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The Reciprocal Impact of Attachment and Transference-Focused Psychotherapy with Borderline Patients

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In this chapter we attempt to illustrate the utility of attachment concepts for clinical work by presenting one case from a longitudinal study on changes in attachment status and reflective function in borderline patients over the course of 1 year of transference-focused psychotherapy (TFP), a form of psychoanalytic psychotherapy based on object relations theory (Kernberg, 1975, 1976). All of us who treat borderline patients know that disorders of attachment are central in borderline conditions. The attachments formed by borderline patients in and out of the consulting room are turbulent and chaotic, with unpredictable shifts between clinging and repudiation, intense idealization and scathing devaluation, and alternating intrusions into the therapist's life and sudden unilateral rejection of others, including the therapist. Object relations theorists believe that this chaos stems from an underlying lack of integration in the patient's psychological structure in that unstable and polarized self and object representations, associated with highly charged and poorly modulated affect states, determine the individual's experience of self and others, and perception of reality. The nonintegration of the different representations of self and other leads to identity diffusion, a state of discontinuity and confusion in the individual's relations to self, others, and the external world. However, even if borderline patients share a lack of internal integration, we

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know that attachments formed by borderline patients are not just of one type: They may be characterized as much by dismissing devaluation of attachment relationships as by terrors of aloneness and persistent cravings for connection. Adding considerations of attachment status to the fundamental state of identity diffusion may help us in understanding the different clinical presentations of borderline personality, and how they may change differentially in the course of treatment.

A number of previous studies have identified insecure attachment organization (Diamond, Clarkin, Levine, et al., 1999; Fonagy, Gergely, Jurist, & Target, 2002; Fonagy, Leigh, et al., 1996; Fonagy, Steele, et al., 1995; Gunderson, 1996; Levy, Blatt, & Shaver, 1998; Patrick, Hobson, Castle, Howard, & Maughan, 1994; Slade, 1999; Steele & Steele, 1998) and deficits in reflective functioning, or the capacity to think in mental state terms (Bateman & Fonagy, 2004; Diamond, Stouvall-McClough, Clarkin, & Levy, 2003b; Fonagy, 1991, 1998, 2001; Fonagy et al., 2002; Levy et al., 2006) in borderline patients, thereby expanding our understanding of the object relations features of borderline pathology. From an object relations point of view, these insecure states of mind with respect to attachment stem both from basic internal identity diffusion, a state that provides no stable internal representation of self or object, and from the structure and nature of the predominant object representations; that is, from the strong presence of negatively valenced or persecutory representations in the patient's conscious experience of self and others, along with the lack of integration of positive and negative aspects of the representational world. Attachment concepts and measures, including the concept of attachment security or insecurity as measured by the Adult Attachment Interview (Main & Goldwyn, 1998) and mentalization as measured by the Reflective Function Scale (Fonagy, Steele, Steele, & Target, 1997), have provided ways of assessing change in aspects of the representational world of borderline patients. Recent investigations have shown significant improvement in attachment representations or internal working models as well as mentalization or reflective function in borderline patients over the course of 1 year of transference-focusing psychotherapy (TFP; Levy et al., 2006).

Transference-Focused Psychotherapy

TFP is a psychodynamic treatment designed for patients with borderline personality disorder (BPD) and borderline personality organization (BPO) and has been delineated in a series of treatment manuals (Clarkin, Yeomans, & Kernberg, 2006; Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989; Koenigsberg et al., 2000, Yeomans, Clarkin, & Kernberg, 2002). TFP is based on a model of borderline pathology that integrates Kernberg's object relations model of the structural organization of personality (Kernberg, 1984; Kernberg & Caligor, 2004) with an understanding of the interaction between behavior and neurobiological aspects of the individual (Depue & Lenzenweger, 2005;

Posner et al., 2002, 2003). Whereas the psychoanalytic view of borderline personality organization has been essential in understanding the psychological experience of the patient and guiding treatment (Yeomans et al., 2002), our 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. Furthermore, we recognize that difficulties in processing negative affect, faulty and ineffective conflict resolution, insecure (primarily anxious/preoccupied and/or disorganized/unresolved attachment organization (Bateman & Fonagy, 2004; Fonagy et al., 1996), and low effortful control all contribute to the deficits in affect regulation and information processing that are at the heart of BPD (Clarkin & Posner, 2005; Posner et al., 2003).

Hence, our model of BPD posits that temperament and environment combine to establish the split psychological structure of borderline patients that evolves in the course of early development. From an object relations perspective, mental representations of frustrating others in relation to a helpless deprived self are internalized and split off from mental representations of gratifying others in relation to a satisfied self. These opposite self–object dyads are imbued with intense affects, both hateful (in association with the frustrating other) and loving (in association with the gratifying other). Early interpersonal experiences are cumulatively internalized in the individual's mind and become established in cognitive-affective structures or "object relations dyads"—units that combine a specific representation of the self in relation to the other, linked by specific affects that in the case of the borderline individual are somewhat loosely and chaotically organized in relation to each other. In addition, these dyads are not exact, accurate representations of historical reality, although they bear the imprint of interpersonal transactions with early attachment figures. In our view, however, the representational world is not delimited by mental representations of self in relation to attachment figures, although the internal working models of attachment based on the child's experience of early parent–child attachment transactions, such as the parents' responses to the child in times of threat, danger, and illness, may form the bedrock of the representational world. The representational world is also patterned by temperament, biological capacities and limitations, impulses, wishes, conflicts, and fantasies that derive from the myriad behavioral systems of sexuality, aggression, exploration, affiliation, and caregiving that Bowlby and others have posited in addition to attachment (Bowlby, 1969/1982). Although a more complete discussion of the relationship between internal working models of attachment and psychoanalytic theories of the representational world is beyond the scope of this chapter and can be found elsewhere, both are thought to operate outside of awareness and to be resistant to change (see Diamond & Blatt, 1994; Eagle, 1997, 2003; Levy et al., 1998; Main, 1995; Main, Kaplan, & Cassidy, 1985; Steele & Steele, 1998).

