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Chapter 6

Mentalization and Attachment in Borderline Patients in Transference Focused Psychotherapy

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INTRODUCTION

Mentalization, or the capacity to think in terms of intentional mental states of self and other, is at the basis of human interpretive capacities, and as such it has been identified as both a major goal of treatment and a key mechanism of change in psychodynamic psychotherapy with borderline patients (Bateman & Fonagy, 2004a, 2004b; Levy, Clarkin, et al., 2006; Yeomans, Clarkin, Diamond, & Levy, in press). More specifically, mentalization refers to recognition that the mind is representational in nature, and that "what is in the mind is in the mind, and reflects knowledge of one's own and the other's mental states" (Bateman & Fonagy, 2004b, p. 36). Fonagy and his colleagues (Fonagy, Gergely, Jurist, & Target, 2002) have linked mentalization to an Interpersonal Interpretive Mechanism (IIM), which is a fundamental aspect of the evolutionary selective advantage of the attachment behavioral system. This mechanism, which involves the capacity for psychological interpretation—that is, the ability to make sense of the beliefs and desires that motivate human behavior, to distinguish psychological states of self and other, to create meanings, and to enrich symbolic thinking—is thought

to be deficient in patients with severe personality disorders. These theoretical formulations are supported by an impressive body of developmental and clinical research (Fonagy et al., 2002) that suggests that deficits in mentalization—which are developed in the context of insecure attachment relationships, often characterized by early unresolved trauma—is an enduring characteristic of borderline pathology (Fonagy et al., 2002). The development of the capacity for mentalization in the context of a secure attachment relationship with the therapist, leading to increased coherence, integration, and modulation in the representational world, has become the hallmark of psychodynamic approaches to treatment of severe personality disorders (Bateman & Fonagy, 2004a; Fonagy, 1999; Kernberg, 2004a). In this paper we will review and critique the concept of mentalization as it is applied to the theory and treatment of patients with severe personality disorders from the vantage point of object relations theory, particularly Kernberg's object relations model.

Finding the most effective methods of treating this group of patients, who are characterized by chronic suicidal and parasuicidal behaviors; identity diffusion; dissociative states that may or may not be linked to early trauma (Paris, 1994); chaotic, unstable interpersonal relationships; affective volatility and impulsivity; impaired occupational functioning; and overutilization of health services (see Clarkin, Foelsch, Levy, Hull, Delaney, & Kernberg, 2001), has become increasingly important as borderline patients have become more prevalent among both inpatient and outpatient groups. Patients with borderline personality disorder now characterize 1–4% of the general population, 10–15% of psychiatric outpatients, and up to 20% of psychiatric inpatients (Lenzenweger, Loranger, Korfine, & Neff, 1997; Paris, 1999; Torgersen, Kringlen, & Cramer, 2001; Weissman, 1993). In keeping with the increased emphasis on the development and implementation of empirically validated treatments, investigations of borderline patients and their treatment have moved beyond theoretical elaborations about the nature of the pathology itself to the development of evidence-based treatment approaches that can be manualized and assessed for efficacy and outcome.

In the psychodynamic realm, the two major manualized treatments for BPD are Transference Focused Psychotherapy (TFP, Clarkin, Yeomans, & Kernberg, 1999, 2006) based on Kernberg's (1984) object relations model, and Mentalization Based Treatment (MBT, Bateman & Fonagy, 2004a),

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based on Fonagy and colleagues' (Fonagy et al., 2002) developmental theory of mentalization, which integrates philosophy (theory of mind), ego psychology, and attachment theory. In the cognitive behavioral realm the major approach is Linehan's (1993) Dialectical Behavior Therapy (DBT), which integrates cognitive behavioral theory with dialectical philosophy and Buddhist principles of mindfulness. All three groups have developed theoretically consistent, evidence-based, comprehensive treatment programs for BPD that have demonstrated efficacy in reducing symptomatology, service utilization, and suicidality in borderline patients (Bateman & Fonagy, 1999, 2001, 2003, 2004a; Clarkin & Levy, 2003; Levy, Meehan, et al., 2006; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Kanter, & Comtois, 1993, Linehan et al., 2006).

Bateman and Fonagy (2004b) have proposed that all effective treatments for BPD are built, in part, on implicit and explicit mentalization, with the former referring to the largely unconscious, procedural mental activity that has its roots in nonverbal mirroring transactions, and the latter referring to relatively conscious intentional reflective processes involved in contemplating the mental states of self and others (Allen, 2003). The concept of mentalization has been operationalized in the Reflective Function (RF) scale (Fonagy, Target, Steele, & Steele, 1997), an attachment-based measure of mentalization, which provides us with a tool to evaluate changes in the capacity to think in mental-state terms over the course of treatment (Diamond, Stovall-McClough, Clarkin, & Levy, 2003; Levy, Meehan, et al., 2006). To date, however, TFP is the only therapeutic modality that has been empirically associated with improvements in the capacity for mentalization as assessed by increases in RF ratings over the course of one year of treatment (Levy, Meehan, et al., 2006; see summary of research below).

In previous publications, we delineated the specific treatment techniques that we believe lead to improvements in the capacity for mentalization for borderline patients in TFP, with a focus on the role of the treatment frame and on the techniques of clarification, confrontation, and particularly interpretation (Levy, Clarkin, et al., 2006). In this paper we will discuss more fully our interpretive approach and its relationship to implicit and explicit mentalization. We first delineate some of the points of contact and divergence between TFP and MBT, and provide a more detailed overview of TFP and its theoretical foundations. Next we summarize recent

research findings from three studies on the efficacy of TFP, which examine changes in attachment status, reflective function, and symptomatology in borderline patients over the course of one-year, twice-weekly TFP treatment. Finally, we present case material to illustrate our general outcome data, as well as data on reflective functioning (RF) as a mechanism of change in TFP, and discuss how our research and clinical investigations have led to an expansion of the concept of mentalization.

MBT AND TFP: COMMON GROUND AND CONTROVERSIES

The concept of mentalization as developed by Fonagy and colleagues, which emphasizes the cognitive aspects of the structuralization of the representational world, is complementary to the object relations foundations of TFP (Kernberg, 2004a). Improvements in the capacity for mentalization are thought by both approaches to go hand in hand with the capacity to develop fuller and more elaborated representations of the self and internal objects (Fonagy, 1999; Kernberg, 2004a). As Fonagy (1999) has observed, "enhanced reflective capacity allows patients to integrate split off parts of the self and create representations with complex thoughts, mixed emotions and differentiated desires" (p. 16). Further, the perspectives of TFP and MBT converge around the idea that changes in mentalization are catalyzed through the here-and-now experiences with the therapist rather than through excavation and exploration of past experiences. However, there are fundamental differences between the two approaches in the following areas: (a) the etiology of borderline disorders; (b) the centrality of affect; (c) the type and function of interpretation; and (d) the nature of the internal world.

