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TRANSFERENCE-FOCUSED PSYCHOTHERAPY AND MENTALIZATION-BASED TREATMENT: BROTHER AND SISTER?

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Transference-focused psychotherapy and mentalization-based treatment are new psychoanalytic treatment forms for borderline patients. How do these forms of treatment differ and how are they alike? What interventions do they yield in clinical practice? In the past few years two methods of psychoanalytic treatment for borderline patients have been developed: transference-focused therapy and mentalization-based treatment. This paper explores the similarities and differences between them, with a special focus on how the different theories lead to different interventions in clinical practice. TFP takes the central problem to be the disorder in object relations, while MBT focuses on the self as agent. Further differences concern notions of the role of aggression, the presence of mental representations and the position of the therapist. Interventions formulated by therapists of both frames of reference in response to some therapy fragments differed substantially. Both theories share a desire to develop a psychoanalytical technique suitable for borderline patients, and both stress the central importance of the handling of the transference and of working in the here-and-now, as well as the necessity for effect research.

INTRODUCTION

For therapists, patients with a borderline personality disorder are often intriguing. Their turbulent relationships and moods, the deep despair and the enormous appeal they often make to therapists poses a challenge to our

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understanding. Until recently, there was consensus in psychoanalytic circles that psychoanalytic treatment was not the treatment of choice for a Borderline Personality Organization,[1] but rather a supportive treatment by psychiatrists, who combine therapy with medication. Two psychoanalytic treatment methods have been developed in the past few years: the transference-focused psychotherapy of O. Kernberg (Yeomans *et al.* 2002) and the mentalization-based treatment of P. Fonagy and A. Bateman (Bateman and Fonagy 2004). Both are psychoanalytic treatment methods for patients with borderline issues and both come with a primer or treatment manual, thus making it possible to conduct empirical research.

During the past 2 years, we have held round table talks at the Netherlands Psychoanalytic Institute where a number of experienced psychiatrists and psychoanalysts[2] explored the differences in clinical practice. Exactly what interventions are formulated stemming from the therapist's theoretical background? Discussions started from clinical vignettes such as the following.

A 35-year-old patient has been in therapy for a year. He comes in agitated and says, 'This morning I started having palpitations as soon as I got up, and it just didn't go away. It just came at me in waves. I called my neighbour and he brought me to Emergency. I thought I was going to die. And for the nth time, they couldn't find anything wrong. So they gave me some oxazepam and when I got home I drank a couple glasses of wine'.

Therapist: 'How are things now?'.

Patient: 'I'm just shaking like a leaf. I can't go to work like this, and right now I really wanted to go for it. Last week things were going so well! Things always go wrong for me! Now I suppose you'll think I'm a loser. Why do I keep on coming? None of it helps anyway. In the end, you have to do it all yourself'.

Commenting on this vignette, the psychiatrists remarked that in their treatment as usual they would focus on the reality:

> I can see that you are having all kinds of very strong emotions and that you appeal to me for comfort. You should really take some rest now and

[1] Kernberg introduced the term borderline personality organization to refer to a broad spectrum of personality disorders between the neurotic organization and the psychotic organization. Clinically speaking, they are people with a non-specific ego weakness, disturbed interpersonal relationships, problems with commitment to work and love, some pathology in sexual relations and super-ego pathology (Yeomans *et al.* 2002).

[2] Participants in the round table talks were: Margit Deben and Jan Stoker as experts in the field of MBT, Cees Kooiman and Rob Janssen in the field of TFP, and Jos Dirkx and Piet Rijnierse as psychiatrists with experience in treating borderline patients in an outpatient setting and a clinical psychotherapy setting, respectively. Annelies Verheugt-Pleiter and Thijs De Wolf served as chairpersons.

> come again next week, so we can discuss what is going on when things have calmed down. No more pills or alcohol, just calm down and come again next week.

With this approach they aim to show that the psychiatrist is not panicky about strong emotions, but stays calm and convinced that this crisis will pass and they will continue working together.

The *TFP therapists* focus primarily on the relationship. They look for characteristic dyads and would say something like:

> Being in therapy with me seems to create a lot of tension in you … Let's look at this tension together. The way I understand it, the tension is your dissatisfaction with the therapy and with me as your therapist. In other words, you want more from me than I do, 'more' in the sense of giving more advice and 'more' in the sense of more therapy appointments. Your dissatisfaction with me causes tension, tension for which you think you cannot blame me. And then you also think that I see you as a failure. I think this is the real feeling that we need to have a closer look at.

