing and carries a risk of self-harm. The overall rate of self-mutilation is known to be around 90% and suicide attempts around 75% in both adolescent and adult patients with BPD [4].

The management of BPD is a challenge. Patients with BPD often do not comply with agreed management recommendations, undergo irregular treatment, persistently develop new problems, have many comorbidities, and stop treatment. However, management must be maximized [5]. Psychotherapy is first-line therapy in patients with BPD and is quite effective for patients with BPD [6].

TFP is psychodynamic based psychotherapy designed specifically for patients with BPD and is considered effective for BPD [7]. The aim of TFP is to facilitate better behavioral control, increase reflection and influence regulation resulting in an integrated identity that leads to a more coherent identity, has better regulatory abilities, reduces self-destructive behavior, forms a more balanced and constant relationship, and increase overall function. The results of the study show that TFP is effective in the management and improving the overall function of patients with BPD [6].

DISCUSSION

Transference-Focused Psychotherapy

Transference-Focused Psychotherapy (TFP) is a psychodynamic psychotherapy for patients with personality disorders, that was pioneered by Otto Kernberg based on his theory of object relations regarding the origin of the development of BPD as affective and non-integrated representations of self and others, leading to instability of feelings, identities, and relationships. TFP originates from the synthesis of contemporary object relation theory and modification of psychoanalytic techniques to treat patients whose pathological severity cannot be managed with standard psychoanalysis [8]. TFP has a clear, emotional framework focused on exploring the patient's therapeutic relationship. The main purpose of TFP is to integrate separate thoughts, feelings, and actions into the patient's consciousness. The principle of TFP is to create a safe situation for patients and therapists through a contractual framework that allows patients and therapists to jointly explore emerging transference flows [9].

TFP refers to a person's psychodynamic processes that have different parts of their mind and are dynamic in nature which can lead to conflict. According to TFP, patients experience and undergo internal images that form psychological structures through their relationship with the therapist called transference which transfers internal images and beliefs to the therapist's current experiences by helping patients learn the images that shape their thoughts into their internal world and help adjust the picture to the world around it, so as to provide a better experience in patient relationships with other people [10].

Transference in TFP is the experience between patient and therapist, which is then sorted based on the patient's experience and current state of mind. TFP assesses that patients have difficulty assessing accurately and objectively what is happening, so we need to frame the dynamics that arise in transference through their relationship with the therapist and help patients understand the relationships seen, further increasing the capacity to reflect on them by examining together what is happening in the patient's relationship and therapist [9].

Basic Theory of TFP

The theory used by TFP is a combination of object relation theory with ego psychology [11]. The theory of object relations describes an individual's experience of himself and the feelings of others which is called a relationship. Self-representations and object representations that are linked through a feeling form pairs of object relations. Experiences about self and other people are the building blocks of individual personality or feelings. Patients with severe personality disorder pathologies, the origin of the conflict is beyond consciousness, the patient can be aware of certain feelings,

but can experience momentary changes, from positive feelings can quickly turn to negative experiences [9]. The transformation of interpersonal relationships into a representation of internalized relationships, when a person develops, they not only internalize objects or people, but also internalize all the relationships they go through [12]. Positive experiences are in the form of affection, with affective pleasure, and negative experiences, due to lack of attention, with negative affective in the form of anger. These positive and negative experiences are then internalized as two opposing sets of object relations consisting of self-representations, object representations, and feelings that connect the two which gradually merge into an eternal mental representation within [12]. The conflict that occurs is a clash between opposing pairs of internal object relations.

Transference is a concept when a patient experiences a situation where the therapist is an important figure from the patient's past, which shows the mental organization patterns of childhood in adult life that are repeated in the present. A figure from the past is associated with the therapist and the feelings associated with that figure will be experienced in the same way as the therapist. Although the transference may partly stem from early childhood attachments, it is also influenced by the therapist's actual behavior. A study on psychotherapy involving transference interpretation showed that patients with object-relation disorders had better results and their effects persisted during follow-up [12].

Countertransference is the process of the therapist's transference to the patient or the therapist's response to the patient's transference which is implicitly an unresolved conflict from within the subordinate realm. Countertransference is the therapist's emotional response to the patient, both from his own psychic life in the past and from feelings induced by the patient's behavior. TFP therapists must identify, tolerate, and exploit feelings of transference and countertransference [11].