THE ETIOLOGY OF BORDERLINE PATHOLOGY

Fonagy and his colleagues have made fundamental contributions to understanding borderline psychopathology by linking it with insecure attachment, and by articulating the basic mechanisms of early parent–infant interactions, including contingent marked mirroring in infancy, pretend play in early childhood, and talk about mental states in later childhood—

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all of which are thought to consolidate the development of secure attachment relationships, setting the foundation for mentalization (Allen, 2003). Our research investigations, along with those of Fonagy and colleagues, suggest that the majority of borderline patients are characterized by insecure and/or disorganized states of mind with respect to attachment, with the latter involving lack of resolution of early traumatic experiences (Diamond et al., 2003; Fonagy et al., 1996; Levy, Meehan, et al., 2006. According to Fonagy and colleagues, borderline patients inhibit their capacity to comprehend the mental states, motivations, wishes, feelings, and thoughts that govern behavior—their own and that of others—either (a) as a defensive reaction to severe chronic abuse and/or neglect, which protects them from contemplating the frightening and heinous intentions of those who abused them; or (b) as a deficit resulting from early pathogenic, unmarked, and noncontingent interactions in which the caregiver either fails to accurately and empathically recognize the child's mental states, or imposes her own mental states on those of the child. In either case the child is left with a legacy of overwhelming unmentalized psychic experiences and/or boundary confusion (Fonagy et al., 2002). As a result of either scenario, the individual shuts down the capacity to think in multifaceted or complex ways about the mental states of self and other, and instead splits the internal world into rigidly idealized and persecutory sectors.

These formulations advance our understanding of the etiology of borderline disorders in expanding the role of trauma into the realm of problematic early attachment relationships. There are now a number of studies that have shown that early attachment traumata and especially physical, psychological, and sexual abuse, are significantly more prevalent in patients with severe personality disorders than in patients with milder personality pathology or the general population (Paris, 1994). However, there is also increasing evidence that irregularities of the neurochemical and neurohormonal systems function as inborn dispositions to levels of intensity, rhythm, and threshold for affective response, and particularly to negative affect, leading to aggressive and uncontrolled behavior (Kernberg, 2004a; Stone, 1993). Our model of borderline pathology posits a dynamic interaction of temperament—especially a preponderance of negative affect over positive affect and low, effortful control—with the absence of a coherent sense of

self and others, under the influence of an insecure working model of attachment (Depue & Lenzenweger, 2005; Clarkin & Posner, 2005; Posner et al., 2003). While we take into account the etiological role of trauma, including trauma deriving from insecure/disorganized attachment, the emphasis of our treatment is on the ways in which trauma contributes to configuring the internal representational world. Fonagy and colleagues acknowledge that, for borderline patients, representations of self and others are imbued with rageful or idealizing affects that are not amenable either to reflection or modulation (Fonagy, 1999). Although these researchers highlight the contributions of deficits in affect regulation, they tend to play down the centrality of negative affect and difficulties with its regulation—which they attribute almost solely to deficits in mentalization—to the etiology of borderline disorders. (We will expand on our understanding of the etiology of BPD below.)

THE CENTRALITY OF AFFECT

In our view, mentalization encompasses not only a set of cognitive functions, such as representing and reasoning about beliefs and desires of self and others, but also the capacity to represent and regulate affects, to signify the subjective aspects of affects, and to connect affects with their representational roots. Kernberg's (2004a) object relations model offers a comprehensive theory of the development of the capacity to symbolize and regulate affect, and of the complex processes through which the concepts of self and other evolve out of early affective experiences. These are all crucial aspects of the process of mentalization that have been perhaps under-theorized given the emphasis on mentalization as a set of cognitive skills and processes linked to theory of mind. In emphasizing the affective roots of mentalization we are contributing to a trend to propel the concept of mentalization (and the theory of mind with which it is linked) beyond the cognitive sphere into the affective realm by focusing on how young children's efforts to manage and comprehend the feelings of self and others provide pathways to understanding of mental states (Carpendale & Lewis, 2004; Fonagy, in press; Gergely & Unoka, in press; Thompson, Laible, & Ontai, 2003). However, despite this recent emphasis on the role of affect activation and modulation in the development of mentalization,

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the focus of Fonagy and colleagues is on the immediate interpersonal processes that are at the basis of mentalizing capacities, rather than on the building up of complex object relationships that structure and modulate affect activation and hence contribute to mentalization. The one exception to this trend is the work of Jurist (Fonagy et al., 2002; Jurist, 2005) on "mentalized affectivity," which integrates Kernberg's object relations theory with the theory of mentalization. Jurist (2005) defines mentalized affectivity as an "exploration of how our affective experience is mediated by the representational world—in other words how current (and future) affects are experienced through the lens of past experiences, both real and imagined" (p. 429). Thus, mentalized affectivity involves the capacity to recognize, understand, and regulate the self's affective states.

Kernberg's object relations model sees affects as the primary psychophysiological dispositions that are activated by early bodily experiences in the context of the development of object relations. Affects become linked with self and object representations in elementary dyads as highly pleasurable and unpleasurable experiences accrue in the course of early development, and come to form in their supraordinate organization the building blocks for libidinal and aggressive drives, while the representation of self and objects eventually evolves into the more complex tripartite structure (ego, id, and superego). In Kernberg's view, then, primitive affects constitute a primary motivational system that integrates cognitive appraisal of the momentary experiences of gratification or frustration with the subjective experience of pleasure or unpleasure in the context of particular object relations. Affects, which are activated by crucial and distinctive patterns of facial expressions in early mirroring exchanges between infant and caregiver that serve a communicative function (Kernberg, 2004a), thus include a cognitive component, as well as a subjective component of pleasure and unpleasure, along with psychomotor activation and neurovegetative discharge phenomena. Thus, the early activation of affects in the context of the mother–infant relationship serves simultaneously to trigger and consolidate the attachment behavioral system and to build up the internalized world of object relations, so that these two spheres are inevitably linked although not synonymous. Further, the early affective exchanges set the foundation for mentalization since in the course of development each momentary activation of a dyadic relation between self and object contributes to and is

then confronted by a more permanent integrated view of self and others against which the momentary state can be evaluated.

From an object relations perspective, then, affects are the primary vehicles that give rise to primary representations (Kernberg, 2004a; Sandler & Sandler, 1998). The movement from primary to secondary representations involves a cognitive framing of affect that contributes to the building up of self and object representations. Through the process of marked and contingent mirroring transactions, which facilitate affect regulation and shape the infant's experience of internal and external reality, primary representations are transformed into secondary representations characterized by more realistic models of self and significant others that are gradually consolidated into a stable, overarching concept of self and object. In the treatment of severely disturbed patients, interpretation contributes to a move from primary to secondary representations, with a concomitant modulation and integration of affective states. In Bion's (1962, 1967, 1970) terms, interpretation functions as "an apparatus for thinking" that serves the purpose of transforming "beta elements" into "alpha elements." The object relations approach in TFP involves working directly with affect through interpretation as it is mobilized in the transference. By contrast, Bateman & Fonagy (2004a) believe that mentalization is most likely to be enhanced when affect is quiescent, and when the attachment behavioral system with its associated affects is not activated.