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split off from one another and determine the lack of continuity of the border-line patient's subjective experience in life. Although the patient has no conscious awareness of the defensive aspects of this split internal world, the idealized and persecutory facets of his or her experience remain consciously available at different times, but defensively sequestered from each other, which accounts for the typical symptoms of borderline personality: chaotic interpersonal relations; emotional lability; polarized, black-and-white thinking; and proneness to lapses in reality testing.

The treatment focuses on the transference, because the patient lives out his or her predominant object relations dyads in the transference, as in other relations. The core task in TFP is to identify the patient's various internal object relations dyads or internal working models of attachment (which are often multiple in the case of the borderline patient), and to help modulate and integrate them into unified, coherent representations of self and other. The combination of understanding and affective experience in the therapy leads to the integration of the split off representations and the creation of an integrated identity and experience of others.

Thus, in TFP, the therapist must attend to (1) the degree of identity diffusion versus integration, and (2) the specific predominant dyads (self- and object representations). These attachment features of borderline pathology are particularly evident in the transference, which in TFP can be seen as the vehicle for mobilizing and transforming the insecure attachment behaviors and their associated internal working models of attachment. The attachment perspective diverges somewhat from TFP's object relations' foundations, which gives more emphasis to dynamic conflicts and particularly the role of aggression as an impediment to the integration of the internal world, and the formation and maintenance of secure attachment bonds, including that with the therapist. However, despite these differences, TFP, like most treatments for BPD, gives centrality to the consolidation of an attachment relationship to the therapist and to the development of increased capacity for reflective function, or the ability to think in mental state terms, that is, to comprehend the intentions, thoughts, feelings, beliefs, and motivations of self and others (Bateman & Fonagy, 2004; Kernberg, Diamond, Yeomans, Clarkin, & Levy, in press).

Attachment Theory and TFP for Patients with BPD

Our research and clinical investigations at the Personality Disorders Institute at Weill Medical College of Cornell University, where TFP was developed, have been influenced by the increasing attention to the application of the writings of Bowlby (1969/1982, 1973, 1980, 1988) and his followers (Fonagy et al., 1995, 1996; Main, 1995). Specifically, the interest in applying attachment constructs to the therapeutic relationship and process (see Diamond et al., 2002; Fonagy, 2001) is central to our work. Bowlby hypothesized that the attachment behavioral system, by which he meant the innate proclivity of

young children to seek proximity and caretaking from an adult member of the species, is active throughout the life cycle, particularly in situations where an individual who is ill and in distress seeks protection or contact with someone deemed older or wiser. Increasingly this model has been applied to the therapeutic situation. Bowlby stated that the chief role of the therapist was to provide "the patient with a temporary attachment figure" (1975, p. 306). In this process, the therapist's own internal working models of attachment, or sets of rules and expectations regarding the interactive attributes of early caregivers, are mobilized along with those of the patient. Like all attachment relationships, the therapeutic one was thought by Bowlby (1969/1982, 1973) to be inherently bidirectional, with attachment-seeking behaviors (proximity seeking, smiling, calling) tending to evoke corresponding adult attachment or caretaking behaviors (soothing, holding, protecting). Allan Schore's reading of the neuroscience literature (2001, 2003a, 2003b) suggests that just as the infant's right hemisphere is involved in the development of the attachment behavioral system, so also is the caretaker's right hemisphere activated in comforting and protecting functions (see also Siegel, 1999). As Schore points out, attachment "is an active dyadic process that occurs between two brains that are cogenerating synchronized emotional communications with each other" (2001, p. 23), and we might apply this formulation to psychotherapy as well. Bowlby (1978, 1988) conceptualized all attachment relationships, including the therapeutic one, as inherently bidirectional, with attachment-seeking behaviors (proximity seeking, smiling, calling) tending to evoke corresponding adult attachment or caretaking behaviors (soothing, holding, protecting).

Bowlby (1988) hypothesized that transference inevitably involves patients' recapitulation of their early attachment history and patterns in the therapeutic arena. Furthermore, Bowlby (1978, 1988) believed that the developmental findings of attachment theory and research would illuminate our understanding of the transference–countertransference dynamics of more severely disturbed patients, particularly those with borderline and narcissistic pathology. In the case of patients with insecure states of mind with respect to early attachment relationships, the internal working models of early attachment relationships are likely to be multiple, contradictory, and unintegrated, leading to complex and sometimes chaotic transferences and countertransferences (Bowlby, 1988; Farber, Lippert, & Nevas, 1995; Holmes, 1996; Main, 1991, 1995, 1999). Bowlby (1988) observed that patients alternately cast the therapist in the role of an early attachment figure and assume the role of that attachment figure themselves in relationship to the therapist, and that the more disturbed the patient, the more chaotic, rigid, and resistant to change such internal working models are likely to be. Hence, in Racker's (1968) terms, the therapist may experience both complementary and concordant forms of countertransference that together provide an important source of insight into the nature of the patient's internal working models of attachment. Particularly with the more severely disturbed patient, the therapist may be able to comprehend fully the patient's often complex and contradictory repre-

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In our own research, we have been observing change toward increased coherence and security of internal working models of attachment in patients with BPD over 1 year of TFP (Diamond, Stovall-McClough, Clarkin, & Levy, 2003b; Diamond et al., 1999; Levy et al., 2006). We have also found that the patient's attachment status or current state of mind regarding early attachment relationships, as assessed on the Adult Attachment Interview (AAI), is a major characteristic that affects the course of TFP for patients with BPD, from the initial stages of establishing a treatment contract to the patients' characteristic responses to separations and endings, and to the nature of the dominant object relations dyads enacted in the transference (see Diamond et al., 1999; Koenigsberg et al., 2000).