The concept of TFP

TFP is separated systematically in steps with the aim of making it more accessible which broadly consists of structural interviews, determining the formulation of the diagnosis and discussing with the patient, determining the personal goals and objectives of patient care, and establishing a joint contractual framework. Structural interviews aim to measure how functional or impaired each patient is, as well as the TFP foundation which consists of a mental status examination tailored to assess personality disorders to evaluate the basic structure of thoughts [13][14]. Structural interviews can be assessed using the RADIOS technique, namely Reality Testing, Aggression, Defenses, Identity Diffusion / consolidation, Object Relations, Superego or moral values [9].

Next is to discuss diagnostic formulations and provide feedback to patients so that patients know how therapists conceptualize patient difficulties and obtain agreement on what problems will be managed together [13]. Furthermore, patients are asked to enter certain personal goals and treatment goals, as part of the evaluation process. The patient is involved in goal setting and is expected to stay focused on that goal. Goal setting also helps direct the therapist to measure the progress or progress of treatment [9].

The TFP contractual framework outlines the responsibilities of the patient and therapist, the possible challenges faced, as a foundation that involves continuous patient and therapist involvement over time [10]. The contract includes all the details of the need for a mutually agreed management process, from scheduling sessions, therapy costs, to the heaviest possibilities that arise, such as crises or hospitalization needs [14]. The TFP contracting process takes as long as necessary, is unhurried, routine, and is free of disputes or patient backlash. The purpose of the contract is to guide the course of therapy and form the basis of care [9].

Application of TFP

Several points are the focus of the TFP, for example, who is confused, name actors, and prepare for a storm of affect. Affect storm is an increased state, such as intense anger or paranoid, that requires a different response from the therapist. "Naming actors" is identifying pairs of predominantly emerging objects and "naming" these pairs, including the patient's self-concept and other people's experiences and related affects. Managing initial confusion by "naming actors" involved in patient and therapist interactions helps control the patient and directs the therapist, or identifies pairs of emerging objects. Furthermore, the roles identified in the relationship are dominant, that are reversed, or inverted to see aspects of their personality that tend to see them in others, but not in themselves. The presumption about the naming of the actor is conveyed to the patient, the patient can accept or reject it, and the therapist can invite the patient to correct it together. The therapist will continue to observe the condition as a pattern over and over. In TFP, initial confusion does not arise. The therapist refines the object of this relationship, the maintenance of the therapist's patient experience, while the pilgrim role reverses, or the patient's way of behaving in ways that the patient previously assumed to be from others. Therapists can structure such behaviors to convey to their patients. Therapists try to bring aspects of patient awareness about things that are not present in patients and become a source of difficulties in their life [9].

In the intervention process, the therapist identifies affective dominance, namely the material that has the highest emotional content or the greatest affective intensity, through repeated

clarification, confrontation, and interpretation techniques to see important aspects of the patient's internal world [9], This affective dominance can be clear and easily determined from the patient's tone of voice or facial expression, but can be difficult when there is no expression or communication is monotonous. In TFP, the patient will speak freely during the session without being directed, except for certain conditions such as when a crisis arises or threats to treatment, then check transference. When there are difficulties, all you can do is listen and wait [11].

In TFP, confrontation follows clarification with the aim of bringing a separate experience to an aspect of the patient's consciousness, where the reaction may reflect self-reflection. Interpretation is given only after a long period of clarification and confrontation because the patient must be prepared to tolerate it [9]. Identifying role reversals in pairs of object relations can be a powerful and effective interpretation. Interventions must be carried out in an atmosphere that is humane, full of compassion and care, courtesy, provides safety and comfort for patients, in a neutral manner without being passive or emotional [11]. Furthermore, the patient will make some improvements in his life, relationships with other people, his presence is more regular, the capacity is developed to speak freely about important and difficult subjects, the patient grows more comfortable. The therapist can pass on these observations to the patient only after a long period and reap benefits. TFP therapists will also actively monitor important elements of a patient's life outside of treatment.