INTERPRETATIVE ACTIVITY AND MENTALIZATION

The focus on interpretation differentiates TFP from both MBT and the cognitive behavioral approach of Linehan (1993). Bateman (Bateman & Fonagy 2004a, 2004b) has proposed that interpretation is at the heart of all psychodynamic treatments for borderline patients. However, he and his colleagues have stipulated that even in interpretive therapies such as TFP, the mutative factor in the treatment is not the specific content of interpretations, but the process of engaging the patient in the contemplation of his or her own mental states and those of the therapist. Furthermore, MBT advises against interpretation except in advanced stages of therapy.

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chodynamic treatment with borderline patients (Bateman & Fonagy, 2004a; Kernberg, 2004a), TFP does not limit its focus to improving mentalization as defined by Bateman and Fonagy (2004a). Rather, our interpretive approach focuses first on clarifying and understanding the conscious mental states experienced in the moment and moves gradually toward the exploration of mental states that are split off, denied, and/or repressed. We now turn to a more detailed explication of TFP to further clarify the relationship between our conceptualizations of BPD and of the roles of interpretation, affect, and mentalization in TFP treatment.

TRANSFERENCE FOCUSED PSYCHOTHERAPY (TFP)

TFP is based on an understanding of borderline personality that combines psychoanalytic (object relations) concepts of the structural organization of personality, especially the concept of the split internal world and identity diffusion (Kernberg, 1984, 2004b, 2006), and ideas of interaction between behavior and neurobiological variables, as delineated above. TFP is based on the idea that early affective experiences are cumulatively internalized in the course of development, and become established in the psychological structure as "object relations dyads"—units that combine a specific representation of the self in relation to a specific representation of the other linked by a specific affect. These dyads are not exact, accurate representations of early experience, but rather reflect the complex mesh of fantasy, drive, affect, wishes, and conflicts that are evoked in interactions with primary attachment figures in early development, as well as the activation of defenses and their adaptive or distorting influence (Diamond & Blatt, 1994; Kernberg, 1980, 2004a).

In borderline individuals, as development proceeds, these separate dyads do not become integrated into unified or mature concepts of self and of others, as is the case in normal psychological development. Instead, dyads associated with sharply divergent affects (e.g., idealized and persecutory) exist in polarized and chaotic relation to one another, and determine the lack of continuity of the borderline patient's subjective experience of self and others. Furthermore, different dyads may be closer to conscious awareness than others, so that, for example, aggressively laden dyads may form a defensive configuration to protect the individual from awareness of more loving, gratifying representations of self and other, or vice versa.

While the patient has little conscious awareness of this split internal world, this structure underlies the symptoms of borderline personality such as chaos in interpersonal relations, emotional lability, black-and-white thinking, inchoate anger, contradictory behaviors, and proneness to lapses in reality testing.

TFP focuses on the transference because the patient lives out his or her predominant object relations dyads in the transference, as in other relationships. For the borderline patient, splitting leads to instability of the internal world, with chaotic alternating identifications with positive and negative, and idealized and persecutory representations or sectors of experience. The core tasks in TFP are to establish a stable relational context, to identify the patient's predominant internal object relations dyads, and to help him or her observe, modulate, and integrate the split sectors of experience into unified coherent representations of self and other. The therapist's task is to listen to the three channels of communication—the verbal, nonverbal, and countertranferential—and first translate enactments and somatization (nonverbal channels through which borderline patients typically find affective expression without conscious awareness) into the corresponding affects, and then elaborate self and object representations that underlie the affect. As treatment proceeds, these dominant object relations are identified, and the roles of self and object are observed to repeat and reverse multiple times, as well as to appear alongside other dyads.

Hence, as treatment proceeds multiple sets of split-off object relations dyads that are derived from a number of behavioral systems emerge in the transference. These dyads' impulsive or defensive functions must be systematically interpreted in order to be worked through. The combination of understanding and affective experience in the therapy leads to the modulation and integration of the split-off persecutory and gratifying representations, and the creation of an integrated identity and experience of others. By interpreting how the patient is experiencing the interaction at any given moment, and how the patient oscillates between identifying with the self and object aspects of the dyad, the therapist also introduces the observing third. Close monitoring of the countertransference, along with consistent attention to the multiple transference manifestations, fosters a split in the therapist in that one part of the therapist is a full participant in the affective

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The nature and content of the interpretive process in TFP depends not only on the patient's stage of treatment, but also on his or her individual characteristics, including attachment status and capacity for mentalization, as well on the dynamics of the particular patient–therapist dyad. In the early stages of treatment, clarification and confrontation of split-off self and object representations predominate. The technique of clarification consists of the therapist's inviting the patient to expand his representation of present feeling states or other material, with the goal of becoming more aware of self states and the perceptions of the other in the moment. After clarification of the patient's appreciation of the experience of self and other in the moment, the therapist uses the technique of confrontation to bring attention to contradictions or inconsistencies in the patient's communication. These may be either within the patient's verbal communication, comparing what he expressed at two different points in time, or between the verbal and nonverbal channels of communication at one moment in time. The therapist engages the patient in reflecting on these inconsistencies.

The formulations of Fonagy and colleagues have led us to expand our conceptualization and application of the technique of clarification. For example, in the case of patients who present with psychic deadness and severe affective constriction, or with severe history of trauma, a prolonged phase focusing on the identification, differentiation, and exploration of affect at the verbal and nonverbal level may be necessary. These techniques set the stage for early interpretations that deal with material that is generally conscious or preconscious, with interpretation of unconscious material coming into play only when the patient shows the capacity to make use of it.

TFP thus involves a stepwise interpretive process in which the therapist moves gradually from clarification and confrontation in the early stages to increasingly complex and multifaceted interpretations in the later stages. In the first phase of the interpretative process, interventions tend to be therapist- or analyst-centered (Steiner, 2002) in that they function to identify and articulate the patient's often polarized and inchoate experience of the therapist at any given moment, without exploring it. Such therapist-centered interpretations function to provide cognitive containment for primitive

affects that may be elicited as archaic split object relations are activated in the transference. The second phase involves identification of the dominant object relational dyads that are activated in the transference relationship, and of the role reversals that occur as the patient alternately identifies with the self and object aspects of the particular object relation. The concept of the patient ultimately identifying with the entire object relationship rather than just one pole of it is central to TFP. The third phase involves the integration of the split-off, idealized, and persecutory sectors of experience as they emerge in the here-and-now of the transference, and interpretation of how consciously held and prominent object relational dyads may defend against split-off material represented by other dyads (e.g., the aggression-laden dyads defending against gratifying or libidinal dyads). Finally, in the fourth stage object relational dyads and primitive defensive operations that emerge in the transference are linked to unconscious motivations, conflicts, and anxieties, and/or are placed in the context of past relationships. The interpretative process outlined above is epigenetic in nature, but involves repeated cycles involving different levels of interpretation adjusted to the patient's progress toward integration or movement away from it.