We have also been investigating the impact of patient and therapist states of mind with respect to attachment in the therapeutic relationship, through an interview adapted from the AAI, the Patient–Therapist Adult Attachment Interview (PT-AAI) (George et al., 1999). In TFP the transference functions as a metanarrative that shapes the therapeutic interactions, both verbal and non-verbal, and becomes the vehicle through which the patient's attachment narrative(s) emerges and changes. Indeed, in developing the PT-AAI, we have been inspired by previous clinical and empirical investigations linking attachment status to (1) transference–countertransference dynamics (Dozier & Tyrrell, 1998; Fonagy, 1991; Holmes, 1995, 1996; Szajnberg & Crittenden, 1997), (2) the quality and nature of the therapeutic alliance (Bordin, 1994; Dozier & Tyrrell, 1998; Eagle, 2003; Mackie, 1981), (3) patients' characteristic responses to endings and separations from the therapist (Gunderson, 1996; Holmes, 1995, 1996, 1998), and (4) patterns of patient–therapist discourse (Fonagy, 1991, 1998, 2001; Slade, 1999). Our initial investigations with the PT-AAI (Diamond et al., 2002, 2003b) suggest that it is a useful instrument to track one aspect of the transference, the attachment state of mind with respect to the therapist, and to investigate the ways in which it recapitulates aspects of the attachment state of mind on the AAI with respect to the parents. The PT-AAI, like the AAI, is scored for attachment classification, using an adaptation of the five-way adult attachment scoring and classification system (Diamond et al., 2003a; Main & Goldwyn, 1998).

Research Findings

In this section we summarize the three major TFP research studies to place the clinical case in the context of our general outcome data, including data changes in attachment status and reflective function over the course of 1 year of TFP. We have conducted a series of three related studies to investigate the impact of TFP on the symptomatology, social adjustment, utilization of psychiatric and medical services, attachment organization, and reflective function

of patients with BPD. With the assistance of a treatment development grant from the National Institute of Mental Health (NIMH; John F. Clarkin, P.I.), we generated initial effect sizes of the treatment over a 1-year period (Clarkin et al., 2001). Women with BPD who had at least two incidents of suicidal or self-injurious behavior in the previous year were selected for treatment. TFP demonstrated significant changes for the patients in a number of crucial areas. There was a significant decrease in the average medical risk of parasuicidal acts and improvement in the average physical condition following these acts. After 12 months of treatment, 52.9% of the subjects no longer met criteria for BPD. There were significantly fewer emergency room visits, hospitalizations, and days hospitalized.

Subsequent to this initial study, we compared the results of patients with BPD treated with TFP to those who received 1-year treatment as usual (TAU) in our own clinical setting. Psychiatric emergency room visits and hospitalizations during the treatment year were significantly lower in the TFP group compared to the TAU group. Patients who completed TFP showed an increase in global functioning, whereas those in TAU did not. All of the within- and between-subject effect sizes for TFP treatment participants indicated significant change, whereas effect sizes for the TAU group either deteriorated or were small (Levy, Clarkin, Schiavi, Foelsch, & Kernberg, 2007).

Encouraged by these initial results, we conducted a randomized clinical trial of TFP (Clarkin, Levy, Lenzenweger, & Kernberg, 2004) comparing our object relations treatment with dialectical behavior therapy (DBT) and a supportive psychodynamic therapy (SPT). Results indicate that patients in all three manualized treatments showed significant clinical change in many domains of functioning after 1 year of treatment, including diminution of depression and anxiety and improved psychosocial or interpersonal functioning. In the domain of suicidality, patients in both TFP and DBT showed significant reductions in suicidality, whereas those in SPT did not. Interestingly, only patients in TFP showed a marked diminution of factors related to aggression such as impulsivity and verbal and direct assault (Clarkin, Levy, Lenzenweger, & Kernberg, 2007).

We were also interested in examining the mechanisms of change, that is, how TFP brings about change, compared to the other treatments (Levy et al., 2006). For this research question, we used the reflective functioning (RF) score (Fonagy et al., 1997), an attachment-based index of mentalization, obtained from the AAI (George, Kaplan, & Main, 1985/1998), given prior to and after 1 year of treatment for patients in all treatment conditions. The AAI interviews are also rated for RF on an 11-point scale that ranges from –1, active repudiation or bizarre formulations of mental states, to 9, 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 1 year of treatment, RF increased significantly in a positive direction for patients in the TFP group but did not change for patients in either the DBT or SPT groups. In addition, we also assessed narrative coherence on the AAI (Grice,

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1975). The Narrative Coherence subscale of the AAI has been found to be the best predictor of attachment security ($r = .96$, $p = .001$) (Waters, Treboux, Crowell, Fyffe, & Crowell, 2001). Patients in the TFP group showed significant increases in narrative coherence after 1 year, whereas those in the other two groups did not. For patients in TFP, narrative coherence scores improved to a level just short of indicating attachment security. Finally, after 1 year of treatment, there was a significant increase in the number of TFP patients classified with secure states of mind with respect to attachment, but not in DBT or STP patients. It should be noted that of the 90 patients in the randomized control trial, 31.7% were initially classified as unresolved, while 18% were rated as cannot classify (Levy et al., 2006).

Case Illustration

We present a patient from our study. Although we focus on how her state of mind with respect to attachment and RF capacity might have shaped aspects of the therapeutic process and the therapeutic relationship during the first year of psychotherapy, our clinical description of the case extends to 4 years of treatment. The patient, whom we will call Nicole, is in her early 30s. She is in her fourth year of TFP with a senior therapist in the project who had over 10 years of experience in treating borderline patients, and was judged independently to be both adherent and competent in TFP. Like all the patients in the study, she was diagnosed with BPO (Kernberg, 1975) and BPD (American Psychiatric Association, 1994), and had a history of parasuicidal behaviors and multiple prior inpatient and outpatient treatments. In addition, like the majority of patients (60%) in the initial sample of which she was a part, her primary attachment classification on the AAI was unresolved with respect to loss and trauma (Diamond et al., 2003b). Also like the majority of the patients in our two initial studies, she was considered a treatment success in that she showed diminution of symptoms, including self-injurious urges and behaviors, fewer hospitalizations, and improved psychosocial functioning after the 1 year of treatment required by the research study (Clarkin et al., 2001). After the research year, she chose to continue with her therapist at a reduced fee.