From this perspective, there is a manifest dyad in which the patient portrays himself as a child asking for help and the therapist is a listening, caring doctor. The therapist works towards discussing the hidden dyad, which is the helpless child whose life is going from bad to worse and a therapist who neglects or ignores him.

The *MBT therapists* strive to encourage mentalization, so that the patient would start thinking about his own mental functioning. One technique is looking for a relationship between the tension and what went on immediately before. The therapist does not ask what the patient thinks and feels, because he assumes that he does not know. He has no thoughts and emotions that he can think about, so that he can explain his own and other people's intentions and moods. To stimulate inner thought and feeling, the therapist asks the patient to illustrate his state of mind:

> It is as if you have to defend yourself in all kinds of ways against things that threaten you. I think you became very anxious; the complaints you describe are all physical expressions of anxiety. It seems to me as if you were in a state of complete panic this morning. Let's try to find out what made you so anxious. What happened this morning?

In this paper we will first discuss each treatment model individually. The theoretical model will be explained on which each approach is based in relation to source and nature of the pathology and frequently used concepts. After that we will discuss the therapeutic strategies in both models and how the therapist's theoretical background shapes his interventions. Finally, we will discuss the differences and similarities.

Transference-focused psychotherapy – theory

View of the borderline personality organization

At the heart of the borderline personality organization is the presence of non-integrated self and object representations, the use of primitive defence mechanisms and essentially intact but highly vulnerable reality-testing. The picture of highly variable self and object representations is called identity diffusion. TFP is a treatment method based on the instinct theory, ego psychology and object relations theories.

The central tenet is that instincts are experienced *in relation to* a specific object, a specific other. The building blocks of mental structure are formed by units consisting of the self, the other and an instinct or an affect that goes with an instinct. These self–other–affect units are termed object-relations dyads. Examples of frequent dyads are: a patient who thinks that he is neglected and that the therapist (the other) is egoistic; or who sees himself as naughty, as sexually provocative and the other as castrating; or who sees himself as accommodating and flexible and the other as dominant and stubborn (Wijts *et al.* 2003). Dyads are self-object representations that manifest themselves in behaviour. However, they do not present accurate representations of the entire self or the other; the dyad is a partial representation of the self, linked by an affect to a certain representation of the object as it was experienced at a certain point in the early years of life. Many inner dyads are formed in the course of early development on the basis of prototypical experiences. The vehemence of the affect in the earliest relationships – for example, in relation to a strong need, an intense fear or the need to avoid pain – is appropriate to the infant's primitive defence structure. Characteristic of the borderline personality organization is that primitive defence mechanisms are still in use. Splitting is most commonly seen as a defence mechanism.

The vignette given above was said to contain a manifest dyad and a hidden dyad: one dyad can fend off the other one. Out of fear for dependence, for example, the patient devalues the therapist. A patient who longs for a dependent relationship with a caring therapist fends it off with a dyad: the dissatisfied patient and the neglectful therapist. Although in themselves the dyads are rigid and fixed, dyads can easily shift, with one dyad suddenly replacing another (figure 1). This often happens without the patient being aware of it. 'If he chides his therapist for being neglectful, he has "forgotten" that in the previous session he was full of praise about his commitment' (Wijts *et al.* 2003: 149).

Thus, according to Kernberg, the central disorder in the borderline personality organization is the object relationship disorder.

The concept of affect

An important role in theory formation behind this model is played by the concept of affect. Experiences differ in terms of their affective intensity. The

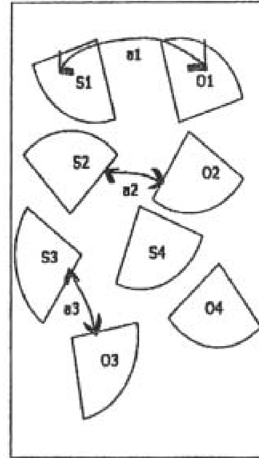
Patient's Inner World

S = Self-Representation
O = Object - Representation
a = Affect

Examples
S1 = Meek, abused figure
O1 = Harsh, abusing authority figure
a 1 = Fear

S2 = Childish-dependent figure
O2 = Ideal, giving figure
a2 = Love

S3 = Powerful, controlling figure
O3 = Weak, Slave-like figure
a3 = Wrath



Source: Yeomans *et al*. (2002).