Although we believe that the more complex and advanced interpretations are an essential ingredient for integration of the internal world and the resolution of identity diffusion, we also hold to the idea that interpretation of any sort for borderline patients whose primary defense is splitting must deal with conscious self-states that are experienced sequentially in a fragmented way or dissociated. It is only in the later stages of treatment, when the patient's primitive defenses have shifted to more mature ones, and in the context of a more consolidated identity, that interpretation deals with assumed unconscious states and motivations. The focus on unconscious meanings in the here-and-now in the arena of the transference follows Sandler & Sandler's (1987) idea that analysis of "the present unconscious" provides a route to the unconscious template reflecting "the past unconscious." That interpretations of split-off material are made primarily as this material emerges in the arena of the transference insures that they will have immediate affective resonance and that the treatment will not be derailed into intellectual speculation or pseudo-collaboration on the part of the patient. Through systematic attention to the transference, there is a "gradual transformation of pathological character patterns into an emotional experi-

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ence and self reflection in the transference" (Kernberg, 2004a, p. 126). The therapist's interpretation of the patient's direct affective experience of the therapeutic relationship is viewed as the route to increased integration of the representational world, to the shift from insecure to secure attachment, and to improvements in the capacity for mentalization.

Our interpretative approach is based on the idea that the symbolic function is not totally deficient in borderline patients, most of whom have preserved reality testing and the capacity for abstraction under most circumstances, and are thus able to symbolize except under conditions of intense affect, when symbolization may deteriorate defensively. In our view, symbolization is a cognitive function that does not depend on object relations alone although it is certainly fostered by it. These formulations differ somewhat from those of Fonagy and colleagues, who have hypothesized that borderline patients are inherently deficient in the capacity for symbolization as well as mentalization, and that they therefore are not amenable to an interpretive approach until late in the treatment. According to Fonagy and colleagues, the thinking of borderline patients remains either concrete, functional, and overly attuned to external reality with little capacity to elaborate a separate internal world (psychic equivalence), or, most often, sequestered in a mode of idiosyncratic fantasy (the pretend mode) leading in extreme forms to a sphere of dissociated experience and thinking (Target & Fonagy, 1996). While such formulations enhance our understanding of the developmental underpinnings of borderline disorders, they do not take into account that, even for borderline patients, the fantasy world in the transitional state may be in fact intensely invested emotionally, and that this enlivens rather than deadens the therapeutic interactions.

The question has been raised about whether interpretations of self-object affect dyads as they are mobilized in the transference are beyond the reflective capacities of borderline patients through the initial and mid phases of treatment (Bateman & Fonagy, 2004b; Gabbard, 2006; Gabbard, Horwitz, Allen, Frieswyk, Newsom, et al., 1994). One concern is that if the therapist talks about complex mental states in interpretive work before the later stages of treatment, there will be a pseudo-agreement on the part of the patient without insight or scrutiny; mentalization may appear to improve but it does not lead to changes in behavior or in external relationships. We view such

a therapeutic process as the result of badly formulated or poorly timed interpretations. While there are certainly individual differences in the ways borderline patients respond to interpretations at different stages of the treatment— which necessitate a flexible, stepwise interpretative approach as outlined above—our research investigations have shown substantial improvements in borderline patients' capacity for mentalization (as measured by the RF scale), as well as in psychosocial functioning and symptomatology, in the interpretive climate of TFP (see summary of research below).

In TFP the therapist's interpretations of self-object affect dyads as they are activated and expressed in the transference in frequent role reversals are designed to present patients with split-off experiences as they emerge in the transferential situation, leading to increased tolerance of contradictory affects and identifications and an expanded capacity to take mulitiple and diverse perspectives on self and others, and in this way help the patient to acquire a deeper sense of mental states of self and others. This in turn makes the patient more capable of making use of transitional phenomena or transitional modes of relatedness in which internal and external experience are both linked and differentiated. It is important to note that Fonagy and Target (1996) have stipulated that psychoanalytically oriented treatment and psychoanalytic interpretation take place in the pretend mode: "Psychoanalysis is in many respects a 'pretend' experience. Play is essential to it, just as it is essential to our psychoanalytic model of the developing mind. Analyst and patient discuss fantasies, feelings and ideas they 'know' at the same time to be false" (p. 459). While this statement applies to psychoanalytic treatment, it is also in our view applicable to the psychoanalytic psychotherapy of borderline patients, who—in the interpretive climate of TFP—develop, in conjunction with the capacity for mentalization, a tolerance of fantasy and the opening of the transitional space that enables them to understand and play with interpersonal distortions as they emerge in the transference (Clarkin, Yeomans, & Kernberg, 2006).

INTERPRETIVE ACTIVITY AND THE ALIEN SELF

The object relations approach in TFP also has implications for understanding Fonagy and colleagues' (Fonagy et al., 2002) concept of the alien self, defined as an "internalized other" that is "unconnected to the structures of

the constitutional self" (Fonagy et al., 200
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is neither contingent nor marked, but ratl
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ND THE ALIEN SELF

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l., 2002) concept of the alien self,
"unconnected to the structures of

the constitutional self" (Fonagy et al., 2002, p. 358). The alien self represents a self-state that develops in situations when the caregiver's mirroring is neither contingent nor marked, but rather represents the imposition of his or her own self-states onto the child. In such situations, instead of developing a second-order or symbolic representation of his or her own affective states, the child internalizes an alien representation that does not correspond to the constitutional self, is experienced as persecutory, and that thus must be repeatedly externalized or projected onto others in the interest of self stabilization.

From our point of view, what Fonagy calls the alien self is really a composite structure consisting of a highly fantastic, primitive self and a correspondent object representation. In the language of TFP, the alien self is conceptualized as a split-off object relation of a highly negative sort, which coexists with an opposite, highly positive object relation representing a defensive and covering attitude of idealization. In other words, we think the "alien self" concept encapsulates a specific relationship framed by a particular affect state. This alien object relation is split off and activated not just as an alien self, but as an alien self relating to an alien object or bad internal object. The patient will alternatively identify with both while projecting the corresponding other onto the therapist. Thus, transference evokes not just an alien self, but an alien object relation with a constituent self and self representations controlled and distorted by severely negative affect. In our view, it is typical for borderline patients to alternately behave as the alien self, or see the therapist as an alien self; whether they enact it or project it, they are in a complementary role. Through our technique, which fosters the bringing together of split-off experiences, the alien self and its corresponding objects are transformed into self, and respectively, object representations that can be integrated with their opposite. This permits the modulation of affect, particularly the mastery and sublimation of aggressive affects, and the strengthening of cognitive functions, including the beginning of reflective function. (See case illustration for an example.)

In contrast, Fonagy and colleagues stipulate that the emotional truth and valence of the alien self, as an element that colonizes rather than is part of the patient's internal world, must be acknowledged and accepted by the therapist who is in the position of carrying this projection. Accordingly,

the therapist's task is to gently question the patient's misperception of the therapist in ways that clarify and validate the perception, while offering an alternative view of the therapist's intentions in the interests of containing and ultimately dissolving the alien self. We agree that clarification of the alien self—or rather, of the object relation that it represents—is the first step. However, in our view, if one tries to dissolve the alien self through containment and other supportive techniques with the assumption that improved mentalization will move the patient beyond it, then one may be neglecting the splitting mechanisms that underlie and characterize the alien self and that may in fact drive conflict into a deeper, less-accessible level.