At 4 months, and then at 1 year, after beginning treatment, Nicole, like the other patients in our study, was given the AAI. At 1 year, both the patient and the therapist were given the PT-AAI. Both interviews were scored for attachment classification by raters who were blind to identifying characteristics and time of administration of the interviews. In the following section we illustrate the clinical utility of the research data for understanding aspects of the course of treatment for challenging and treatment-resistant patients with BPD such as Nicole.

Nicole's personal history was one of unrelenting loss, abuse, and neglect. The mother developed a severe degenerative illness after the patient was born. Nicole remembers her mother being "angry all the time" and describes her as

alternately neglectful and abusive. When Nicole was 3 years old, the father left the family (which also included two older brothers) for another woman, whom he married, and who discouraged all contact with his children. Nicole's mother subsequently deteriorated substantially and had to be hospitalized on numerous occasions for both emotional and physical disorders. When Nicole was 7, her mother became a paraplegic and was hospitalized until her death several years later. Nicole and her siblings were shuffled among their relatives, because their father refused to care for them and in fact failed to pick them up the day of the mother's death. Significantly, Nicole's earliest memory, at age 3, is of her father forgetting to pick her up to take her out for her birthday when her mother was in the hospital, and of feeling as though she would "perish and die." In adolescence, she developed anorexia and was hospitalized on several occasions for eating disorder and self-destructive behaviors. She married in her early 20s and had a son with her first husband. Her self-destructive behaviors, such as cutting, suicide attempts, and abusive behaviors toward her family (particularly her husband) led to a number of inpatient hospitalizations and failed outpatient treatments. About 6 years prior to the current treatment, she engaged in sexual relations with her therapist at the time. After that experience she became repulsed by sex. Her husband divorced Nicole because of her sexual involvement with her therapist. She remarried but almost immediately began an affair with her son's teacher, which led to a pregnancy and abortion. Her suicidality and destructive behaviors escalated, and after she attacked her husband's car with a baseball bat, Nicole was rehospitalized and subsequently referred to the borderline project.

Course of Treatment

Given Nicole's history of failed treatments and boundary violations, it is not surprising that the course of therapy was not only extremely stormy right from the beginning but also filled with dramatic, self-destructive enactments. She began treatment with a defiant, oppositional, and dismissing attitude, saying, "I don't want you or this treatment, but I need to get over my stupid symptoms so that I won't need anybody in my life and can live totally on my own." Based on his model of borderline pathology, the therapist understood this initial negative therapeutic reaction as representative of only part, albeit the dominant part, of Nicole's internal world. He listened to her in the first weeks of therapy with the intention of more fully comprehending and eliciting the full scope of her internal representational world. More data were provided by Nicole's way of dealing with the treatment contract. Initially, she gave lip service to the contract, but without reflection or intention to follow it, as evidenced by the fact that she refused to go the emergency room to be evaluated when she overdosed. Throughout the first 6 months, Nicole continued to drink intermittently, to overdose periodically, and to engage in other destructive and self-destructive behaviors that represented a challenge to the treatment contract and to the continuance of the therapy itself. During this period, Nicole's aggression toward herself and her therapist were interchangeable,

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Nonetheless, over the first year of therapy, Nicole's suspicious, denigrating stance devolved into kaleidoscopic shifts between persistent devaluation and rejection of the therapist, and intense preoccupation with closeness to and caring from the therapist. Her strivings for contact and emotional engagement quickly elicited fears of rejection and abandonment that led to retreat into devaluation of the therapist and the treatment. Interspersed with her alternations between distancing devaluation and fearful clinging were dramatic enactments of a sexual and aggressive nature. There were multiple episodes in which she acted out within the sessions in a sexually aggressive manner, sometimes attempting to climb in the therapist's lap, unbutton his shirt, or undress herself in the sessions. These enactments represented an accretion of elements, including her conviction that others were objects to be exploited and abused as she herself had been exploited and abused. At times she acted out this object relational dyad with her therapist, as in the incident when she cut herself in the session, then beat her therapist on the chest for intervening, or when she made overt sexual advances toward the therapist. His firm but empathic refusal and containment of her sexual overtures gradually led her to relinquish her persistent beliefs that his interest in her was based primarily on sexual exploitation. Nicole's relentless attempts to seduce the therapist sexually, along with her initial glib acceptance, then blatant disregard of the treatment contract, represented also a manifestation of her antisocial traits that had contributed to the destruction of other treatment relationships.

By the end of the first year, Nicole began to respond well to the structure of the therapy, and her acting out gradually diminished. In the second and third years of therapy, sexual acting out inside and outside the sessions ceased, and she developed the capacity for more mature interdependence that was evident in her relationship with her husband, whom she began to value and relate to more fully, both emotionally and sexually. In addition, her functioning at work improved markedly in that she was capable of more sustained effort and took more pleasure in her success than she had previously.

Nevertheless, in Nicole's fourth year of therapy, destructive acting out returned, bringing renewed challenges to the treatment frame and contract. After she broke her contract by drinking and overdosing on her medications 2 days in a row, the therapist told Nicole that it was impossible for him to continue with her as an outpatient (as he had explained would be the case after the first overdose, if she did not go to a hospital). He told her that she would have to be hospitalized at that point, with the understanding that she could reenter therapy after 2 months provided that she demonstrate she could follow the hospital staff's treatment recommendations and be willing to adhere to the terms of a new treatment contract.

After 2 months, Nicole did resume treatment with the therapist with a more stringent treatment contract. Since that time she has ceased such self-destructive and destructive acting out, and has begun to explore a number of

issues, including her excruciating history of loss and abuse, her guilt about her past affairs and abortion, as well as her sense of self as irrevocably bad and evil. Therapeutic exploration of her regression revealed that Nicole had felt only "half better" and that she feared improvement would lead to the loss of the therapist, for which she was unprepared. Her acceptance of the frame, and acknowledgment of the finitude and limits of therapy, have also led to mourning the loss of her past idealized expectations of therapy, as evidenced by her statement, "I've gotten a lot better in this therapy, but you've taken something away from me. Before I could believe in a perfect ideal love and now I see it's not possible. . . . I've accepted that." In accepting that her fantasy of ideal all-gratifying love with the therapist was not possible, Nicole showed marked progress in increasing her capacity for intimacy and gratitude in relation to the significant others in her life, including the therapist.