Indication and contraindication

Indications for TFP are patients with BPD who have a severe diffusion of identity, impaired work function and interpersonal, social relationships, and with other specific symptoms [15]. TFP is used specifically for severe personality disorders, especially BPD, but can also be used for other personality disorders such as narcissistic, paranoid, schizoid, and schizotypal, antisocial, histrionic, or certain hypochondriacal syndromes [10]. TFP can also be used in BPD patients with severe complications such as alcoholism, drug dependence, eating disorders such as anorexia nervosa, antisocial behavior but not antisocial personality. TFP can also be used in cases that can be managed by ordinary psychoanalysis.

The contraindication is antisocial personality disorder, or patients who are found to have a heavy antisocial image, patients who do not want to be open and honest, thus affecting honest communication with the therapist, thus making the transference process difficult. In patients with social behavior that is aggressive, provocative, irresponsible, but still has a level of loyalty, a good interpersonal relationship can still be done by TFP. Patients with psychotic thought processes, patients who do not have a social life at all, even though they are given facilities by their families, but are ostracized, are considered as people who have serious illnesses, are also contraindicated in TFP. Patients undergoing TFP must have a normal IQ optimally [10].

1.5 Comparison of TFP with Other Psychotherapy Approaches

The frequency of TFP sessions is reduced, seat position, and is oriented towards management and patient personal goals, is not directed for self-understanding such as psychoanalysis, and continuous therapist exploration into the patient's life outside the session. The patient's life outside the session is also important for resolving object relations in the patient's relationship with other people who are disturbed, as it manifests most in BPD patient. The focus of TFP is based on the dominant focus of intrarpsychic conflict in the here and now, in the patient's life situation, both inside and outside, not only with the exploration of deep intrapsychic conflict of the patient's or family's childhood situation as in pure psychodynamic psycotherapy [9][15]. TFP is important because it is based on the understanding that the psychopathology of BPD patients lies in the disturbed object relations that is reflected in the transference relationship between the therapist and the patient. TFP use techniques such as psychodynamic psychotherapy through clarification, confrontation, and interpretation for the patient's intrapsychic conflict but TFP emphasizes the here and now. TFP also uses a neutrality technique that sets limits under threat conditions. The TFP therapist's efforts in the dominant theme of transference are guided by the transference itself in formulating interpretations. The TFP approach to interpersonal relationships also focuses on direct interpersonal interactions. The focus on systematic pairs of object relations and primitive defensiveness distinguishes TFP from other psychoanalytic psychotherapy, besides that it also tends to combine interpretative and supportive techniques [10]. The nature of the interpretation of TFP is different, not directed to impose mental content on patients who are not experienced consciously, but directed to help patients relate different mental conditions, and consciously experience them in their interactions with therapists [15]. The increased attention to patient conflict does not have the main objective of enhancing the patient's mental processes, but explores the meaning of transference in the patient's life through conscious therapeutic situations, so that TFP differs from MBT (Mentalization Based Therapy). The general difference between TFP and DBT (Dialectical Behavioral Therapy) is that TFP differs in an attempt to resolve intrapsychic conflicts between conflicting internalized object relations and their distorted perceptions with integrating object relations. Whereas DBT combines affective status validation with stress tolerance to avoid or distract with the aim of reducing or eliminating painful emotions, and stopping

destructive behavior to reduce symptoms [15]. DBT focuses on dialectical thinking, whereas TFP focuses on indecisiveness in object relations between self-representations and other affective-charged relationships and in integrating self and other representations. SFT focuses on sudden shifts between schema modes of thought, behavior, and emotions that reflect a person's emotional state or behavior at any given moment. MBT emphasizes a shift in the mentalization process towards an effective mentalization process [16].

Application of Transference Focused Psychotherapy in Borderline Personality Disorders

Abnormality in Borderline Personality Disorders and Management Focus

Patients with BPD experience a chronic and stable diffusion of identity syndrome, as well as a significant lack of integration of self-concept and other people's concepts. There is a failure of psychological integration resulting from the dominance of aggressive object relations that are internalized rather than idealized [15]. Identity diffusion appears in the inability to assess oneself and others accurately and deeply, inability to commit deeply to a job or profession, inability to build and maintain stable intimate relationships, and lack of sensitivity to understanding in normal interpersonal relationships [10]. The mental manifestations that occur in patients are thought to originate from the internalization of the attachment relationship with the caregiver that is experienced again with the therapist [12]. In the TFP model, the dominance of negative affects is seen as the basis for the activation of splitting-based defenses and the associated dissociative processes [6].

