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An Object Relations Treatment of Borderline Patients With Reflective Functioning as the Mechanism of Change*

Frank E. Yeomans, John F. Clarkin, Diana Diamond, and Kenneth N. Levy

Introduction

Transference-focused psychotherapy (Clarkin, Yeomans, & Kernberg, 2006) is a form of psychodynamic psychotherapy specifically modified and structured for patients with borderline personality organization (BPO), a broad grouping of severe personality disorders that includes the more narrowly defined borderline personality disorder (BPD). Although there is growing evidence that TFP results in clinical improvement (Clarkin, Levy, Lenzenweger, & Kernberg, 2007) this paper considers aspects of how the treatment works. In psychotherapy research, it has become increasingly recognized that treatment development must involve empirical information not only on whether the treatment in question achieves its desired outcomes, but also on how that outcome is achieved through the specific interventions of the treatment package in question (Kazdin, 2001; Clarkin & Levy, 2006; Levy, Clarkin, Yeomans, Scott, Wasserman, & Kernberg, 2006; Gabbard & Westen, 2003). In this regard, the state

of reflection on TFP is similar to that on other treatments for borderline personality disorder such as mentalization-based therapy (MBT; Bateman & Fonagy, 2004) and dialectical behavior therapy (DBT; Linehan, 1993).

Through clinical and research investigations we have established reflective functioning (RF) as one of the mechanisms of change in TFP. In this paper, we present a case illustration to demonstrate the specific techniques and tactics in TFP that promote RF, and place this case in the context of our general outcome data, including data demonstrating changes in RF over the course of one year of TFP. Like DBT and MBT, TFP is an entire treatment program, that is, it contains many elements in a year-long, or longer, intervention with borderline patients who bring both general and idiosyncratic issues to the treatment situation. Thus, although we emphasize transference interpretation as central to the therapy and therapeutic change, it is only one among many elements of the treatment (see Figure 5.1).

Our Working Model of Borderline Pathology

Our clinical research efforts in the development and evaluation of TFP have been guided by a model of borderline pathology based upon both psychoanalytic understandings of the structural organization
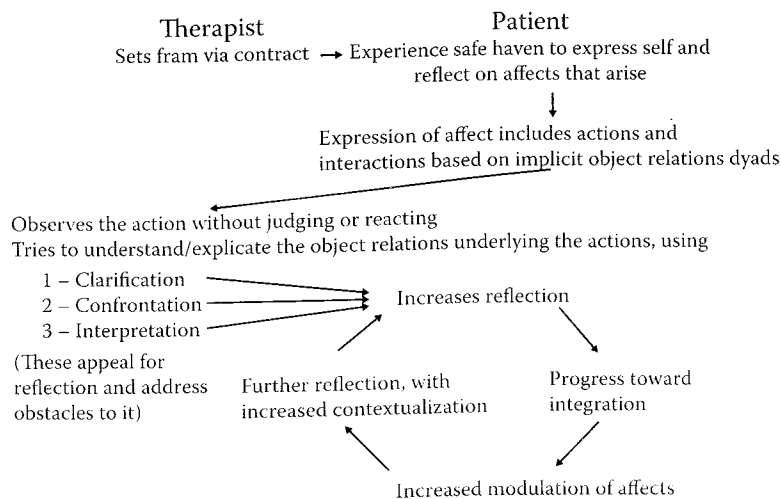

Therapist   **Patient**
Sets fram via contract → Experience safe haven to express self and
reflect on affects that arise

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Expression of affect includes actions and
interactions based on implicit object relations dyads

Observes the action without judging or reacting
Tries to understand/explicate the object relations underlying the actions, using

1 – Clarification
2 – Confrontation   Increases reflection
3 – Interpretation

(These appeal for
reflection and address   Further reflection, with   Progress toward
obstacles to it)   increased contextualization   integration

Increased modulation of affects

Figure 5.1   Proposed Mechanisms of Change in TFP

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of personality (Kernberg, 1984, 2004), and the interaction between behavior and neurobiological aspects of the individual (Depue & Lenzenweger, 2005; Posner, Rothbart, Vizueta, Levy, Thomas, & Clarkin, 2002). The psychoanalytic view of borderline personality organization with the central concept of a split internal world and identity diffusion has been essential in understanding the psychological experience of the patient and guiding treatment (Yeomans, Clarkin, & Kernberg, 2002; Clarkin, Yeomans, & Kernberg, 2006). Our working model of BPD posits a dynamic interaction of temperament, especially a preponderance of negative affect over positive affect, low effortful control, and an absence of a coherent sense of self and others in the context of an insecure model of attachment. The borderline experience is characterized by an information processing system that is actively influenced by negative affect, faulty and ineffective conflict resolution, and insecure (primarily Anxious/Preoccupied and/or Disorganized/Unresolved) attachment organization (Fonagy et al., 1996; Bateman & Fonagy, 2004). Treating these features of borderline pathology requires specific therapeutic foci and intervention strategies. Interventions focused on the information processing system, especially in the social interpersonal sphere, will have the most impact on the patient in achieving the combined goals of symptom reduction and healthy involvements in relationships and work.