AAI Ratings

Nicole's state of mind with respect to attachment on the AAI, as assessed four months into treatment, predicted the chaotic treatment course and kaleido-scope of transferences that ensued. She was initially classified with a primary state of mind of Unresolved (U) because she showed severe lapses in discourse and logic and dramatic behavioral reactions in response to questions on loss and trauma. In addition, she received a secondary classification of Cannot Classify (CC) because she oscillated among different mental states with respect to attachment, using both dismissing/derogating (Ds2) and preoccu-pied/enmeshed (E2) strategies. We are presenting a patient with such a com-plex admixture of attachment states of mind because, in our experience, even those patients who show a dominant and consistent discourse strategy in their research interviews (AAI) often show a mixture of dismissing (Ds), preoccu-pied (E), and unresolved (U) strategies in the narratives that are the stuff of clinical reality. We provide some examples from the AAI transcripts to illus-trate the characteristics of narrative discourse captured by these classifica-tions. Although Nicole was able to complete the first AAI interview, her dis-course and collaboration deteriorated markedly during the questions on loss and abuse. When asked about past experiences of abuse, for example, she acknowledged that her mother (and brothers) had abused her during child-hood, but then alternated between acknowledgment and denial of the abuse. Nicole's speech became fragmented, disorganized, and incoherent, and she appeared to dissociate with regard to her memories surrounding her mother's abusiveness, stating, "She wasn't there," and "I just wish I was related to someone else." Similarly, when asked about her mother's death, she withdrew from the interviewer, began to mutter incoherently, made gestures to scratch herself, and ultimately lapsed into a mute, frozen state reminiscent of the freezing or trance-like behaviors of infants judged disoriented/disorganized in the Ainsworth Strange Situation. Such an extreme behavioral reaction, together with cognitive and linguistic disorganization, is indicative of lack of

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resolution of traumatic experiences on the AAI (Main & Goldwyn, 1998). In summary, Nicole's narrative was disrupted and fragmented by unmetabolized pain about past traumatic experiences.

At other points in the interview, Nicole oscillated among different attachment states of mind. As is characteristic of dismissing speakers, she initially strove to curtail the influence of attachment on her thoughts and feelings by approaching the interview tasks on an abstract level. When asked to give five words to describe her mother, for example, she first provided somewhat idealized words such as "understanding," "supportive," and "friendship." However, when prompted to provide specific memories to illustrate these words, she stated that she misunderstood the task and had thought she was supposed to describe the "ideal" mother. She then abruptly switched her descriptors to five words that were unrelentingly negative: "unloving," "unkind," "not understanding," "not supportive," and "definitely not a friend." She was mostly unable to provide specific memories to illustrate these words, instead giving general and vague statements, such as "She was always angry at me; she was always critical of me" (her elaboration of unloving). When asked to choose five words to describe her relationship with her father, Nicole also initially dismissed him in a derogating and contemptuous manner, stating, "I didn't have a relationship with him," and "I guess, stranger." But in elaborating on these words, she became overwhelmed by involving anger, which broadened to include both parents, losing the boundary between past and present, self and other, as the following passage indicates.

> "I, my memory of him is when he was telling me he was leaving. . . . And I started, I, I was sitting on his lap; he was in the kitchen and I started to cry. And he thought I was crying because I, because he was, because he, I thought, he thought that I thought he was leaving right then and there. And, like, I knew what he meant. . . . I can't, I can't do this. I can't. I'm sorry if I inconvenienced you . . . like, I don't even know why I'm crying, 'cause normally it doesn't bother me at all. I mean, I could care less. It's just makes me think, like, I just can't believe how, like, people could be like, so—like, how can you beat your kids, they're like, your life, and how could you like, mistreat them? And, then, like, I, I, I—he's not a bad person—I, I just think that . . . you know, and my mother was the same way toward me, but not my brothers. You know, so I just, like, I can't. Because of that, I know how I love my kids. You know, and nothing anyone can do could ever make me feel differently toward them, even if they grew up to be like, killing. . . . So how could my mom and father do that to me? And, so there must be something wrong with me if they're not like that toward other people."

Nicole's angry/preoccupied state of mind was evident in the run-on, garbled sentences listing the failings of her parents, in the way that she brought current feelings about her own children into the interview during queries regard-

ing the past, and in her attempts to engage the preoccupation of the interviewer by insisting that she was unable to continue with the interview. In summary, on her AAI, Nicole initially strove to deactivate thoughts and feelings related to early attachment experiences, but ultimately she became overwhelmed by angry preoccupation toward attachment figures and at times retreated into a dissociated state in which she enacted through repetitive, self-destructive gestures her history of early traumatic loss and abuse. Thus, this interplay of Ds, U, and E states of mind with respect to attachment in the AAI paralleled the configuration of transference and countertransference that emerged in the clinical process, as described earlier and on the PT-AAI interviews at 1 year.

PT-AAI: Patient

Just as Nicole had initially maintained a stance of rejection and devaluation in the therapeutic area, when asked on the PT-AAI to describe her relationship with the therapist, she initially replied in a scathing and derogatory fashion, "I don't understand when you say relationship, cause there's no, like, relationship." She then retreated into a positive wrap-up, typical of dismissing speakers, stating, "No, it's uh, he's fine. He's helped me with like, stuff. . . . I mean, I just, I see him twice a week." Nicole's dismissing state of mind was also evident in that derogation of the significance of attachment relationships alternated with idealizing tendencies (Ds1). The words that she ultimately gave to describe the therapist were uniformly positive (e.g., "nice," "patient," "mellow," "caring," and "professional"), but she provided unconvincing and/or contradictory examples to back them up, as is typical of dismissing speakers. For instance, when asked what experiences come to mind about his being patient, she replied:

> "I don't know . . . I just can't like really, it's like, that I hate him, but I really don't hate him. . . . He always tries to help me. Like, he'll try and help me speak, like, and sometimes I don't trust him at all. But . . . it's like sometimes I trust him, sometimes I don't trust him."