Figure 1. Patient's inner world.

way in which the mother does or does not respond to hunger, pain or fear of the baby will be an intense experience. According to Kernberg's theory, those experiences with intense affect lead to the internalization of primitive object relations. This is also linked to the biological function of the very young child to survive. The memory structures, charged with affect, that are then forged influence the internalization of rewarding, or all-good, object relations or aversive, or all-bad, object relations. When affects are extreme, the child remembers what was important in obtaining what he or she needed and in avoiding what was painful.

In relation to the concept of dyad, this means that at one end of the continuum there is an idealized image of a dyad with a perfectly nurturing other and a completely satisfied self. At the other end, influenced by frustrating experiences, there is a completely negative dyad of the hostile and threatening other and a needy, helpless self.

In the vignette, the dyad of the child asking for help and the concerned, listening therapist was called the manifest dyad and the helpless child, whose

life is going from bad to worse, and the neglecting or ignoring other was the hidden dyad.

Splitting

In the course of the development, this splitting leads to the formation of a segment with idealized images and a segment with negative images of the relationship (Yeomans *et al.* 2002: 16). In normal development, positive and negative self-object relations become integrated. When positive experiences with important others dominate, then the child learns to tolerate the less satisfying aspects of his parents. The reality that all relations have their ambivalent aspects becomes bearable. Integration of positive and negative representations of oneself and others leads to a more complex, differentiated sense of self and others.

Without the integration of positive and negative self-object representations identity diffusion in later life becomes probable. If the child is subjected to neglect and abuse, the negative affect takes over, in particular hatred of the neglectful, abusive object.

Precisely when there is such a high degree of hostility, the two segments need to be actively distinguished so as to protect the idealized representations from the negative. This splitting of good and bad is seen as a central symptom and defence mechanism in borderline pathology. This splitting can result also in sexual perversions, especially sadistic and masochistic features. Unconscious anal or oral fantasies dominate the sexual life, involving attacks on and destruction of object relations (Kernberg 2004).

The therapeutic methods of TFP

TFP is an individual therapy with sessions being held twice a week, in which the contract phase is of particular significance. A contract is drawn up setting down the responsibilities of the patient and the therapist in such matters as dealing with crises and medication, but it also contains agreements about the ground rules. The patient is asked to associate freely. The contract is intended to protect the treatment. If there are no breaches of the contract that require being discussed first, in each session the therapist waits to hear what subjects will be broached by the patient and how. Compared to the classical psychoanalytical approach, he relies more on non-verbal counter-transference aspects in the communication, is more active and less neutral. He must be able to endure a greater intensity of affect (Wijts *et al.* 2003).

The aim of TFP is to integrate split-off partial objects so as to resolve the identity diffusion. To this end, the dominant object relation dyads and the role reversals in the dominant dyads are observed and interpreted. The interpretations also aim to link dyads that are used as defences against each other. The inner conflict can be resolved by interpreting the dyads, after

which the more mature, integrated affective experiences will be discussed (Yeomans *et al.* 2002).

The therapist as transference object

In the early stages it is basically the impulsiveness and the self-destructive behaviour that need to be brought under control. If things go well, the affect storms will more and more come to take place during sessions. As to technique, transference interpretation is the most important means of bringing about intrapsychic integration. Clarification and confrontation are seen as steps on the way to interpretation.

The transference analysis is a systematic analysis of resistance and defences as they occur in the transference. In the long run, this technique strengthens the ego, because it helps the patient to integrate his libidinous and aggressive impulses.

Aggression

Much of what must be integrated is related to split-off hostility. TFP ascribes an important role to constitutional factors in the aggressive component of instincts, that expresses itself in hostility towards self or others. Kernberg (2004) stresses the chronic intense hatred and envy in patients with a borderline personality organization, their defences against this hatred and against their wishes for dependence. The treatment always aims to focus on and to interpret the negative transference. The therapist must be particularly alert to the activation of a victim-victimiser paradigm: this dyad must be re-analysed each time it repeats itself in the transference, along with the accompanying role reversals (Kernberg 2004: 43).