In the object relations model of borderline pathology, the patient's internal world is conceptualized as being made up of multiple sets of relationships dyads, comprised of a specific representation of the self and a specific representation of the other linked by a specific affect. In individuals with borderline personality organization, these relationship dyads consist of simplistic, polarized, and caricatured representations of self and others in contrast to the multifaceted and modulated sense of self and others that characterizes more mature individuals (Clarkin, Yeomans, & Kernberg, 2006). These one-dimensional representations of self and others are often in contradiction with one another and therefore underlie the identity diffusion and contribute significantly to the interpersonal difficulties of the borderline patient. The fragmented, diffused sense of self leaves the patient at risk for inaccurate, extreme perceptions accompanied by overwhelming affects in the experience of the moment, leading to misrepresentation of self and others, and to affect dysregulation—both of which are the focus of therapeutic intervention in

TFP. These split polarized representations are seen as the motivating force behind the patient's perceptions and constructions that lead to self-defeating and self-destructive relations with others. Treatment, therefore, must be structured in such a way as to control acting out and provide a frame within which the patient can experience, observe and reflect on his or her representations of self and others in a context that might allow modification and ultimately integration of the representational world.

Transference-Focused Psychotherapy

Recently, following the idea that from a scientific viewpoint, studies of psychotherapy outcome are incomplete if they do not address the specific mechanisms of change, we have investigated the specific mechanisms that promote change in TFP (Levy et al., 2006). TFP is based on the understanding that the object relations dyads that structure the internal world of the patient will emerge in the transference to the therapist. A fundamental mechanism of change is the facilitation of the reactivation of dissociated or projected internalized object relations under controlled circumstances. The therapist helps the patient elaborate his or her experience with the over-all goal of first observing and gaining awareness of the nature of the internal representations and then integrating them into a fuller, richer, and more nuanced identity. In order to achieve this goal, the therapist must create conditions that contain intense affects and acting out and enhance the possibility for reflection. The first step is to structure the treatment conditions in such a way as to avoid the disruption of the treatment and to create a frame that helps focus the patient's observations and reflection. This begins with discussion of a treatment contract to provide safety and stability in the therapeutic environment and containment for the reactivation of internalized relationship dyads. The dyadic intimacy of the treatment setting along with the unequal roles and relationships of patient and therapist lead quickly to the activation of the internal object relation patterns that underlie borderline pathology and that determine the patient's perception of self and others. As this occurs, the therapist tries to clarify cognitively what the patient perceives and its relation to what the patient feels. TFP emphasizes monitoring the three channels of communication

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This model considers the role of mental transformation processes and does not assume that the reactivation in the present is an exact reproduction of what has actually happened in the past. The patient's responses to the therapist do not reproduce a specific experience or relationship from the past, but rather represent an internal construction, the ultimate origin of which cannot be identified precisely. Our focus is the current psychic reality and how it is structured, and this structure is the focus of modification in the treatment. The disorganization of the borderline patient involves not only fragmented internal representations of self and others with the predominance of primitive affects, but also the manner in which this fragmented structure defends against the anxiety that arises in the patient when opposing affects and representations approach one another. The protection of primitive ideal images of self and others from the rage associated with primitive aggressively-laden ones requires the maintenance of the fragmented internal state. This fragmentation functions as a defense against anxiety, but also prevents the patient from having full awareness of what is occurring in his or her internal world. This defensive structure distorts and erases awareness and thinking. Borderline patients manifest a fragmentation and disconnection of thinking by attacks on the linking of thoughts (Bion, 1967). At its extreme, powerful negative affects are expressed in action without cognitive awareness. A goal of therapy is to transform impulsive, automatic behaviors into an understanding of the internal relationships that gave rise to them.

The postulation of internalized relational scenarios that involve an image of self in interaction with another with concomitant expectations of interpersonal transactions is common to object relations dyads and to internal working models of attachment. By engaging the patient in identifying and observing these scenarios as they are experienced in the therapy setting, the therapist appeals to the patient's capacity to reflect on them as constructions rather than as veridical images of self and others, with the goal of increasing his or her cognitive capacity to represent affect. The therapist then helps the patient understand the anxieties that make it difficult to integrate primitive positive (libidinal) and negative (aggressive) affects. In cases where, for constitutional and/or historical reasons, the patient experiences high internal levels of aggression, movement

toward integration of disparate affects with respect to the same figure, including the therapist, may create anxiety because of fear that aggressive affects will destroy positive idealized representations. When paranoid anxieties predominate, the patient may fear that any expression/experience of libidinal affect may provoke an onslaught of mistreatment or persecution.