The pervasively fearful preoccupation with traumatic thoughts and experiences (E3 rating) was evident in Nicole's use of frightening imagery about cutting herself and in her catastrophic fantasies about the death of the therapist during separations. She reported, "I hate when he goes away on vacation. . . . It makes me sick . . . 'cause, like I think about, like, a plane crash or something . . . like he's never coming back."

On the PT-AAI, Nicole was also found to be still struggling with a great deal of current involving anger toward the therapist (E2). For example, in elaborating on her descriptor of her therapist as "patient," she lapsed into garbled run-on sentences and entangled anger typical of preoccupied speakers, stating:

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"Like I just need and um—and I can't really talk, and—or I'll get like really angry or, or then I just . . . like, a part of me gets, like, stupid. And, like, like if he says, you know, like every thing he says I'll just like—like, I'll, I'll fight with him, but like, there's a part of me that doesn't, is like, saying, 'Well, OK, well, you'll just struggle and . . . " I don't know, I just can't like, really. It's like, that I hate him, but I really don't hate him, I don't hate anyone. I hate the Pope for some reason. But when, when I start getting like that—I, I um, I have a hard time."

Thus, on the PT-AAI at 1 year, Nicole was alternately dismissing, devaluing, angrily preoccupied, or fearfully preoccupied in her state of mind with respect to the therapist, just as she had been with respect to early attachment figures on the first AAI, leading to a PT-AAI classification of cannot classify (CC/Ds1/Ds2/E2/E3).

In addition to capturing the recapitulation of her predominant attachment states of mind with respect to the parents in the therapeutic relationship, Nicole's responses on the PT-AAI also delineated shifts in her states of mind as a result of the therapeutic work. For example, there was some evidence that the therapeutic relationship provided her with the stability to begin to modulate her inchoate anger toward attachment figures. She reported drawing on her relationship with the therapist in regulating her affect and behavior during a recent argument with her husband, as follows:

"I feel like, that I understand him [the therapist], because he can, um, sometimes he'll say things that—that, like, are exactly the way I think, or feel something about. Or, um, or he'll say things that I'm not aware of, and then when he says it I'm like, 'Wow, yeah, that's. . . .' And then, so then, when it happens again to me, like, then like, I think about it like more. Like, I'm able to like think. . . . So then sometimes I can, um, like diffuse the situation, like, instead of like, I mean, it's not often but it's getting better, but, like, instead of like, um, like I, I had an argument with my husband yesterday, but I didn't, like I, I didn't touch, like usually I would punch him, kick him, or throw things. (*Mmm hmm*) But, I didn't. I mean, I was going, like I wanted to, but I just didn't."

Nicole reported that her work with the therapist has enabled her to "go with the flow of things, instead of, like, taking everything so personally," suggesting that through her therapeutic work she has become less paranoid and untrusting. That these shifts devolve in part from her internalization of the therapist and his reflective capacities is indicated by the following response to the question about whether she thinks of the therapist outside of sessions:

"Yeah, sometimes when I'm alone. Like, something he, he had said about—like, if he brings up something and then, like, I'm in that situation, and then I realize what I'm doing isn't the right thing, and then I'll

think about, like, what he had said. . . . Yeah, yeah, I hear, like, his voice."

This internalization of aspects of the therapist was evident in the improvement in Nicole's capacity for mentalization on the PT-AAI at 1 year. The AAI at admission was rated as severely deficient or lacking in reflective function (–1 on the RF scale), because she retreated into silence, burst into tears, or gave hostile remarks or gestures on the demand RF questions. But on the PT-AAI at 1 year, she showed some limited capacity for consideration of mental states, albeit at a rudimentary level, leading to a rating of low or rudimentary RF (3). For example, in the following passage, in which she reflects on how the thera- peutic work has affected her, Nicole demonstrates some capacity to take a developmental perspective on mental states:

> "It's helped me because . . . I'm able to see like, more things that he's done. . . . I'm kind of like, maturing. . . . I just feel like I see things better than I did because of the therapy. Like, I, I don't see it so bad. . . . I've grown up, you know . . . it's like, I'm old, but I don't feel that way. Like, sometimes I feel real . . . mature.

The interview indicated that she drew on her rudimentary identification with and even imitation of her therapist's reflective capacity to help her to recog- nize her own thoughts, feelings, desires, wishes, and impulses as intentional mental states that can be explored and modulated in the therapeutic encoun- ter. That she remained somewhat deficient in her capacity to explore the mind of the therapist and others is evidenced by her laconic and unreflective reply to the question about why she thinks the therapist does therapy the way he does: "He probably works with everyone like that. That's just his, the way he was taught to do therapy, I guess. I don't know."

PT-AAI: Therapist

When asked initially on the PT-AAI interview to describe his relationship with the patient, the therapist presented a contradictory picture of a patient who is alternately volatile, seductive, destructive, and withdrawn, paralleling the patient's CC attachment status on the AAI and PT-AAI. He acknowledged that her contradictory presentation posed a challenge for him even as an expe- rienced clinician, and shaped an equally complex set of countertransference reactions. The therapist began his interview by comparing the treatment to Shakespeare's play *The Taming of the Shrew*, stating that this "fiery patient kind of pulls for . . . a kind of involvement." The therapist also stated that there was a "contrast between how fiery she could be at times and how some- times she just looked like the shell of a person, almost like a ghost, and you wondered where the person in her went to." Just as the patient presented in starkly contradictory ways, so the therapist vacillated between feeling hope- lessly frustrated by the patient and finding the work "quite gratifying,"

because, as he said, "I think she's beginning to get better and certainly the sessions are a lot easier with her." The five words he gave to describe Nicole—"intense," "ambivalent," "scary," "gratifying," and "fun"—convey the combination of captivation and aversion that characterized his interview. He elaborated on the word "intense" by describing her sexual overtures toward him:

> "Even more intense were those instances when she was trying to physi-
> cally seduce me. She would get up from her chair, come over, try to sit in
> my lap, and I would have to stand up so she couldn't sit, and once she
> actually got into my lap before I realized. . . . I've never had this happen.
> So she sat in my lap and I would have to, you know, sort of fight—
> 'struggle' perhaps is a better word—to disengage her physically from me.
> . . . It was quite difficult to do, of course. Even if I did it gently, she expe-
> rienced it as a total rejection. . . . It's stopped now and, I hope, for good
> . . . and, you know, I, I mean, on the one hand, that was assaultive to
> me; on the other hand, I think it was very humiliating for her. So it was a
> fine line."