Mentalization-based treatment – Theory

View of the borderline personality organization

The MBT model sees the disorder in the perception of self as agent as the central disorder of the borderline personality organization.[3]

Fonagy and colleagues based their theory on the development of self from attachment research and the study of mother-baby interaction. They primarily studied how a child develops a coherent self, including the perception that the self is an agent: physically (if I push something, it moves), socially (if I cry, my mother comes), teleologically (I do something to achieve

[3] The theory and technique of the treatment according to Linehan is beyond the scope of this paper, but when compared to TFP (central disorder concerns object relations) and MBT (central disorder concerns self as agent), Linehan calls the central disorder in borderline personality organization the disorder in affect regulation.

a goal), intentionally (I do something because I have certain ideas about it) and representationally (I can think about my own thoughts and those of others). The latter skill, being able to think about one's own thoughts, ideas, wishes and fantasies and the mental states of others is called *mentalization* (Fonagy *et al.* 2002).

Mentalization is closely linked with both the self as agent, and with the represented self or subject, the 'I' and the 'me'. Mentalization has both a self-reflective and an interpersonal component, and it enables a person to distinguish inner from external reality, and intrapersonal emotional processes from interpersonal communications. Mentalization, a function of the prefrontal cerebral cortex, is almost a sort of folk psychology, something we all implicitly use in getting along with others and understanding what moves them, as well as what motivates us.

According to Bateman and Fonagy (2004), it is not a new concept, at most a new word. It gives us a means of understanding the causes of a borderline personality organization and a means for its treatment. The fact that the relationships of borderline patients are turbulent and chaotic, shifting from clinging to rejecting, idealizing to derogating, is viewed in connection with their ability to mentalize, which is absent or very low: they simply have no room to think about their own thoughts or those of others.

Attachment research has shown that the development of mentalization is largely predicted by a safe attachment to the primary care-giver, usually the mother (Deben-Mager 2003). A total of 75 to 90% of patients diagnosed as having a borderline personality organization have a disorganized attachment representation, a very large part of which involves a preoccupied attachment of the fearful-overwhelmed type (Lyons-Ruth and Jacobovitz 1999).

The concept of affect

The central premise in MBT theory is that we need to learn what goes on inside ourselves. Fonagy *et al.* (2002) disagree with the idea that we are automatically aware of our various emotional states through introspection. Infants learn to differentiate their inner patterns of physiological stimuli that are accompanied by certain emotions by observing the mirroring reactions of the parent (Bateman and Fonagy 2004). Mirroring will have a modulating effect on the infant's emotions if an emotion is represented accurately, while at the same time making it clear that it is a reflection of the infant's emotion and not an emotion on the part of the mother. If the parent does not accurately mirror the infant's emotions, or does not mirror them at all, emotions remain unnamed and undifferentiated, confusing; they are not symbolized and difficult to regulate. A child who has not experienced the integrating effect of mirroring of his or her affective state is unable to make any representations of it, and because of this will later have difficult

distinguishing between reality and fantasy and distinguishing physical from mental reality – in short, with mentalization.

The parent's mirroring may be *too congruent*, without markedness, much too realistic (Gergely and Watson 1996). Some mothers, because of their own emotional difficulties may become overwhelmed by their infants' negative affect-expressions. The infant may then experience his of her own negative affect as 'out there' as belonging to the other. This constellation corresponds with the clinical phenomenon of projective identification which is so characteristic of a patient with a borderline personality organization. It predisposes to the persistence of a psychic equivalent mode of experiencing internal reality (see the next paragraph). On the other hand, if the mirroring is *not congruent*, and does not have a link to the child's primary experience, it can lead to a false-self structure where representations of internal states correspond to nothing real. This predisposes the individual to the pretend mode of experiencing internal reality (Bateman & Fonagy 2004: 83). Inaccurate mirroring will lead to the internalization of representations of the parents' state, creating what Fonagy calls 'the alien self'. The alien self disrupts a sense of coherence of self or identity, which can only be restored by projection.

Failure of the ability to mentalize

If understanding that a thought is only a thought is an ability developed by the child, what does mental reality look like before it is perceived as mental? Fonagy and Target (1996; Target and Fonagy 1996) say that there are initially two ways: the equivalent mode and the pretend mode.

In the equivalent mode, the inner and external world are equated ('What I think is someone else's reality'). In the course of the first year of life, play, or the pretend mode of mental functioning arises alongside this and separate from it, in which the child's own experience is entirely separate from reality. In the pretend mode, the child can believe that his wooden gun is real, without expecting real bullets to issue from it ('Imagining is real, but not reality').

In normal development, the child integrates these two manners into a reflective mode, mentalization, in which thoughts and emotions can be experienced as representations. Inner and outward reality are then seen as related, but separate, while not being equivalent to or isolated from each other (Deben-Mager and Verheugt-Pleiter 2004).