TFP fosters change by insuring that the reactivation of primitive object relations under the carefully constructed treatment frame does not lead to the vicious cycle of affective reactions that the patient usually arouses in significant others. The therapist's stance of technical neutrality (not to be confused with coldness or indifference) assists both in the reactivation of the patient's characteristic object relations dyads and helps the patient to observe, to see, accept, and eventually integrate parts of the self that previously were not consciously tolerated but were either enacted and/or projected, whether they be associated with aggressive or libidinal affects. By fostering reflection and containment through the identification of self object dyads and their linking affects, the repetitive re-enactment of such internal dyads is short-circuited, and there is a gradual cognitive structuring of what at first seems both rigid and chaotic. Through clarification, confrontation, and interpretation of the patient's self and object dyads in relation to the therapist and external figures, the patient is encouraged to expand his capacity to reflect on his understandings of self and others as an instrument in working toward an integrated identity. In trying to understand the process by which our patients develop the capacity to reflect on mental states of self and others in the service of integrating their internal worlds, we have reviewed the work of Fonagy and colleagues on mentalization.

Considerations of Mentalization and Reflective Functioning

Fonagy and colleagues have contributed to our understanding of the representational world of borderline patients (and personality pathology in general) by investigating, both developmentally and cross-sectionally, the development of the individual's capacity to understand and reflect on mental states of self and others. In this context, mentalization, which has been operationalized in the concept of reflective function (Fonagy, Steele, Steele, & Target, 1997), has been defined as an acquired capacity to envision and represent

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the mental states of self and others. Bateman and Fonagy (2004) use this concept as the basis for mentalization-based treatment (MBT) for borderline personality. Fonagy (Fonagy, Gergely, Jurist, & Target, 2002) posits the existence of an *internal interpretive mechanism* [IIM] or function that enables the individual to deal with interpersonal relations. It is hypothesized that this function is genetically defined and located in the medial prefrontal cortex (p. 132). In pathological conditions, such as severe personality disorders, this interpretive function is compromised, and the capacity for sustaining a clear distinction between self and other is defective. The functional ability to arrive at representations of the motivations of others uncontaminated by the motivations of the self (which may also not be clear to the individual) is severely compromised. In fact, the most complicated challenge in treating severely personality disordered individuals, according to these authors, involves strategies to approach the patient's externalizations of unbearable self-states. Our clinical vignette will demonstrate how TFP approaches the borderline patient's externalization of painful states and helps him or her to recognize them as part of him or herself, and to integrate them into more accurate and nuanced appreciations self and others.

Fonagy and colleagues (2002) conceptualize reflective functioning not as an invariant trait but rather as an evolving skill shaped by particular emotions, interactions with particular people and events. As such, an individual's reflective functioning will have uneven development and the individual will demonstrate variation in the use of the skill. RF is thus conceptualized as a particular skill tied to specific tasks and domains, and not as a general capacity. In the course of normal development, the individual tends to integrate the capacity for reflective functioning with other control systems. In contrast, in the development of the individual with personality pathology, unevenness in the use of reflective functioning across situations may be more marked, and may be a result of conscious or unconscious attempts to avoid reflecting on the mental states of others who have been experienced as abusive or neglectful. In such situations, the individual may shut down reflective capacities altogether or may adopt a hypermentalizing stance in which there is inordinate focus on the mental states of others and inadequate attention to the mental states of the self. These authors assume that experiencing abuse or maltreatment is associated with fractionation or splitting of reflective functioning across domains and tasks. It is especially in the

context of conflicts in interpersonal relationships that the nonreflective behavior may dominate in personality disordered individuals.

It is suggested by these authors that psychotherapy works precisely because it improves the functioning of the IIM. For any psychotherapy to create this improvement, the treatment must be delivered in an interpersonal context that fosters an attachment relationship between patient and therapist, focuses on both cognition and affect, and proceeds with coherence and consistence. Although these general treatment strategies are accurately related to the goal of treatment, the therapeutic techniques to actually increase patient reflective functioning in the treatment sessions need further explication (see Bateman & Fonagy, 2004; Clarkin, Yeomans & Kernberg, 2006, for overlapping but somewhat different views of what is highlighted later). We agree with Bateman & Fonagy, 2004, as our case illustration later suggests, that one of the most complicated challenges in treating severely personality disordered individuals involves the issue of how to approach the patient's externalizations of unbearable self-states. This may be why many therapies with a supportive, in contrast to an exploratory, emphasis accept the patient's externalization and attempt to help the patient cope better with problems, (e.g., by teaching coping skills) or to target symptoms (e.g., by medication) rather than to help the patient resolve conflicts between warring aspects of his psyche that, until recognized and integrated, prohibit successful life adjustment. Fonagy and colleagues (Bateman & Fonagy, 2004) indicate that the therapist should constantly encourage mentalization on the part of the patient, that is, the gradual clarification of what the patient is experiencing and what he thinks the therapist is experiencing, and how this motivates the therapist's actions—what we see as a first level of RF—with the idea that an improved ability to assess self states and the mental states of others will diffuse intense emotional reactions. We do not disagree with this position, but feel that more specific attention should be addressed to thematic and affective content in addition to focusing on the patient's processing of the interaction.