Finally, according to Fonagy and colleagues, in borderline patients who have experienced trauma, the interpretation of the transference may actually stimulate states of arousal (in both the prefrontal and posterior cortical and subcortical systems) such that the individual shuts down mentalization in the face of increased activation of attachment via the transference. In such cases, interpretations are thought to range from being useless to harmful (Bateman & Fonagy, 2004a). We agree that in such situations—as always—interpretations must be tailored to the patient's capacity to work with them productively. However, the work of LeDoux (1996, 2002) points to the importance of interpretation for the ultimate resolution of trauma. There is neurophysiological evidence that the emotional charge associated with experiences, stored subcortically, cannot change without cortical involvement (LeDoux, 1996, 2002); therefore, a therapy that uses the transference and thus brings such implicit structures into play in an emotionally meaningful way, and utilizes cortical techniques such as transference interpretations, seems not only desirable but arguably a critical component of therapeutic action in the context of trauma.

RESEARCH INVESTIGATIONS

In developing an object relations outpatient treatment for patients with borderline personality disorder, we have systematically followed the steps of treatment development (Kazdin, 2001), including (a) describing the treatment in a manual; (b) investigating the impact of the therapeutic approach on a small group of patients; (c) comparing the clinical progression of these

individual treatments to a comparison group that r
in the clinic; and finally (d) comparing TFP to o
for these patients over a one-year period. For sev
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Encouraged by the positive results of our init
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effect sizes, we embarked upon a randomized cl
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We were also interested in examining the
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For these investigations, we used the reflective
attachment-based index of mentalization obtai
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individual treatments to a comparison group that received treatment as usual in the clinic; and finally (d) comparing TFP to other plausible treatments for these patients over a one-year period. For several years we videotaped sessions with borderline patients conducted by senior clinicians in our group, and gradually developed our principles of treatment that are explicated in a treatment manual (Clarkin, Yeomans, & Kernberg, 1999, 2006). This process of developing and refining the manual, along with the initial empirical investigations, has been has been delineated in detail elsewhere (Clarkin, Levy, & Schiavi, 2005).

Encouraged by the positive results of our initial studies of TFP (Clarkin et al., 2001; Levy, Clarkin, Foelsch, & Kernberg, 2004), which showed large effect sizes, we embarked upon a randomized clinical trial (RCT) of TFP (Clarkin, Levy, Lenzenweger, & Kernberg, 2004, 2007), in which borderline patients were randomly assigned to one-year ambulatory treatment with TFP, DBT, or a psychodynamic supportive treatment. This RCT of psychotherapy of BPD patients, which was funded by the Borderline Research Foundation (O. Kernberg and J. Clarkin, Co-PIs) and NIMH (K. Levy, PI), is unique in a number of ways. Perhaps most importantly, we examined not only symptom change, emphasized in most studies, but also changes in the organization of the personality as reflected in such domains as mentalization (reflective functioning) and identity.

Preliminary results indicate that patients in all three treatments showed significant clinical change in many domains at the end of one year of treatment, including diminution of depression and anxiety and improved psychosocial or interpersonal functioning (Clarkin, Levy, Lenzenweger, & Kernberg, 2007). Patients in both TFP and DBT fared significantly better in the domain of suicidality, while only patients in TFP showed a marked diminution of factors related to aggression such as impulsivity and verbal and direct assault (Clarkin et al., 2007).

We were also interested in examining the mechanisms of change; that is, how does TFP bring about change, as compared to the other treatments? For these investigations, we used the reflective functioning score (RF), an attachment-based index of mentalization obtained from the Adult Attachment Interview (AAI, George, Kaplan, & Main, 1998) given prior to and after one year of treatment for patients in all treatment conditions. The AAI

(George, Kaplan, & Main, 1998) is a semistructured interview designed to assess the individual's state of mind with respect to early attachment relationships and experiences. It provides an index to attachment representations of self and others. Interviews are classified into one of five attachment categories: secure, preoccupied, dismissing, unresolved for loss and trauma, and cannot classify (Main & Goldwyn, 1998). Interviews are also rated for Reflective Function (Fonagy et al., 1997) on the 11-point RF scale, which ranges from −1, or active repudiation or bizarre formulations of mental states, to 9, or the formulation of unusual, highly elaborated, original, and multifaceted depictions of mental states of self and others, with a midpoint of 5, which shows a clear, explicit (if somewhat ordinary) capacity to think in mental state terms. After one year of treatment, RF increased significantly in a positive direction for the patients in the TFP group, but did not change for patients either in the DBT or the supportive treatment groups (Levy, Meehan et al., 2006). In addition, patients in all three groups improved in the coherence of their narratives about early attachment experiences on the AAI, although the TFP group improved the most, with scores after one year in the near average range (Main & Goldwyn, 1998). We will now turn from this global picture of overall group effects to examine specific clinical aspects of one case.

CLINICAL ILLUSTRATION OF IMPROVEMENT IN MENTALIZATION: THE CASE OF SARA

Sara, a single, unemployed Asian-American woman, started TFP at age 36 after many years in other treatments. Her condition had worsened to the point where she spent the six months prior to beginning TFP isolated in her apartment, lying in bed with chronic suicidal ideation, binge eating, and only rarely bathing. Sara was the middle of three daughters in an upper middle class family. Although Sara described her father as emotionally absent and preoccupied with his legal career, she also experienced him as obsessed with his children's educational performance to the point of abusing them verbally and sometimes physically if they did not perform up to expectations. She described her mother as an emotionally unstable woman whose frequent panic attacks made her unable to consistently care for her children. The patient dropped out of college and then held a series of jobs, but was repeatedly fired because of interpersonal difficulties that often

involved her perception of others as hostile or nega
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being hired. The patient understood her conflictual
as the result solely of racial discrimination. She had
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limited history of overt self-destructiveness, cuttin
on occasion, but had persistent wishes to kill herse
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der. She had been on many medications, all of wh
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In the research evaluation, she met criteria n
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involved her perception of others as hostile or negative toward her. She stopped working when news of her belligerent character kept her from being hired. The patient understood her conflictual relations with others as the result solely of racial discrimination. She 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, cutting herself superficially on occasion, but had persistent wishes to kill herself. She had had three psychiatric hospitalizations and had been diagnosed with bipolar disorder. She had been on many medications, all of which were discontinued during the first year of TFP.