In short, the therapist's words to describe the patient capture his contradictory and complex countertransference feelings, which in turn reflect the oscilla-tions in the transference evident in the patient's CC PT-AAI rating. However, because the therapist was able to describe his somewhat conflictual, angry, and overinvolved feelings toward Nicole in a coherent, contained, and humor-ous fashion, his interview was rated as secure–autonomous (resentful/con-flicted, while accepting of future involvement [F5]), albeit on the preoccupied end of secure.

Interestingly enough, given the therapist's concern about rejecting the patient, there were also intense feelings of rejection by the patient, providing evidence of an object relation of a rejecting, abusive other and a desperate self that we might see as an example of projective identification. That the therapist struggled with such difficult, conflictual feelings elicited by the object relations dyads that emerged in the transference is evident in his affirmative response to the question "Have you ever felt rejected by this patient?"

> "Yeah. Uh, it's interesting because I think there's a great sort of strong
> attachment from her to me. So I, I shouldn't feel rejected because every
> time she says she's going to drop out it, it um, it's like a child, you know,
> who says they're going to run away from home. But at, at the beginning,
> I didn't realize it . . . and at first I would think, you know, all my effort,
> and you're just going to, you know, turn your back on it. So I felt
> rejected at those times. Then I just realized that she says it but she's very
> attached and she probably won't really leave."

The therapist described the experience of separation from Nicole as anxi-ety provoking. He reported that although she initially denied having any feel-ings about separations, as treatment progressed, she sometimes threatened sui-

cide or demanded that he give her personal possessions, such as his necktie, to keep during his absence. Nonetheless, the therapist maintained a high level of RF capacity (7) about the transference distortions that fueled her acting out and treatment-threatening behaviors, along with an understanding of how his mental states were causally related to those of the patient and vice versa. For example, when asked why he believed the patient acted the way she did and how she felt about him, he vividly described the complex admixture of ideal-ization and paranoid distortion that characterized the transference, along with some playful acknowledgment of his own role in her internal world:

> "I think she's very attached to me. I think she, um, considers me some sort of savior. She doesn't understand me because she, like, she says she doesn't understand why anybody would be good, and I think she basi-cally sees me as good when she's not being paranoid and thinking that's a mask behind which evil is lurking. Um, and I think at times, I mean she's really, uh, there's been this mixture of idealization . . . thinking that the only way somebody could care about her is if she offered herself sex-ually, and then a certain amount of sexual aggression toward me. . . . 'Cause um, well, how did she feel about me? Um, I think . . . in some ways she'd like to dump her husband and have me as her husband instead."

In reflecting on what he has learned from the experience with this patient on the PT-AAI, the therapist stated that he had never seen such a "clear-cut case of a paranoid transference" and that his work with Nicole had helped him to understand better the ways in which such a transference may represent a defense against the developing attachment to the therapist. Furthermore, he stated quite candidly that his work with the patient had helped him to grow as a therapist, in that it made him pay more attention to "what goes on with the affect in the room" after "you've got the theory and technique down." He concluded, "So, if there's been a change in me, it's sort of realizing you can't do this work without a certain amount of personal engagement, but you have to be careful how much."

Evolution of Transferences

Through the therapist and patient's retrospective accounts of the treatment on the PT-AAI, we can piece together the mosaic of the antisocial, perverse, paranoid, and depressive transference manifestations (Kernberg, 1992) that emerged in the course of treatment. In the initial phases of TFP, Nicole accepted the treatment contract in bad faith, without reflection, and without any intention to follow it. Such conscious, deliberate deceptiveness is charac-teristic of antisocial transferences (Yeomans et al., 2002). Although antisocial patients have the worst prognosis of all patients with personality disorders (Kernberg, 1984), the therapist maintained some hope in this case, because he

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saw Nicole as borderline with narcissistic, paranoid, and antisocial traits rather than as a full-fledged antisocial personality. He interpreted her decep-tiveness and disregard for the contract, her insistence that she did not need anybody, and her initial indifference to separations as attempts to objectify him to avoid and contain the unmetabolized pain associated with unresolved attachment traumas that led to breakdowns in discourse and logic on the ini-tial AAI. As stated earlier, the therapist observed that approximately 4 months into the treatment, Nicole began to manifest yearnings and need for emotional closeness to him. She experienced these longings for emotional contact with him as intolerable and quite quickly reverted to perverse enactments in the therapy, culminating in her attempt to seduce the therapist, and also evident in her cutting herself in sessions. The therapist conceptualized this stage of trans-ference development as the chaotic alternation between two principal object relations dyads: one in which Nicole came across as a fierce "tiger lady," and the other in which she experienced herself as a desperately needy child. Such perverse transferences, which often entail enactments involving a confluence of sexual and aggressive wishes, are motivated by the patient's relentless desire to corrupt the therapeutic situation, to infiltrate it with hatred and destruc-tiveness, and to destroy the helpfulness of the therapist. In true antisocial per-sonalities, these actions would be motivated solely by the pleasure of triumph over others; in Nicole, they were largely to protect herself from the betrayal she feared if she let her longing show through. From an attachment perspec-tive such a perverse transference also reflects the patient's underlying unre-solved state of mind with respect to early losses and attachment traumas that, because they cannot be verbalized coherently, erupted in extreme behavioral reactions in the therapeutic arena. Kernberg (2004) has observed that in the course of their resolution, both psychopathic and perverse transferences tend to shift into paranoid transferences. As we saw earlier, the therapist described Nicole as in the grip of a "clear-cut, chronic paranoid transference." At one point this paranoid transference reached delusional proportions, when she thought her therapist might be the devil in disguise. Shortly thereafter, she hal-lucinated the presence of the devil in her bedroom, exposing a transient para-noid regression in the transference (Kernberg et al., 1989).