In TFP, the mechanism of change originates from the BPD theory which conceptualizes the disorder related to feelings and representations of self and others that are not integrated [6]. The focus of TFP management is the object relation that underlies a patient with BPD to be reactivated through the patient's interaction with the therapist in the here and now transference [11]. The primary task of the TFP therapist is to observe and interpret object-pair relationships as they are activated in the therapist-patient relationship. This internal representation is a relationship between self-representation and other people's representations that are connected with affective.

Elements of TFP Application in BPD

TFP requires a therapeutic setting designed to facilitate reactivation of the patient's internal object relations in care that can be explored, interpreted, and discussed.

Strategy

The main strategy of TFP consists of the process of facilitating reactivation of separate internal object relations that are observed and interpreted in the here and now transference [15]. Patients do free association, usually starting around the problems that bring them to the therapist, the therapist is limited to listening and observing carefully the activation of separate relationships that appear in transference [15]. In TFP sessions, attention is constantly exercised to track which feelings of dominance are present and how they are affected. According to studies, the most important information at any given time is conveyed less through the patient's verbal narrative than through the patient's behavior, or through projections in the countertransference process. The therapist's reflection on his own feelings at some point is very helpful in identifying dominant feelings [17].

Once dominant feelings are identified, the therapist can begin to embed the patient's self-representation that is active at that time and the corresponding therapist's representation as depicted in Figure 3 above. Next, mention the actors who play the role, their interactions, and their effects, and explain to the patient. The therapist clarifies to help understand the affect and condition of the patient who is active at that time and helps patients identify affective states about themselves and the therapist at that time. It should be noted that in response to interventions that make the patient contemplate something painful, or confusing, or without the expected validation or support, the patient may suddenly become aggressive and angry with the therapist.

Role reversals in dominant object pairs may also occur. In one session a patient suddenly feels depressed, ineffective, weak, and jealous of those whom he finds more comfortable, healthy, attractive, or successful, but in another session the patient comes in with anger, humiliation and superiority over other people and therapists. . Part of the TFP strategy is to track shifts or oscillations in this pair of objects.

TFP therapists should try to remember that this partner of abuse generally defends the patient's awareness of the set of relationships that the ideal world and the therapist desire. Despite the patient's denial, difficulties in tolerating self-views that can be good but sometimes demanding, angry, and confused produce pressure for inner perfection and therapist perfection, forming the ideal partner on the surface, but also generating inevitable aggression with frustration because they do not find other people or themselves to be ideal as expected. When this fragile ideal cannot be sustained, it will suddenly change and bring the patient and therapist back to the side of the abuse. Abuse can often protect a relationship that the patient longs for but is difficult to express under the surface fear and anger.

Tactics

Tactics are the rules regarding the involvement of the therapist and the patient which allow the application of modified psychoanalytic

techniques according to the nature of the transference development. Important tactics include establishing a treatment contract, selecting priority themes to be managed in each session in the material presented by the patient, maintaining the right balance between exploring incompatible views of reality between patient and therapist in preparation for interpretation and constructing common elements of shared reality, regulates the intensity of affective engagement [10]. The combination of setting boundaries and interpreting the appropriate transference development is effective as a tactic that can save the course of the treatment process [15]. In terms of selecting which themes will be discussed at certain times in the material that the patient brings to the session, the most important tactic is that interpretation must be carried out when the strongest affect appears, namely the dominant affect which will determine the focus of interpretation [10]. Affects that are strongest can be expressed in the patient's subjective experience, in the patient's nonverbal behavior, or sometimes in countertransference when dealing with flat-looking material or situations without the emergence of a dominant affect [15]. The next consideration in determining what theme to interpret is the nature of the transference, a large effect develops coinciding with the development of the transference. However, there are times when most of the effects that occur are related to the condition of the patient's external world. Affective dominance also has transference implications in external situations, but the main focus remains on interpreting the transference obtained from the patient's current interaction with the therapist in the care setting, then switching to external situations. This is an important tactic and reflects the flexibility in TFP, which focuses simultaneously on transference and on the development of this patient's external life.