In the research evaluation, she met criteria not only for borderline personality disorder, but also for narcissistic and avoidant personality disorders on the International Personality Disorders Examination (IPDE, Loranger, 1999; Loranger, Sartorius, Andreoli, & Berger, 1994), and she met SCID-I (First, Gibbon, Spitzer, & Williams, 1996) criteria for current dysthymia. Her reflective functioning (RF) score prior to the initiation of treatment was minus one (−1), indicating that she actively repudiated any consideration of mental states of self and other, and showed cognitive disorganization and confusion in the face of questions designed to elicit reflection on mental states. In the few instances in which she spoke in RF terms, she gave unintegrated and bizarre responses. On the Adult Attachment Interview (AAI) she showed contradictory and inconsistent states of mind with respect to attachment, shifting chaotically between dismissive devaluation of early attachment figures, and angry preoccupation with parental objects with whom she was emotionally entangled, leading to an attachment classification of Cannot Classify, with mixed Preoccupied and Dismissing states of mind (CC/E2/D2). Finally on the Inventory of Personality Organization (IPO) (Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001), she scored very high on identity diffusion, and high on primitive defenses, compromised reality testing, and aggression.

From the first session, Sara's interactions with her therapist were characterized by a nonstop monologue that blocked his participation in the therapy. If he tried to speak, she spoke over him. His first interventions consisted of clarification of this self-state. In the initial sessions, he directed

her attention to this behavior, offered a description of it, and wondered with her what might motivate this way of interacting, which appeared designed to exert control over him. Sara tearfully responded that if she did not control him, he would leave. Such interventions brought into focus a dyad—that of the abandoner and the abandonee, with the abandonee trying to prevent abandonment by controlling the other. It was only after repeated clarification of this dynamic in the context of the therapeutic relationship that Sara was able to sort out the feelings of anger and fear of abandonment that fueled her controlling behavior and begin to question her view of the therapist. With a clearer articulation of her experience of self and other, she began to occasionally notice that, while she chronically complained of others treating her harshly and rejecting her, she could treat others, including her therapist, in a similar way; this was the beginning of understanding her projection of aggressive affects within her, as the process became apparent in observing the oscillations of a dyad involving a harsh critic and the object of the criticism. So, in the initial phases of therapy Sara became able first to articulate how she saw the therapist, to consider that he might have a different state of mind than that which she attributed to him, and then to recognize that she could behave in the way she had experienced him behaving.

In a session that took place six months into the first year of treatment, 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 stating that she had been feeling suicidal and had taken a minor overdose. As the therapist tried to understand the affect and the fantasied relationship motivating her suicidal gesture, Sara said: "My wanting to kill myself has nothing to do with your going away." (The therapist was leaving for a week.) The therapist pointed out that Sara had made this connection herself and that it may be humiliating to care so much about him when she felt he did not care about her.

She replied: "You say the same thing to every one of your patients! I'm not like all of them!"

Therapist: "You feel like you're one on an assembly line."

Sara: [with sudden change of affect, from angry to sad]: "I don't feel that I deserve to be here . . . I don't know [patient covers her face with her hands]. I just feel badly that I have to walk around with other human beings. I just don't feel like . . ."

Therapist: "I think you don't want me to see
you feel. You don't mind if I see you in your ang
me. You don't want me to see the longing, becau
that to humiliate you, by rejecting, by turning aw

The therapist then suggested that her fear of
the off-putting way in which she interacted: she m
feel she controlled it.

Sara: "You mean because I think that reject
confirm it, like by dressing this way? I just feel lik
thing, of all of this, is that I have help available . . .
with me . . ."

The oscillation or alternative distribution
noted above must be differentiated from the split
carrying polarized affective charges. The final ste
sists in linking of the dissociated positive and negat
to an integration of the mutually split-off idealiz
ments of experience with the corresponding res
sion. As Sara shifted from her discussion of wanti
she was feeling toward her therapist, she moved f
negative affect that served defensive purposes (th
jecting the helpless unworthy self) to a dyad imb
She continued "I guess there's a longing in a w
time, I didn't really want to come, but I do long
I guess I do. And it's not the same thing betwe
you. I'm more attached to you than I was to him.
remember this boy in high school. There were
students there. . . . I was one of the only ones. .
speak to me. One day . . ."

Her questioning and relinquishment of her
erent stance toward others can be understood ir
begun to "take back" and metabolize the negati
tently projected onto others, which in turn allow
more positive and nuanced states of mind with
therapist. Her therapist's approach was to ask her
states as they played out between them. Thus, the
on clarifying which part of her experience belo

Therapist: "I think you don't want me to see you in the longing that you feel. You don't mind if I see you in your anger and your rejection of me. You don't want me to see the longing, because you think I'll just use that to humiliate you, by rejecting, by turning away from you."

The therapist then suggested that her fear of rejection could explain the off-putting way in which she interacted: she might induce rejection to feel she controlled it.

Sara: "You mean because I think that rejection is inevitable I try to confirm it, like by dressing this way? I just feel like the tragedy of everything, of all of this, is that I have help available . . . You're actually working with me . . ."

The oscillation or alternative distribution of the roles of the dyad noted above must be differentiated from the split between opposite dyads carrying polarized affective charges. The final step of interpretation consists in linking of the dissociated positive and negative transferences, leading to an integration of the mutually split-off idealized and persecutory segments of experience with the corresponding resolution of identity diffusion. As Sara shifted from her discussion of wanting to kill herself to what she was feeling toward her therapist, she moved from a dyad imbued with negative affect that served defensive purposes (the harsh critical object rejecting the helpless unworthy self) to a dyad imbued with positive affect. She continued "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. And it's not the same thing between seeing Dr. Smith and you. I'm more attached to you than I was to him. . . . I like you more. . . . I remember this boy in high school. There weren't many Asian-American students there. . . . I was one of the only ones. . . . I never thought he'd speak to me. One day . . ."

Her questioning and relinquishment of her 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, which in turn allowed her to experience other more positive and nuanced states of mind with regard to herself and the therapist. Her therapist's approach was to ask her to reflect on these shifting states as they played out between them. Thus, the therapeutic work focused on clarifying which part of her experience belonged to the other person

and which part to her self, ultimately expanding her capacity to experience a range of mental states with respect to self and therapist.

In her external life, Sara's complaints of mistreatment decreased. She reported less anxiety and more positive interactions in her volunteer work setting, where she was offered a paid position. With regard to intimate and sexual relations, in the period of time when Sara was still utilizing 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. An erotic transference emerged fitfully during the first year of treatment, first in moments of seductive posture and only rarely verbalized. Her mention of sexual feelings alternated between shame and a sense of danger. In the course of treatment, as she progressed in taking back projected anger and hostility, she started a relationship with and eventually married (after three years of therapy) a more appropriate loving and empathic man.

The work described so far took place mostly in the first year of therapy. It is interesting to look more closely at the AAI that was given at admission and at the one given after this year of TFP. As mentioned previously, on the AAI, Sara advanced from a reflective functioning score of minus one (−1), to a score of 6, which indicates not only the capacity to form stable and multifaceted mental models of the minds of self and other, but also some flashes of complex and original thinking about mental states of self and others. A comparison of Sara's responses to the AAI question "*How do you think your childhood experiences have affected your adult personality?*" at time 1 and time 2 illustrate the dramatic increase in her capacity for mentalization and coherence. At time 1, she gave a response that began with some explicit references to mental states in that she wondered what she would have been like if she had had parents who assured her that "nothing bad was going to happen," but became increasingly bizarre, incoherent, and even shocking—a hallmark of deficient RF—as she veered off into describing a movie she saw as a child with her father in which a woman is tricked and raped.