An insecure attachment predisposes a child to fail in developing mentalization, first of all because of the inadequate mirroring (which must be both accurate and not too realistic) and, second, because of the absence of a playful attitude in the parent. Without playfulness, the child cannot experience thoughts and emotions, wishes and fantasies as important, although not the same as reality. Bateman and Fonagy (2004: 84) go so far as to say, 'The undermining of a playful attitude may be the most serious deprivation associated with child maltreatment'.

Third, insecure attachment is often accompanied by neglect, maltreatment and even abuse, thus increasing the child's susceptibility to later traumas because they cannot be properly mentalized. The equivalent mode is manifest if a traumatized person is afraid of what is going on in his own head. His thoughts are then equated with reality. Flashbacks are so frightening because they are experienced in the equivalent mode. In the pretend mode, we see the dissociation, the withdrawal from reality, which is the result of the trauma. Characteristic of borderline patients is their oscillation between these two manners of perceiving mental reality, the dual mode (Bateman and Fonagy 2004; figure 2).

The therapeutic methods of MBT

The method was studied in a research project in which patients with a borderline personality organization were treated for 18 months on a daytime admission basis, combining group therapy with individual therapy (Bateman and Fonagy 2004). However, the same therapeutic strategy is also applicable in various outpatient settings, even including psychoanalysis. The model, which is based on developing mentalization, is intended more to supplement than to renew present therapeutic practice. Present psychoanalytic therapeutic practice is taken to be working with patients with neurotic issues and reasonably good

Fig. 3.6 Attachment model of trauma-related psychopathology

Source: Bateman and Fonagy (2004).

Figure 2. Attachment model of trauma-related psychopathology.

reflective abilities, where the interpretation of subconscious conflicts is an important effective technique.

According to Fonagy *et al.* (2002), promoting mentalization is actually something all forms of therapy aim at, although often implicitly. Consider that psychotherapy usually involves: (a) attempting to form an attachment relationship with the patient; (b) to make this into an interpersonal context with a focus on understanding the patient's states of mind; and (c) re-creating a situation in which the self is recognized as intentional and real and making sure that this is clearly understood by the patient.

For borderline patients, more so than for more neurotic patients, the focus of treatment comes to lie on developing and differentiating mental functioning.

The therapist as development object

The therapist works in the transference, without interpreting it, by establishing and maintaining an attachment relationship with the patient.

Transference is understood as the need of the patient to elicit certain behaviour or emotions in the therapist, so as to keep the self coherent. As Bateman puts it:

> Thus, the TFP therapist talks to the patient about the relational aspects of the transference and does so at the very beginning of treatment. Within MBT many such externalizations would not be seen as primarily relational but rather as externalizations of parts of the self, particularly the core self or a foreign aspect of the self. An important technical implication of this is that the MBT therapist would not expect the patient to understand much of the discourse that the therapist might verbalize in relational terms. The self and the therapist are experienced with a rigidity that is often strikingly without relationship implications. Interpretation in relational terms too early then leads to destabilization (Bateman 2004: 4).

So within the transference, attention is focused on subconscious implicit patterns, such as habitual aspects of the patient's behaviour, or systematically recurring ways of thought.

Just as in ordinary (mother-child) attachment relationships, a very important task for the therapist is to infer a representation of the patient's affective state. Based on a variety of signals such as posture, voice modulation, and so on, the patient's state of mind is interpreted: this is affect representation. The therapist tries to stay in touch with the patient's mental state, despite the latter's sometimes dramatic enactments. He verbalizes states of mind, makes distinctions in them and helps to decrease anxiety. This is an initial impetus towards developing the pretend mode, in which the patient can think about ideas as ideas rather than as reality, although with a link to reality. After the pretend mode of mental functioning is developed, it will need to be integrated

with the equivalent mode to arrive at mentalization (Bateman and Fonagy 2004).

Aggression

Many characteristics of the borderline personality disorder, such as the incoherent self, affective instability and impulsiveness, can be explained by the model based on developing mentalization. The model also makes the use of violence by the patient directed against himself – for example, auto mutilation – or against others, understandable: it is an attack on the alien self, the bad introject, that which cannot be thought about. The introject must be ejected for the self to become more coherent (Bateman and Fonagy 2004).