Bateman & Fonagy, 2004, are reluctant to go beyond this level of work with borderline patients in the early and middle stages of therapy because of their concern that the borderline patient's inability to mentalize curtails their capacity to work productively with interpretation. Thus, if they use interpretation, they delay it until a very late stage of therapy. They believe that borderline patients are not capable

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of symbolic representation. Because they see borderline patients as lacking this capacity, their focus is to use brief here-and-now statements that help the patient gain awareness of his current mental state and that of the therapist and thus understand the meaning and motivation in his own and the other's behavior. They describe the transference as the emergence of latent meanings and beliefs that are evoked by the therapeutic relationship and then are implicitly contrasted with the actual experience with the therapist. When a feeling is identified in the room, the patient is encouraged to consider who engendered that feeling, what their role may have been in engendering it, and how states of mind of self and other (the therapist) may differ. We agree with the overall strategy of the exploration of a mind by a mind within an interpersonal context. We differ in our understanding of the capacity of borderline patients to work with symbolic representation. We feel it is useful for the therapist to appeal to it and that it can be engaged to help the patient integrate split-off toxic material.

We believe that Bateman and Fonagy (2004) may underestimate the capacities of borderline patients and also misunderstand the interpretive approach in TFP, seeing it as an isolated technique that is applied regardless of the patient's individual characteristics or reflective capacities, rather than as part of an evolving process in which the groundwork for understanding and using interpretations is laid through prior focus on clarification and confrontation.

Interpretation in the here and now begins with an effort to understand an affect, or an action that may be geared to discharge an affect, in terms of the representations of self and other that lie beneath and motivate the affect/action. This often involves addressing attention to representations with characteristics that are unacceptable, particularly in terms of the affects and drives involved—whether they are aggressive or libidinal. Bringing these underlying representations to conscious awareness helps the patient clarify the motivation behind his feeling or action and allows for further elaboration of the accuracy of the representations. When successfully carried out, this increased understanding of self and other in the momentary experience helps the patient tolerate disavowed affect(s) without having to discharge it (them) in action.

In the clarification process, the patient is invited to expand his representation of present feeling states. The patient's feelings, toward the therapist or toward others, may be clearly articulated

and noncontradictory at times, and at other times at variance with what the patient has communicated before, or at variance with overt behavior. Confrontation is the technique of addressing these variances. Confrontation is not a hostile challenge, but rather a matter of presenting the patient, who is often unaware of the discrepancy, with discrepancies in his articulation of feeling states, or discrepancies between articulated feelings and behavior. Clarification and confrontation constitute the level of the interpretation process that involves achieving a more accurate view of self and other in the moment. A second level of interpretation helps the patient become aware of how the understanding of a particular affect in relation to an object could be related to other, conflicting affects that exist within the individual. An example of this is: "It may be that you talk about dropping out of treatment after each session where we have experienced a positive contact because a part of you is convinced that my positive approach to you is geared to trick and ultimately hurt you. If this were true, it would make sense that you would want to leave, and explain that you seem to be more 'at home' in hostile relations." A later stage of interpretation might focus on the patient's split-off and projected identification with an aggressive part that makes it impossible to escape from relations that take on an aggressive tone and that, once understood, could be integrated, so that the awareness of the aggressive part both removes it as an obstacle to more successful libidinal fulfillment and allows for adaptive uses of aggressive affects, such as striving for higher achievement.

Fonagy describes mentalization as if it were a unitary function. In our view, mentalization can be conceptualized in two levels. Although we believe that changes in the cognitive sphere, and particularly in the individual's capacity to think about self and other in mental state terms are essential, our treatment is not focused on mentalization directly and exclusively as described by Bateman and Fonagy (2004), but rather on mentalization as it applies to the borderline patient's affectively charged internal representations of self and others. This model of internal dyads of the representation of self and others can be conceptualized at two levels of complexity and can be linked to RF. At the first level, the individual experiences his or her feelings in the moment of a specific interaction. The immediate experience involves a conception of self, a conception of the other, and an affect state related to these representations. The first level of RF is to understand this moment accurately. In borderline patients,

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this understanding can transform an action powered by an unarticulated and split-off affect into an understanding of self and other in the momentary experience so that the patient can tolerate and modify the affect without the need to discharge it in action.

Beyond achieving understanding of the mental state of self and other in the moment, at a second level of RF the individual is both aware of the representations of self and other involved in a momentary affective state and, furthermore, can place these representations into a general context of knowledge about self and other across time—an integrated view of self and other that has coalesced. At this level, the patient can contextualize momentary feelings toward another into the broad internal sense of experience of the relationship that has developed over time. In promoting the movement from identity diffusion to an integrated identity, TFP increases the patient's capacity to reflect at this higher level.