> I think that if somebody had been in my room, put me to sleep, and assured me that there was nothing bad going to happen, I think a lot of this stuff would have gone all right, I don't think I would be talking about all of this . . . My dad and I, we went to

> a movie once . . . and it was a movie about this
> um, the woman that I remembered upset me a lot.
> maybe third or fourth grade then. It was about th
> married, and she goes to this party, and um, he
> husband doesn't come with her to the party. A
> well you know, [you] like this guy, he'll take
> He doesn't exactly take her home. He rapes h

After one year of TFP, Sara responds to the questio
coherent response that not only explores the impac
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> argument that . . . I was born overly sensitiv
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> 3 years old and my parents not being there. .
> an interest in us. . . . I didn't live up to my po
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> I just couldn't do it like now . . . certainly
> better now. . . . I regret the fact that I'm 37 a
> program at 36 . . .

This response shows the development of a stabl
mind of self and parents along with a transactio
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and behaviors.

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in the AAI after one year of TFP, the therapist
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was that the patient was more capable of reflec
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> a movie once . . . and it was a movie about this woman. . . . and um, the woman that I remembered upset me a lot. And I was about, maybe third or fourth grade then. It was about this woman—she's married, and she goes to this party, and um, her friend—and her husband doesn't come with her to the party. And her friend says, well you know, [you] like this guy, he'll take [you] home . . . He doesn't exactly take her home. He rapes her.

After one year of TFP, Sara responds to the questions with a multifaceted, coherent response that not only explores the impact of her parents' behaviors on her mental states, but also shows recognition of the role her own mental state might have had on her choices and behavior.

> Oh my God, my adult personality. . . . I really don't buy that argument that . . . I was born overly sensitive I don't think so. . . . Not when I can remember experiences as far back as like 3 years old and my parents not being there. . . . They didn't take an interest in us. . . . I didn't live up to my potential . . . so I may have had dreams and wishes and I had the potential to do it but I just couldn't do it like now . . . certainly my life is so much better now. . . . I regret the fact that I'm 37 and I only found this program at 36 . . .

This response shows the development of a stable coherent model of the mind of self and parents along with a transactional perspective on mental states—that is, the way in which her mental states were shaped not only by biological predisposition but by her reactions to the parent's mental states and behaviors.

While the patient's reflective functioning went from −1 to +6 as rated in the AAI after one year of TFP, the therapist reported variability in her capacity for mentalizing in the therapy sessions. His clinical impression was that the patient was more capable of reflection in situations of stability, but would regress to unreflective thinking under the influence of primitive defense mechanisms in threatening situations. Sara's reflective capacities faltered when sexual feelings arose in sessions. She often directed seductive looks or gestures toward her therapist without any capacity to

talk about the meaning of her nonverbal behavior. Periodically she would burst out with a comment that he wanted to force her to talk about sex. When he wondered about this impression, she either referred to her experience with the man she had accused of rape, an accusation she began to question, or talked about her own sexually aggressive behavior toward her sister when they were prepubertal. It was only after the emergence and working through of an erotic transference that she was able to integrate loving and sexual feelings.

AN EXPANDED VIEW OF MENTALIZATION

Detailed examination of our clinical process and outcome data has led us to identify three phases in the development of mentalization. In this section we present a theoretical model that links these three phases to the interpretive process that characterizes TFP. In our view, mentalization is a process whereby, sequentially, the individual develops (a) the capacity to know that he or she has a mind that is like another; (b) the capacity to think about the other in mental state terms and to recognize one's own mental states in the mental states of the other; and (c) the capacity to observe his or her own mind as if it is another mind, which involves placing mental states of self and other in a wider historical and temporal context where understanding in the moment is linked to a broader set of integrated positive and negative representations of self and others. Working independently, Semerari and colleagues (Semerari et al., 2003) identified three phases in the attainment of mentalizing capacities including (1) understanding one's own mind; (2) understanding the mind of the other; and (3) mastery of mental states. Each of these levels of mentalization is reflected in the level and aim of the interpretative activity of the therapist in TFP and in the progression of changes in object relations and ego and superego development that occur in TFP treatment.

The first phase of mentalization involves the capacity to cognitively frame mental states out of diffuse psychic experience. The capacity to cognitively clarify mental states in one's own mind develops in early life via the child's experience of congruent, marked interactions. In the therapeutic situation, the first step in the development of the capacity for mentalization involves helping the patient to understand her own state of mind, through

identifying initially how she sees the
in TFP as tolerating the confusion an
the therapist to introduce the idea tha
a different state of mind than that w
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Thus, the therapeutic task involves h
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identifying initially how she sees the therapist, a process that is referred to in TFP as tolerating the confusion and clarification. It is also important for the therapist to introduce the idea that it is possible that he or she may have a different state of mind than that which the patient attributes to him or her. The patient's realization that her perception of the therapist does not necessarily correspond to what is in the therapist's mind enables her to learn that there is a discrepancy between her own mind and that of the other. Thus, the therapeutic task involves helping the patient to accurately identify the affect that is being experienced in the immediate interaction with the therapist, and to recognize that these polarized affects are linked to specific representations of self in interaction with others. In borderline patients, 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 immediately into action. In our case illustration, for example, Sara's coming to awareness of her relentless attempts to control the interaction with the therapist, and the way that this represented an avoidance of split-off fear and rage linked to an object relational dyad of a powerless, devalued self in interaction with a controlling, rejecting object, epitomizes the first level of mentalization.

At the second level of mentalization, the patient recognizes that he or she experiences the therapist in quite disparate and even opposite ways that cannot be reconciled. Further, the patient realizes that some of her mental states regarding the therapist correspond to states that she had previously perceived in the therapist, while the therapist is perceived as experiencing a state akin to what the patient formerly experienced. This involves the recognition that aspects that she attributed to the object actually represent aspects of the self. At this stage the awareness of the alternation or interchange of roles within the same object relational constellation is crucial. The therapeutic task at this phase is to help the patient to understand and tolerate the double identification with self and object representations, through interpretation of the many repetitions and reversals of specific object relational dyads as they emerge in the transferential relationship, and to interpret the splitting of the libidinal from the aggressive aspects of self as represented by different dyads. The patient's alternation between identification with self and object representations of a particular dyad infused with a particular affect

leads to an expanded understanding of the mind of the other as well as her own mind in that it enables her to recognize that her mind is representational in nature; that is, that her experience of self and others is shaped in part by myriad mental models of self in relation to others. In the case illustration, interpretation of Sara's attempt to omnipotently control the supposed rejecting other led to an awareness of rejecting and critical elements in herself, and this identification with both poles of the dyad enabled her to take back the projection, clearing the way for more libidinally charged gratifying experience of the self in relation to the therapist to emerge, and for integration of her disparate experiences of self and object.