Rather than of aggression, the model generally speaks of disintegrating tendencies, that can express themselves in extreme panic or in hostility. In this model, aggression is seen as the final stronghold against the unbearable fear of the barren, empty inner landscape and the awareness that your parent, your attachment figure, does not really 'see' you, and may even hate you. The panic and hostility are not interpreted as negative transference, but the therapist attempts to understand where the panic comes from. In the treatment, for instance, the panic that occurs upon separations will be discussed. This is important because separations are experienced as desertions, leading to a re-internalization of the ego-dystonic introject, thus further undermining the coherent self.

Similarities and differences in practice

The question that we asked ourselves in the round table talks was what interventions are related to the therapist's theoretical background. Reactions to a fragment from the treatment of a borderline patient which was used in the NPI discussion can illustrate the difference in approach between TFP and MBT therapists.

Patient: 'I'm just sick and tired of it, I just don't have any energy any more to stay with the therapy. … The feeling that I am again at an impasse. Okay, right now I'm calm, but last night I was just terribly angry and desperate – then I just don't know. And then I'm very angry with you'.

Therapist: 'Angry?'.

Patient: 'Well, there's just so little point. I only start to hate myself. I wonder how much longer we'll have to muddle through; I just don't feel like it. Nothing has really changed in my life. I still go on eating binges and I still hurt myself and no-one can do anything about it except me, and still I go right on doing it'.

Therapist: 'That's how angry you are with me'.

Patient: 'Yeah, and this too, I just get so fed up with it, all those interpretations, we've talked about it at least a hundred times'.

Therapist: 'How do you see it?'.

Patient: 'Well, I um … I'm much more dependent on you than you are on me. If I were to stop now, I would still find my life unbearable and would still not want to go on with it. I really don't want anything any more'.

The TFP therapists saw the patient's remark as her resistance to her need for and fear of the contact with the therapist. They would suggest that the patient wants to end her therapy because the therapy has brought her to see how vulnerable she feels when she shares confidences with someone else, that it makes her feel dependent, that the therapist can affect and move her. Another option for them was that the patient is in fact angry because she wants much more contact than just twice a week. The working hypothesis would then be that by acting out, the patient exerts control on the outside world and fends off her emotions of vulnerability in this way. She prefers binge eating to feeling vulnerable and she wants to disrupt the therapy with a similar mechanism.

In reaction to this fragment the MBT therapists stressed working in the attachment relationship which the therapeutic relationship had become for this patient. They would say something about her desperate sense of so much wanting to attend sessions and at the same time being so angry. A second aspect was the disappointment expressed by the patient with all the talking while in actual fact it was not helping, and she was still cutting herself and binge-eating. From the point of view of affect representation, they would talk about how terrible it must be if you discover that, despite all your efforts, the therapy is not helping and is not having any results; that she has to eat and then be sick to get that unpleasant, unresolved feeling out of herself. In this way they aim to give reality value to her inner experiences and to avoid talking only about constructions in the therapy (pretend mode) instead of giving words to the real experiencing self.

Dealing with the aggression

A central focus in treating patients with a borderline personality organization is enduring, and talking about, intense emotions, particularly hostility. Most therapists agree that mechanisms such as projection, projective identification and splitting are primary. Opinions differ on the meaning of the hostility and how to use it. TFP places much emphasis on aggression as an autonomous instinct that can play a role between subject and object. MBT views hostility as an expression of an unbearable sense of being lost and abandoned, as an aspect of huge panic. This model does not so much aim to show how the patient projects his own anger onto the therapist, thus turning the therapist into a

threatening other, but to understand that the patient has an insecure, probably even disorganized attachment representation, due to attachment trauma. Therefore the therapist *is* threatening for him or her. MBT therapists thus sooner tend to formulate the panic as the dominant affect. As Bateman (2004) puts it: 'affect dysregulation is attributed to constitutional anomalies, temperamental differences and the absence of symbolic control in TFP, but is seen in MBT as a consequence of symbolic failure, particularly associated with incongruent mirroring' (Bateman 2004: 4).

The meaning ascribed to a symptom such as auto mutilation differs as well: the TFP therapist sees the defensive function of the symptom – for instance, exercising control of one's surroundings – as fending off one's own vulnerability and powerlessness. The MBT therapist sees it as an attempt to remove an alien introject, so as to increase cohesion of the self.

The MBT view is supported by the fact that anxiety and aggression form a single biological system (the fight/flight system).