Empirical Research on Reflective Functioning

Improvement in the IIM can be assessed by the RF scale (Fonagy, 2002), according to these researchers. With funding from the Borderline Personality Disorder Research Research Foundation (O.F. Kernberg & J.F. Clarkin, PIs), we have conducted a randomized clinical trail (Clarkin, Levy, Lenzenweger, & Kernberg, 2004; Levy et al, 2006; Clarkin, Levy, Lenzenweger, & Kernberg, 2007) comparing three types of interventions in a one-year outpatient treatment study: TFP, dialectic behavioral therapy, and a psychodynamic supportive therapy. Additional funding from the American Psychoanalytic Association (PI: Kenneth Levy) enabled us to administer the AAI before and after the one-year intervention to the patients in all three treatments. Our data analysis suggests that in general the three treatments were effective to varying degrees in reducing symptoms and improving functioning from the beginning to the end of the treatment year. Patients in all three treatment groups showed significant positive change in depression, anxiety, global functioning, and social adjustment. Only TFP and DBT were significantly associated with improvement in suicidality. Only TFP and supportive psychodynamic therapy were associated with improvement in anger. TFP and supportive therapy were each associated with improvement in facets of impulsivity. Only TFP was significantly

predictive of change in irritability and verbal and direct assault (Clarkin et al., 2007). Most relevant to the current article, we conceptualized reflective functioning as a mechanism of change in the treatment of borderline patients, and hypothesized that by the nature of the treatment, RF would improve in TFP but not in DBT or supportive psychotherapy. Results showed that the mean RF score of the patients who had been treated with TFP increased while the RF score of the patients in the other two treatments did not change significantly (Levy et al., 2006).

A first question in response to this finding is what the clinical relevance of increased reflective functioning may be. A second question is what these data suggest in terms of therapeutic techniques that help in the treatment of borderline patients. With regard to the first question, the increased ability to reflect on one's own and an other's mind should lead to less of the inaccurate attribution of negative intentions to others that is typical of patients with BPD. Consequently, benign or positive events will no longer be seen as malevolent and the patient will be able to avoid the downward spiral of misinterpretation and engendering of negative responses. We would predict that individuals with increased RF make better choices in work, social and love relations and are able to achieve not only stability but also fulfillment in their lives. The case example found later offers one example of this, but more importantly, we are engaged in a long term follow-up study of our cases with the hypothesis that patients whose RF increased are more able to maintain their symptomatic improvement and are also able to have fuller involvements in love and work relations.

With regard to relevance to therapeutic technique, the data suggest that interpretation has a role in increasing the patient's RF. Our study compared TFP, in which the interpretive process is considered a mechanism of change (see Figure 5.1), with DBT and a manualized supportive psychodynamic therapy that avoided the use of interpretation. Interestingly, DBT includes an emphasis on mindfulness, which shares certain characteristics with mentalization: the encouragement of the nonjudgmental awareness of the self in the here-and-now moment. The fact that our data do not show an increase in RF in the patients treated with DBT suggests that interpretations that expand the patient's awareness of split-off and projected parts of himself and help build the broader contextualized sense of self and other that we consider the second level of RF may be instrumental in achieving increased RF. The fact that the supportive psychodynamic

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treatment, which also did not lead to an increase in RF ratings, emphasized clarification of internal states without interpretation further supports the idea that interpretations have a role in increasing RF.

Clinical Illustration of Improvement in Reflective Functioning: The Case of Sara

Sara was a single, unemployed woman of color who started TFP at age 36 after many years in other treatments. Over the years, her condition had worsened to the point where she spent the prior 6 months isolated in her apartment, lying in bed with chronic suicidal ideation, watching television, gaining weight, and only rarely bathing. Sara was the middle daughter in an upper middle class family. She described her father as preoccupied with his career and his children's educational performance. She portrayed her mother as emotionally unstable and unable to consistently care for her children. The patient's education ended when the patient dropped out of college after one year. She then held a series of jobs in lawyers' offices but was repeatedly fired from these jobs because of difficulty getting along with others. She stopped working when news of her belligerent character kept her from being hired. The patient felt that her relations with others were negative because of the prejudice she felt everyone bore toward her racial group. Sara had no history of sexual relations except for one occasion when a man she had dated three times began to make love to her. She panicked, stopped the interaction before intercourse, and later brought formal rape charges against him.

Sara had a limited history of overt self-destructiveness. She cut herself superficially on occasion and talked frequently about her wish to kill herself. She had had three psychiatric hospitalizations. Her prior therapists most often diagnosed her with bipolar disorder. She had been on many medications, all of which were discontinued during the first year of TFP. In the research evaluation of this patient, she met IPDE criteria for not only borderline personality disorder, but also narcissistic personality and avoidant personality. She met SCID criteria for current dysthymia. On the IPO she scored very high on identity diffusion, high on primitive defenses, compromised reality testing, and aggression. Her AAI revealed an attachment classification of CC/E2/D2, which indicates that she showed contradictory

and inconsistent strategies of representing her early attachment rela-tionships, shifting chaotically between inchoate anger and dismiss-ing devaluation. Her reflective functioning (RF) score prior to the initiation of treatment was minus one (–1), the lowest possible score, indicating that she actively repudiated any consideration of mental states of self and other.