However, from an attachment perspective, one might also see the para-noid transference as the activation, through the intense closeness of the ther-apeutic relationship, of Nicole's dominant attachment state of mind, which the therapist characterized as her conviction that "worse than evil, you can't trust anyone, and you can't expect real kindness or caring from anybody." Hence, the therapist saw the paranoid transference as defending against its opposite—an intense attachment that Nicole could not allow herself to experience. The paranoid transference may also be seen as the externaliza-tion in the therapeutic relationship of a part of the self that the patient can-not accept, specifically, identification with the abusing, rejecting other that Nicole could not tolerate experiencing as part of herself, but expressed in aggressive enactments toward self and others. Since she could not tolerate

awareness or exploration of this split-off, internal aspect of herself, she was driven to projects it onto others.[1]

Repeated interpretations to this effect led eventually to the emergence of signs of a depressive transference involving guilt and concern about the therapist, and remorse over past failures and transgressions toward others. One sees glimmerings of such depressive anxieties and object relational patterns on the PT-AAI in Nicole's statements about her strivings to contain her anger at her husband, in her assertion that she draws on the therapist's internal presence to regulate and modulate her affect, in her acknowledgment that she is growing old and maturing, in her regrets about the tremendous damage she has wrought on her body through cutting, and her fears that her children might be affected adversely by her destructive and self-destructive activities. Such depressive themes have formed an increasingly major aspect of the treatment from the end of the first year, when the PT-AAI assessment was conducted, to the present.

With regard to major developments over the course of the therapy, we can speculate as to the significance of the interruption of the treatment when the patient's acting out flared up in the fourth year. Whereas, on a superficial level, the patient claimed that the therapist abandoned her, one might surmise that his insistence on the limits and structure necessary for the continuance of therapy contributed to Nicole achieving a more integrated and modulated view of him, as one who is not omniscient or omnipotent, but who has limits in his capacities, and can be hurt and injured. Yet enough of a positive transference—which in Freud's (1914/1958) view involved the process of "attaching him [the patient] to the treatment and to the person of the doctor" (p. 139)—had developed in the meantime that the destruction was not total, and Nicole could hold on to a positive image of him even during the period when therapy was suspended. The resumption of therapy was followed by a period in which the patient presented as depressed, apathetic, and without enough energy to perform daily tasks. Though tempted to rely on antidepressant medication, the therapist addressed this by interpretation, suggesting that Nicole was experiencing guilt and concern over the ways in which loved and needed objects were threatened by her aggression, evident as well in her fears that her children might also have been harmed by her destructive acting out toward self and others. Most recently, Nicole has also been exploring guilt over her affair and her abortion, which she fears have branded her as murderously evil. Therapeutic exploration at this stage focused on the linkage between these negative self-representations and the effects of guilt and remorse that she was beginning to experience and her ongoing identification with powerful, punitive internal object representations that she had previously projected onto others. By identifying the guilt and remorse behind Nicole's depressive, apathetic state, her therapist brought her to reflect on it and become aware that it did not define her totally. She came to realize that just as she had once split off and projected her identification with hostile internal objects, she now was splitting off and denying the libidinal side of her self.

This reflection assisted her in integrating her loving and hateful feelings toward the therapist, manifested in increased capacity for mature dependency and collaborative work, and in the extension of this capacity to relationships outside the treatment setting. This integration took place both gradually and unevenly. As is typical in the midphases of therapy, movement toward integration was often followed by a temporary regression to the paranoid constructions in the transference; but with each cycle, the regressions were less intense and briefer (Clarkin et al., 2006). The patient's experience of trust and deepening attachment to the therapist would set off a renewed fear of vulnerability and risk that had to be explored. Ultimately, as Nicole's internal integration solidified, the dialogue in the therapy sessions became a mutual exchange in which patient and therapist could explore the meanings of the patient's experience in the transference. In summary, Nicole's case indicates how, in the course of TFP treatment, the patient may oscillate among psychopathic, perverse, paranoid, and depressive transferences that parallel to some extent the fluctuations among different states of mind with respect to attachment on the AAI and the PT-AAI.

Conclusion

This chapter has illustrated some of the major issues that have arisen in attempts to apply attachment concepts and attachment research to therapeutic work with more severely disturbed patients, which was one of Bowlby's (1988) original goals for attachment theory. Specifically, the case demonstrates how systematic investigation that through the AAI provide us with a blueprint about the patient's attachment state of mind, may both predict and be complemented by clinical investigations through the transference, providing a more nuanced view of the often chaotic and contradictory, distorted, and fragmented internal working models of attachment in clinical groups. This patient dramatically illustrates how more disturbed patients often have multiple, contradictory, oscillating states of mind with respect to attachment (Main, 1991, 1999) necessitating a CC rating on the AAI or PT-AAI. Furthermore, the PT-AAI may capture the therapist's contradictory and complex countertransference feelings toward a patient with clear oscillatory tendencies in the transference. Knowledge of the AAI (and PT-AAI) and their scoring systems may help the clinician in practice to listen for multiple, conflictual, and contradictory attachment states of mind, including fleeting secure states that may emerge from an exploration of the patient's history and from here-and-now interactions with the therapist. Our investigations with the AAI have expanded our understanding of the split internal world of the patient with BPD that, from an object relations perspective, is thought to be a fundamental aspect of the pathology. Indeed, this chapter illustrates that it is through such creative syntheses of empirical and clinical investigations that advances in the application of attachment theory and research to clinical groups will be made.

Acknowledgments

Note

1. A related, but somewhat different, formulation would be that the paranoid transference was the patient's way of managing the "alien self" (Fonagy et al., 2002). Fonagy sees the alien self as an element that "colonizes" the mind of the patient without being a part of it and that, therefore, does not need to be integrated, but can "dissolve" as the patient's capacity to mentalize self and other improves. We think, rather, in terms of a bad or aggression-laden internal objects linked to the preponderance of negative affect, particularly aggression, and/or engendered by traumatic or problematic experiences with attachment figures, that needs to be integrated so that it can be mastered and used in appropriate ways, such as ambitious or competitive strivings.

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