Different views of the personality structure

Therapists of the two persuasions do agree that, for a patient with a borderline disorder, it is often not possible to reflect on his inner world and that of others. He cannot say, 'I have a lot of anxious emotions'; he *is* anxious; he quite literally experiences it in this way, including the physical symptoms. MBT would call this 'unmentalized', while TFP speaks of 'splitting': as long as the patient splits, he is unable to reflect.

The TFP therapists assume that borderline patients have an observing ego, no matter how rudimentary. It is precisely what they appeal to during therapy. They also assume that there is a layered structure in which one feeling can fend off another.

The MBT therapists, on the other hand, say that these psychological mechanisms cannot work because mentalization – thoughts and emotions as separate entities about which a person can think – is low or absent. Consider the following vignette: A 27-year-old woman has come to therapy following a suicide attempt. She has a history of anxiety attacks, turbulent relationships and work-related problems. In the first seven sessions she has now had, she behaved nice and easy, telling superficial stories. The therapist repeatedly tried in an empathic way to call her attention to her own aggressive instincts. In the eighth session, which we discussed in our work on differences in interventions, she started with tales about some car trouble, then moving on to complaints about her husband, who couldn't fix the car. She concluded that it might be better to divorce him, which is what she thinks the therapist has been suggesting all along.

The MBT therapists remark in connection with this vignette: concerning the divorce it would be important to ask her which signs she has that the therapist would suggest a divorce. It is possible that the therapist said things,

which can explain why she thinks this. For the MBT therapists this would constitute their first focus: to give realness to her inner life. The TFP therapists agree with introducing aggressive impulses in all this easygoing talking. They would stress the fact that the patient struggles with her own ambivalent emotions.

They would try to point to the underlying dyad, namely that beneath the cosy surface, she also experiences the therapist as unconcerned or even hostile, someone who begrudges her a satisfying life with her husband.

This example elucidates the different views that therapists can hold on aggression, depending on their theoretical background. Also it illustrates that the TFP therapists presume a capacity to think in terms of relations. The MBT therapists stay closer to what the patient herself has named as an emotion or thought, explore carefully in order for her to develop her own emotions and thoughts.

Role of the therapist

TFP stresses the therapist's role as a *transference object*. From the outset, the strategy is to establish the dominant dyads and their counterparts. The treatment revolves around hypotheses about how the patient sees the therapist. The intensity of the transference relationship is used to make the patient aware of present and past dyads.

In the preceding example the suggestion of the patient that the therapist wants her to divorce her husband, is read as an indication of her transference relation, namely a relation in which she experiences the therapist as unconcerned and not 'giving' and herself as someone who is not worth having a man. This dyad is masked by the cosy dyad, in which therapist and patient are communicating as a friendly and kindly disposed couple. By interpreting this transference the therapists hope to further integration of positive and negative representations.

The MBT therapist acts as a developmental object. The aim is to specify implicit patterns, try to stay in touch with the patients' mental functioning mode (equivalent or pretend) and to try to identify and clarify the affect accurately. The MBT therapists in our group would say 'What have I said that makes you think that I want you to divorce your husband?' and, second, try to identify the affect, such as 'I think that you may be feeling helpless in fixing the car and fixing your own life?'. They keep in mind that the therapy will re-evoke attachment representations which are insecure by definition with borderline patients. Transference is seen as a way of eliciting reactions in the therapists so as to retain a coherent self. So, in this example, it could be that the therapists becomes more and more frustrated about the patient's resistance: the patient then would have succeeded in putting her alien self (that tells her that she is worthless and helpless) into the therapist. The therapist has to keep the patient's mind in mind.

Effect study

Both approaches to borderline personality organization have their own manuals. This would make it possible to do comparative research although, as far as we know, a randomized control trial between TFP and MBT has not yet been carried out (Roth and Fonagy 2004, Fonagy *et al.* 2005).

The conditions for the two forms of therapy differ: TFP assumes a long-term, twice-weekly individual treatment, MBT an integrated treatment team using a combination of individual and group therapy. The difference in conditions may lead one to suspect that TFP was developed for 'higher level borderlines' and MBT for 'lower level borderlines'. However, this need not be an obstacle to carrying out effect study of the two types of treatment in a group composed of comparable borderline patients.