She began therapy with an immediate demonstration of her defensive structure. Walking into the office for the first meeting, she was talking nonstop about someone who had looked at her on the subway, complaining angrily that the woman was looking critically and hostilely at her. Her therapist had to talk over her to remind her that this was a consultation session and that he could not address a specific problem with her yet because he did not yet have a sense of who she was, how to understand her problems or what treatment approach to recommend. His efforts to carry out a structural inter-view were limited by her ignoring his questions and talking over him in a pressured way. After three such consultation sessions, the therapist decided that the patient's presentation provided the infor-mation necessary to proceed with treatment even though the factual information derived from the interviews was limited. His diagnostic impression was borderline personality with narcissistic features. He discussed this and a corresponding treatment contract, explaining to the patient that the treatment would require agreement on certain conditions. One was that Sara would have to engage in a structured activity, in the form of either studies or some type of work, at least on a part time basis, in addition to attending therapy sessions. This treatment parameter was geared to help Sara reflect on the difficul-ties that arose in situations with others. Sara initially rejected the idea, saying that this was precisely where she had trouble. Her thera-pist suggested that therapy offered the possibility to reflect on her experience as she was having it in a way which could help her sort out the difficulties in these situations. Sara announced in the next session that she had obtained a part-time volunteer job, indicating a motivation and health-seeking side that had not been apparent in her earlier presentation.

Once the therapy began following the contracting phase, Sara filled every session by flooding her therapist with a pressured stream of discourse, and by interrupting him when he attempted to inter-vene. He perceived her relentless monologue and lack of tolerance for his interventions as an intense need to control every interaction

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as a means of attempting to diminish the anxiety she experienced in interactions with others. Sara's interactive style posed a particular challenge for psychodynamic therapy: in a setting where the basic rule is for the patient to associate freely, there was the risk that this patient would continue talking indefinitely with a controlling discourse without changing. Initially the most effective intervention was to tolerate the confusion and frustration that such a stance engendered in the therapist and to explore the countertransferential feelings that emerged. The initial period of tolerance and self exploration on the part of the therapist was followed by discussing the representations of self and other he observed in the interaction and experienced in the countertransference with the assumption that these underlying self and other representations would help explain her anxiety. The main dyad being enacted appeared to be one of a controlling domi-nant figure interacting with a subordinated, trapped figure.

In sessions, Sara described this dynamic in various areas of life: in the description of a father who rigidly controlled his children with critical comments while ignoring their feelings, and in the racial discrimination she perceived in school and that paralyzed her. Sara attributed her paralysis and anxiety to this perception of constant criticism and rejection from the world. She spoke mostly of these themes, often repeating that she could never succeed because of the animosity others held toward her. She regularly included her thera-pist with those who were responsible for her fate: "You *don't* know what I'm talking about! You're white. And you're not helping me. You're just like the rest."

Although the therapist acknowledged and empathized with the difficulties she endured because of her minority status, he attempted to help her to understand how her difficulties were also a reflection of her internal world, such that she repeatedly perceived the roles of oppressed versus critical oppressor and abandoned versus abandoner in a stereotyped and polarized manner that stunted her relationships and inhibited her development. The therapist noted elements of envy and hostility in Sara's descriptions of her interactions with others and also in the here-and-now interactions with him. Yet from Sara's point of view, these affects always originated in others.

The therapist's efforts to conceptualize the situation centered on three things. First, the fact that Sara was anxious and was flooding him with material, which he experienced as both an effort to control him and yet also a maladroit form of reaching out to him for help.

Second, the fact that every time he spoke up, she disregarded him and spoke over him, suggesting that narcissistic issues—the need to be in control and be powerful and right, and to devalue the other—were more apparent than dependency issues at this stage. Third, the fact that his experience in sessions was often of being mistreated, of being treated rudely, and with no consideration, just as Sara complained she was treated by others. Thus the relational dynamics were quickly present in the transferential arena. An aspect of TFP that is illustrated in this material, and in which we differ from MBT, is attention to working in the transference with the aggressive elements in the representational world. Some of the internal self-object dyads of borderline patients are generally infused with aggressive affects. Although the patient's conscious experience of the dyad is typically to identify the self as the victim of aggression and the other as the aggressor, the whole schema is internalized with, as we see it, an identification with the aggressor as well as the victim. Clinically, as described earlier, one sees repeated oscillation between the roles. The work of therapy includes encouraging awareness of both identifications so that the aggressive affects can be integrated into a more nuanced whole, with the goal of enhancing the patient's capacity to manage his or her aggressive strivings.