The process of identifying the various self-object-affect clusters or dyads that emerge in relation to the therapist in TFP, along with increased awareness of and tolerance for identifications with both aspects of each dyad, leads to increasing integration of the representational world and a concomitant modulation of affective experience, which sets the stage for the third phase in the development of mentalization. This stage involves the capacity to integrate and modulate the positive and negative segments of experience, which occurs when the patient recognizes that he or she experiences loving and aggressive feelings toward the same person, and that these contradictory states correspond to divisions in his or her own internal world (Klein, 1946, 1957). The recognition that the individual can have completely opposite feelings toward the same person—feelings that he or she may have previously attributed to that person—enables the individual to feel a sense of responsibility over aggressive or negative feelings or states, instead of having to project them. This leads to the development of a sense of concern about the object that the individual wants to preserve.

The emergence of the sense of concern and of responsibility for others sets the stage for the development of superego functions. Insofar as the superego derives from the awareness of the effects of the internalized prohibitions and demands of others, it consists of mental states. The capacity to connect disparate mental states with each other and with their historical antecedents enables one to understand how mental states that derive from the demands and prohibitions of others can be compared with other states. Mental states that involve awareness of parental prohibitions and strictures are recognized as only one set of mental states among others. This recognition in turn expands conscious awareness and tolerance of mental states that

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As mentioned above, clinical obs
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might engender conflict. Mentalization thus leads to improved functioning in the sexual realm, in that it enables one to recognize that states linked to intense passion and/or erotic excitement are transient heightened mental states in which one experiences reality differently, while the capacity to correctly identify—and identify with—the mental states of the other, enhances sexual passion.

Sara provides an example of a patient with excessively persecutory and prohibitive superego elements accompanied by a severe inhibition in sexual functioning, which was significantly modified in the course of treatment. At the beginning of treatment she represented all sexual relationships, when she allowed herself to think of them, in the most primitive form—that of exploiter and exploited. As her reflective capacities improved in the course of treatment, this patient was able to establish and sustain a fully intimate emotional erotic relationship in which tenderness and sexuality were integrated. The progress in this area paralleled her integrating projected aggressive elements of herself, but with a delay. Even after she was able to understand the relation between her fear of verbal attacks from others and the capacity she discovered in herself for angry criticism and rejection, sexual feelings remained a source of anxiety. Her anxiety was related not only to the aggressive elements that her sexual feelings carried, but also to her fear of lack of control; she worried that sexual feelings would lead to uncontrolled promiscuity. Sara anticipated condemnation each time these came up, and a lengthy and intermittent period of interpretation of her fear of her desires and their imagined consequences eventually led to her ability to enjoy sex and sexual fantasies.

As mentioned above, clinical observation, as in the case of Sara, suggests that RF is variable across different self and object representations that may be evoked in response to the activation of different behavioral systems. It may be that the attachment relationship between patient and therapist is well consolidated in the early to mid phases of treatment, leading to a substantial increase in mentalization, but if later what emerges in the transference is a recapitulation of an eroticized or seductive relationship with an early attachment figure, or aggression, then mentalization may decrease. Different levels of mentalization thus may be activated in response to the activation of different behavioral systems (e.g., attachment and sexuality). In our case illustration, the patient's capacity for reflective function was noted

by the therapist to be variable through the later stages of treatment; it diminished markedly when an erotic transference developed, even though her RF improved significantly in the context of a discussion of early attachment experiences on the AAI at one year.

SUMMARY AND CONCLUSION

Our research and clinical findings suggest that after one year of TFP, borderline patients show significant improvement in their capacity for mentalization (as indicated by increases in RF ratings described above), an improvement in their capacity to create a coherent autobiographical narrative (as indicated by the increase in coherence subscale scores of the AAI), and a decrease on measures of aggression (Clarkin et al., 2007; Levy, Meehan, et al., 2006). That these gains occurred primarily in the interpretive climate of TFP, and not in either DBT or supportive psychodynamic psychotherapy (STP)—one of which (STP) also used psychodynamic techniques (but not interpretation)—suggests that the described improvement in RF may be in part a result of specific techniques in TFP not present in the other treatments. Our hypothesis is that the improvements in the complexity and integration of the Reflective Function scores are a result in part of the interpretative process that is unique to TFP. In this process, the therapist moves from defining the dominant object relations, identifying role reversals between self and object poles of the object relational dyads as they occur in the transference, and confronting splitting of idealized from persecutory aspects of self in different dyads, to then offering a hypothesis about why it occurs and gradually linking these primitive defensive operations to unconscious wishes, fears, and motivations. This interpretive process leads to the gradual integration of disparate, split-off self and object representations into an overarching stable concept of the self and objects. We propose that the consolidation of identity in turn fosters mentalization in that it provides a stable and consistent working model of self and others against which momentary mental states, even those that are affect- or drive-laden, can be assessed and evaluated.

Further investigation of other factors in the treatment that might account for gains in RF will have to be conducted before we can definitely

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link the improvement in RF to the increasingly complex interpretive focus that is unique to our treatment. In support of our formulations are the recent investigations of Høglend and colleagues (Høglend et al., 2006), which showed that transference interpretations were more helpful for patients with more severe pathology of object relations. Ultimately, however, as Gabbard (2006), Blatt (1992), and others have pointed out, the challenge is to refine our understanding of the particular characteristics that might make patients more or less amenable to different therapeutic approaches.

Our use of the RF measure to assess mechanisms of change in TFP has made us more aware of the strengths and limitations of the instrument at both the theoretical and empirical level. Our research and clinical investigations suggest that mentalization is a complex and multistaged process that involves transformations in cognitive and affective ego and superego structures. In particular, our findings on improvements in mentalization in TFP lend support to the idea that a focus on the identification, articulation, and regulation of affect, and the ways that it is linked to specific constellations of self and object representations, is a significant catalyst for understanding mental states. In our view, the development of the capacity for mentalization, along with the development of secure attachment with which it is linked, are cumulative processes that reflect the building up, modulation, and integration of object relations. These complex processes, particularly the affective components of RF that cannot be disconnected from object relationships, are not necessarily captured by one reflective function global rating. Thus, the RF scale as it is now constituted reduces to one numerical score a complex array of variables. In addition, mentalization may fluctuate markedly within the same individual as different behavioral systems are evoked in individual maturation, in different interpersonal contexts, and at different stages in treatment. As Fonagy (Fonagy et al., 2002) and others have noted (Diamond et al., 2003; Yeomans et al., in press), borderline patients can be reflective under certain circumstances and not under others. It is not clear that the AAI interview, from which the RF rating is derived, captures or addresses the situations and issues that are particularly difficult for the individual patient, and that may lead to lapses in mentalization. The above formulations are offered in the interests of advancing the fruitful dialogue between MBT and TFP, two psychodynamic perspectives on borderline

pathology and its treatment that continue to enrich and enhance each other. An honest assessment and exploration of points of contact and divergence can only lead to increased precision in our treatment approaches and their theoretical underpinnings.

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