Some empirical evidence exists for each separate model of MBT and TFP. Mentalization-based Treatment (MBT) as a psychotherapeutic day hospital treatment of 18 months that specifically targets individuals with severe BPD is shown by Bateman and Fonagy to be an efficacious treatment compared to routine general psychiatric care for patients with BPD (Bateman and Fonagy 1999). Major improvement in depressive symptoms, reduction of suicide attempts, and a better social functioning began at 6 months and continued during follow-up, even up to 36 months.

In an ambitious and comprehensive randomized control trial Clarkin *et al.* (2005) compared transference focused therapy with dialectical behaviour therapy and psychoanalytic supportive therapy. The improvement was most marked for the TFP group, but this difference was not statistically significant. Reflective function scores, based on the Adult Attachment Interview and related to mentalization, showed light improvements in the other two treatments but was only significant for the TFP group (Clarkin *et al.* 2005).

In a randomized trial in Holland TFP has been compared with the Schema Focused Therapy with the conclusion that both are effective, but the SFT more so (Giesen-Bloo *et al.* 2006). The somewhat lesser results of TFP were attributed to the more confrontational and less supportive technique, resulting in higher dropout rates.

Similarities

In this paper we have primarily attempted to illuminate the differences between the two approaches, based on theory and on clinical practice: to what interventions do different background theories lead? However, there are also similarities. Both TFP and MBT, although essentially psychoanalytically informed, differ from classical psychoanalysis in their focus on adjusting the technique to the patient. The two approaches agree that particularly patients with a borderline personality organization require a re-orientation on the part of the analyst, because the psychoanalytic theories of neurosis do not apply. Rather

than revolving around the extremely individual characteristics of the patient-analyst pair or the complexity of the analyst's intuitive understanding of the manifestations of the subconscious, they both aim to respond as closely as possible to the patient, aiming at more than amelioration of symptoms, namely aiming at enhancing mentalization or even cure (Kernberg 2004).

Both models attach much value to interaction in the here-and-now, and counter-transference is clearly a compass. Both are aimed at making the big affective quantities manageable. MBT assumes that there is a disorder in mental processing and offers an operational model to facilitate further development. A much more optimistic approach than the earlier Freudian concept of irreparable defects.

TFP assumes a conflict model, with emphasis on defences and raising awareness. Still, Kernberg's notion of identity diffusion bears resemblance to what Fonagy would call inhibition of mentalization. Both models are complementary to Freud's model of neurosis: they do not replace it, but add to it.

CONCLUSIONS

Kernberg (2004) has criticized MBT by saying that the way it aims to structure the primitive internalized object relations is primarily cognitive. Basically, he is of the opinion that TFP and MBT are quite compatible. Interestingly, the TFP group includes measures of the level of reflective functioning in their last research projects, indicating that mentalization is an important buffer against the identity diffusion of the borderline patient.

Conversely, MBT spokespersons Bateman and Fonagy (2004) have always said, that a lot of therapies can enhance the level of mentalization. That effect is not exclusive to their MBT. Bateman criticizes TFP for approaching patients too abstractly. TFP, he says, deals with patients as if they can think intentionally, as if externalizations are about the therapeutic relationship and not the alien self, as if the patient isn't often stuck in an equivalent mode of thinking.

In other words: the theoretical model of the TFP assumes that there are mental representations present and the model of the MBT says that they still need to be developed. TFP capitalizes on the problem of object relations, whereas MBT primarily focuses on the problem in the self as agent. MBT may be more suitable for low-level borderlines and attach much importance to the attachment relation, while TFP carries more risk of dropout and puts a greater strain on the working alliance because of the more confrontational interventions.

The round table discussion meetings at the Dutch Psychoanalytic Institute showed clearly how therapeutic strategies and interventions based on each distinct theoretical background, differed substantially. It may be that the leading

clinicians are already slowly converging in their theories and practice toward a common understanding, while we, who have tried to learn from them, are still somewhat caught up in the first outlines.

Still, the two approaches show a certain affinity: they are rather like brother and sister, because they both try to take a stand for the psychoanalytic treatment of borderline personality organization. To this end, they adjust the psychoanalytic technique while making it open to empirical effect study by providing a manual. Both focus on mental life and aim to facilitate further development, rather then aiming for symptom reduction *per se*.

The participants in the meetings all felt that TFP calls for a higher level of development, while MBT may be designed for low-level borderlines, but could be applicable in all kinds of cases. In any case it would seem of the utmost importance that the therapist him or herself has a coherent theory in mind. Further studies will have to support the notion that both therapies increase the level of reflective function and that this is indeed what is needed with borderline patients.

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