MBT rejects the notion of identification with the aggressor. The MBT therapist would not interpret the hostile or destructive element as part of the self. Rather, he or she would hold and contain the projection of the aggressive object with the assumption that as the patient is able to achieve better mentalization of self and other, the sense of the hostile or aggressive other who is persecuting the patient will dissolve. We are aware that the TFP strategy of guiding the patient to take back the projection may temporarily increase the patient's anxiety because it challenges his defensive system of segregating internal parts, but we feel this way of working dynamically with the material can help resolve splitting operations, with the patient taking back his projections and both modulating affects and enriching his internal world with a fuller range of affective coloring and drive mastery.

With Sara, the therapist pursued the strategy of focusing on her affect in the context of her style of interacting, her way of being, with him. In the fourth month of therapy, assuming that what he saw on the surface was defending against material that was split off or dissociated, he made the following intervention:

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"You know, since you are speaking so quickly and often change topics, it's hard to focus on what you say. At this point there might be more important information being communicated in *how* you are saying it—how you are interacting with me. Have you had any thoughts about the way our interaction goes?" [appealing to the patient's reflective function]

Sara angrily replied: "I'm just doing what you told me to do—to say whatever's on my mind. What's your point?"

Therapist: "It's true that I said that, but then our job is to observe what happens then. In most sessions, your way of carrying out seems to be to talk almost nonstop and to talk over me when I speak up. This creates a situation where you seem in control and I am a captive audience. I think it would help to try to understand what feelings or fears may lead you to do that. It's as though you are holding me in the grip of your words. Do you have any thoughts about that?"

Sara: "Now you're proving what I always knew anyway—you're not really interested in what I have to say. Why should I expect anything different? You're white, and you're rich. You just sit here and use me as your guinea pig for your study. You probably say bad things about me behind my back, like everyone else."

The therapist realized that describing the dyad he saw as operant on the surface—that of the controller and the controlled—did not engage the patient's curiosity; however, he noted an alternate dyad revealed in the patient's last comment that might be more directly linked to the affect she was experiencing in the moment. Interventions are most likely to strike a chord if they address the immediate affect. This dyad was that of an indifferent, and critical, caretaker relating to a neglected, disliked child who is longing for caring. The therapist thought the affects related to this dyad—longing, fear of neglect, criticism, and abandonment—might explain the predominance of the controlling/controlled dyad.

Considering both the possible motivation of her controlling behavior and the sense of being neglected that came through the last comment, the therapist said: "We might have the answer to why you behave with me the way you do right here in your last comment. You may be convinced that I'm not interested in you, that I don't care, and that I have a negative opinion of you. You feel that you're always doomed to neglect. Someone who believes that might want to control the interaction for fear that if she weren't in control, she'd be mistreated by the other person or lose him altogether."

Sara replied, bursting into tears: "Of course I'd lose you. Even my parents weren't interested in me, so why should you be?"

Sara's direct expression of affect seemed a first breaking through of her chronic defensive system. Her therapist's making contact with her affect in spite of her defensive pushing him away momentarily broke through her conviction that he was indifferent, neglectful, and critical. His ability to empathize with a part of her which was split off and only obliquely visible suggested that she might be dealing with a different other. This experience confronted her with two possible others: the familiar indifferent, critical, rejecting other and a "new" other who was concerned enough to make the effort to see other aspects of her. In that moment, she seemed to experience a confused combination of connection and wariness, of trust and mistrust. The situation itself, catalyzed by the therapist's empathic comment, was a challenge to her belief system and thus an invitation to reflect—a confrontation in action. This situation marked a beginning of communicating in therapy with a sense of authenticity. Sara was now able to intermittently question her negative beliefs with regard to her therapist and these moments allowed her to consider the possibility of a new object relation—where the other party was not threatening and might even have positive intentions toward her—and thus to interact in a less defensive way.

The therapist pointed out that Sara did not generally allow herself the chance to find out if he was interested in her. By controlling the interaction to create a *semblance* of interest in her, she supported the belief that he was not really interested in her. In the process of this, she devalued him and experienced herself as devalued. He further suggested that while attempting to hold him in her grip, she was actually remaining distant from him, because her monopolizing the interaction did not allow him to be in the room as a full-bodied person. For the first time, there seemed to be a dialogue in the room. Sara became calmer and could acknowledge that she did not allow her therapist to exist in the room and that this was because of her fear that he would treat her badly or leave if she left him to his own devices. As the discussion continued, it became clear that this strategy left her alone in relation to others, a condition she traditionally blamed others for.

After this positive session, Sara returned to treatment with much the same style of interaction that she had presented from the beginning. Her therapist had to return again and again to the interpretation

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of her omnipotent control and the fear it represented. It was only after repeating this interpretation many times, in the context of the therapeutic relationship where Sara questioned her initial convictions, that she could sort out what feelings came from whom. She began to alternate between moments of complaining about how others treated her and noting how she treated others, including her therapist aggressively. She began to talk about her own racism toward whites, an indication of her beginning to take back the projection of an aggressive element.