Techniques

The main technical instruments of TFP are interpretation, transference analysis, and neutrality techniques [15]. Interpretation in the early phase of the interpretive process, namely clarifying the patient's subjective experience. Clarification of what is on the patient's mind and confrontation draws attention to any inconsistencies or contradictions in patient communication, whether between what the patient says over time, between verbal and nonverbal communication, or between patient communication and what the transference evokes. Interpretation is the formation of hypotheses regarding the unconscious function of what clarification and confrontation, here and now, has proposed or is also called the current unconscious. In interpretation, the therapist offers cognitive formulations of separate object relations when activated in transference, and the reasons why they remain separate. Interpretation aims to overcome deeper levels of conflict [6]. In the TFP transference analysis, concerns about the patient's dominant problems are reflected in major conflicts that bring the patient into care or those identified during treatment [10]. Neutrality technique is the therapist's ability to listen to and respond to patients without imposing judgment or bias. In technical neutrality, the therapist's ability to remain equidistant from the patient's id, ego, and superego is required. However, technical neutrality is not always appropriate when the patient has the potential to injure himself or others or violate the therapeutic framework, the therapist needs to take a non-neutral stance. An attitude in which we listen impartially and use what we hear to understand rather than judge, is called technical neutrality. Maintaining technical neutrality is met with empathetic validation. In TFP, empathy is defined as the ability to connect with the patient's overall internal experience even the parts they are not aware of [6].

When these internal object relations are revealed in relation to the therapist, the TFP therapist will seek cognitive clarification of the patient's internal experiences. This clarification technique is able to explain the internal state and reflection. Confrontation techniques are used for conflicting elements of verbal and nonverbal communication. Interpretation helps the patient see that he identifies each pole of the pair of dominant object relations in him at different times, and that these representations can shift unnoticed. Increases the patient's awareness of his range of identities, increases his ability to integrate different parts. This integration caused anxiety at first. With the guidance of the therapist, patients become aware of the extent to which their perceptions are based more on internalized representations than on what is happening now [18].

Clinical challenges

One of the most visible challenges in TFP is managing countertransference. The most common sense of countertransference is fear that the patient will not be safe, so that the therapist may feel insecure for himself, or feel the need to save the patient and the ongoing treatment process [11]. In TFP, concerns about patient risk behavior are addressed at the start of treatment when the patient and therapist negotiate a treatment contract. The therapist may feel pressured to be a good object, fear the patient's anger, or be tempted by feelings of love and rejection. Anxiety and guilt are also feelings often experienced by therapists. The therapist feels like he has to do something to calm the patient. The therapist should take the attitude of understanding the patient's experience, not trying to defuse it. Therapists should not do anything, just listen and try to understand [11]. The feeling of being an abusive therapist that often occurs when setting

boundaries in therapy. This is overcome by establishing a contract. Therapists who discuss moral values can be interpreted as correcting the patient's bad behavior, and this violates the neutrality technique. When contract breaches are unavoidable, therapists usually have a hard time. After giving the patient a second chance, the therapist must consistently follow the rules and offer continuation of treatment with the understanding that a second breach will inevitably end treatment. These same considerations also apply to setting new limits or modifying contracts. Patients who present with threats of suicidal behavior. Joint sessions with the patient and family members or loved ones should be attempted. In the TFP, it is necessary to emphasize the importance of contractual arrangements. It is necessary to make informed consent if necessary and to consider the therapist's safety, both physically, emotionally, socially, legally, and protection of property and personal life [10].

Summary

BPD is often found in psychiatric practice and in the community. The management of BPD is a challenge in itself. Psychotherapy is the first-line therapy for BPD. TFP is a psychodynamic psychotherapy approach designed specifically for BPD patients. Chronic and stable diffusion of identity, and a significant lack of integration of self-concept and other people's concepts as the basis for the TFP concept. The focus of TFP management is object relations which are reactivated through patient-therapist interaction in transference. The principles of TFP are in the form of clarification, confrontation, and interpretation in the transference relationship between the patient and the therapist. TFP has several concepts consisting of structural interviews, discussion of diagnosis formulations, setting management objectives, and contractual framework. There are several indications and contraindications for the application of TFP. TFP elements consist of strategy, tactics and techniques. TFP has some challenges in implementing it but has had good results in patients with BPD.

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