In a session 2 months later, Sara initially presented with a similar defensive structure, but was able more quickly to reflect on the interaction and consider other perspectives. She began by angrily reporting suicidal ideation and that she had taken a minor overdose. As the therapist tried to understand the affect and the fantasized relationship motivating it, Sara said: "My wanting to kill myself has nothing to do with your going away." [The therapist was to be away the following week]. The therapist pointed out that Sara had made this connection herself and that it must be humiliating to care so much about him when she felt he did not care about her. At that point, Sara became tearful and hid her face in her hands. Her therapist pointed out that it was difficult for her to experience or reveal the longing that she felt, that she was more comfortable expressing rejection of him and anger to avoid the feeling of rejection and humiliation. Sara replied that before the session she had had a fantasy of humiliating him, and added: "I just feel like the tragedy of everything, of all of this, is that I have help available... You're actually working with me....I guess there's a longing in a way, cause I did come on time, I didn't really want to come, but I do long to come here, in a way, I guess I do."

Thus, we see two major interpretive thrusts: One—of her need to control the other as a means of controlling a critical, rejecting part of herself that she experienced as coming from others; and 2—of her difficulty acknowledging her longing for love and caring, that she hid because of her anticipation of rejection and humiliation. Both involved naming a part of the patient that she experienced as other and helping her see it as part of herself. MBT might see this type of intervention as threatening the stability of the self-system by encouraging awareness of a toxic element that the patient could not tolerate. Yet our clinical experience and research data show that patients can work with these interventions when they are done tactfully and lead

to a broadening of the general context of the patient's knowledge of self and others across time.

The work focuses on clarifying what part of the experience comes from the other and what part from the self. Sara begins feeling rejected and humiliated by her therapist's planned absence, while presenting rejecting behavior and describing a fantasy of humiliating him. The exchange between them clarifies that what she has experienced as external is within her. This shift from a chronic defensive belligerent stance toward others can be understood in relation to Sara's having begun to take back and metabolize the negative affects she had consistently projected onto others. Her initial psychological structure was based on a primitive separation of positive and negative affects. Her baseline assumption that others would treat her badly and eventually leave both led to a chronic effort to control others that engendered negative affects, and also allowed her to experience and express her own negative/aggressive affects as though they were a justifiable, acceptable, and even good response to the mistreatment by others. Her therapist's approach was to ask her to reflect on this system as it played out between her and him. Did she notice that she was controlling of him in sessions? What view of him, and her, might lead to this chronic behavior? This line of inquiry and interpretation allowed movement beyond the chronic defensive position to the experience and discussion of positive affects that were concealed, and thus protected, by the assumptions of the defensive position.

Interpreting the patient's use of omnipotent control in the first year of therapy helped the patient observe and understand this behavior, free herself from it and enter more deeply into other themes that it had been defending against. With the help of her therapist, Sara began to reflect on the theme of being criticized and attacked by others, and how it might defend against longing for closeness. Interpretations at that point addressed Sara's projection of an internal critical part in her mind—a part that could be aimed at herself or at others. With the therapeutic dialogue more established, Sara could begin to see what her therapist had tried to point out at the beginning: that she was capable of treating others as she complained they treated her. She became more aware of an angry critical part of herself that she experienced as residing in others but that both resided in herself and was directed at herself.

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In her external life, Sara's complaints of mistreatment decreased. She began to report less anxiety and more positive interactions in her work setting, where she was offered a paid position. With regard to her initially split-off libidinal strivings, Sara's discourse and behavior in therapy began to give evidence of positive, loving feelings. With regard to intimate and sexual relations as they evolved in the course of treatment, in the period of time when Sara was still under the influence of primitive defense mechanisms—omnipotent control and projective identification—she was attracted to a narcissistic, unavailable man into whom she had deposited her critical judgmental part. After these defenses began to give way to more mature ones, she became involved with and eventually married (after 3 years of therapy) a more appropriate man.

The evaluation of the AAI after a year of therapy revealed that this patient advanced from a reflective functioning score of minus one (–1) to a score of 6 by the end of the first year of therapy, which shows not only clear and coherent evidence that she understands the mental functioning of self and others, but also some marked and original formulations of mental states. A fuller discussion of her RF and attachment classification ratings and their relation to the clinical course will be available in a forthcoming paper (Kernberg, Diamond, Yeomans, Clarkin, & Levy, in preparation).

In summary, we share Fonagy's view that a most difficult aspect of therapy is helping the patient resolve the externalization of unbearable self-states. Our clinical vignette presents an approach to this challenge in which engaging the patient's reflective capacity and interpreting the function of maladaptive defenses go hand-in-hand. Clarification, confrontation, and interpretation of affects and attributions in the here-and-now enhance the patient's reflective capacity by helping the patient consider the externalized material and reflect on its source. Acknowledgment of some measure of this material opens the way for integration and mastery of what had previously seemed external and immutable. Mentalization, the ability to reflect on heretofore irreconcilable internal conflicts of self and other representations, may both contribute to the process of integration and be furthered by that process. As projections are accepted internally, they become part of a richer appreciation of self and others which in turn increases the capacity to reflect on internal states.

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