The Clinical Implications of Current Attachment Research for Interventions with Borderline Patients*

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Introduction

Over fifteen years ago I heard Mary Main speak at the International Infancy conference in Los Angeles, where she first presented data on the predictable relation between parents' narrative accounts of their early attachment experiences on the AAI, and the attachment behaviors infants display toward that parent in the Ainsworth Strange Situation. She introduced her findings by saying that she believed they fulfilled Socrates's dictum that the unexamined life is not worth living. I knew then that these findings had significant clinical implications, and indeed I have spent the last fifteen years grappling with how to apply them to clinical research and practice, particularly with borderline patients.

Insecure attachment is one of the hallmarks of borderline conditions. The features of borderline attachments, including the unpredictable shifts between clinging and repudiation, intense idealization and scathing devaluation, terrors of abandonment and unilateral rejection of others, have been reconceptualized as sequelae of insecure attachment organization and as failures of reflective function (Fonagy 1991, 1998, 2001, Gunderson 1996, West and Keller 1994). Indeed, several studies of the autobiographical narratives that borderline patients give on an Adult Attachment Interview (AAI; George et al. 1985, 1996) have shown that the majority are classified with

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preoccupied and/or unresolved states of mind with respect to early attachment experiences, with a minority classified as dismissing (Fonagy et al. 1996, Patrick et al. 1994). Each of these insecure attachment classifications, as Main (personal communication, 2001) has pointed out, involves contradictory, incompatible working models of attachment: the preoccupied person oscillates between good and bad evaluations of self and other; the unresolved person shows logically inconsistent simultaneous beliefs (such as believing that an individual is dead and not dead) or sudden breaks in discourse, while the dismissing individual holds a "positive or idealized" working model at the semantic level and a "negative" contradictory model at the episodic level. Such contradictory unintegrated models are particularly evident in the transference, and those who treat borderline patients know that in the same session the patient can shift abruptly from a collaborative behavior to a devaluing and hostile, or withdrawn and disengaged, stance. In psychoanalytically oriented psychotherapy, the transference is the vehicle for mobilizing and transforming such insecure attachment patterns, but until recently we have lacked reliable and valid measures to assess changes in such patterns and the mental models of attachment relationships that underlie them.

In an ongoing longitudinal research project on the psychotherapy of borderline personality at the Personality Disorders Institute (PDI) at New York Presbyterian Hospital-Weill Medical Center of Cornell University, we have recently begun to use the AAI to assess attachment representations of borderline patients, and the way they change over the course of a psychoanalytically oriented psychotherapy called Transference-Focused Psychotherapy (TFP). A comprehensive description of the overall study and assessment procedures has been presented in other publications (Diamond et al. 1999, Diamond et al. 2002). Here we will focus on the measures and procedures relevant to our clinical cases in TFP treatment, beginning with a description of the treatment itself. Transference-Focused Psychotherapy (TFP) is based on object relations theory (Kernberg 1975, 1976, 1994) and is designed to achieve change in the patient's representational world through the interpretation of the transference relationship with particular emphasis on the here and now (Clarkin et al. 1998). Clinical researchers at the PDI have described the tactics and techniques of TFP in three volumes of a treatment manual (Kernberg et al. 1989, Clarkin et al. 1998, Yeomans et al. 2002). The primary goal of TFP is to help borderline patients develop im-

ages of self and others that are integrated, multidimensional and cohesive, to modify primitive defensive operations, and to resolve identity diffusion. TFP involves several major treatment phases: 1) an initial contract setting phase designed to identify and contain the major areas of self-destructive acting-out, 2) an early treatment phase that involves the identification of dominant object-relational patterns as they are lived out in transference, 3) a mid-phase of treatment that focuses on the integration of split, polarized and part-object identifications via here-and-now transference interpretations, 4) an advanced stage of treatment that involves genetic interpretations that link current relational and transference patterns with early experiences, and 5) a termination phase. Although TFP is a manualized treatment that stipulates a specific sequence of treatment phases and guidelines for phase-appropriate interventions, the progression through those phases is thought to depend partly on individual patient characteristics and on the nature of the particular patient–therapist dyad. These guidelines are designed to maximize the goals of TFP, which in short involve changing those characteristics of the patient's object relations that lead to repetitive maladaptive behaviors and chronic affective and cognitive disturbances.

An outcome study from the PDI with seventeen patients who completed one year of TFP found that borderline patients showed a significant reduction of suicide attempts and behaviors, a decrease in medical risk, and severity of medical condition following self–injurious behaviors, and a decrease of hospitalizations (Clarkin et al. 2001). A second non–randomized comparison study (Levy et al. in review) comparing twenty-six TFP–treated BPD patients with seventeen patients in treatment as usual (TAU), found that TFP–treated patients showed a significant reduction in emergency room visits, hospitalizations, and days hospitalized compared with TAU patients. In addition, preliminary data analysis on changes in attachment organization of twenty-five patients after one year of TFP showed that there was a significant improvement in the coherence of narrative on the AAI, although only a minority of the sample showed an overall shift from insecure to secure states of mind with respect to attachment at one year (Levy 2002).

In this study, we have been assessing changes in the patient's attachment organization with the AAI, (George et al. 1998), a semi–structured in-depth interview designed to elicit early attachment memories and experiences. The AAI is given at four months and after one year of TFP, and is then rated for attachment classification according to the five-way Adult Attachment

Scoring and Classification System (Main and Goldwyn, 1985–1994). (For a comprehensive description of the AAI and its scoring system, see Hesse 1999.) Patients' symptomatology was also assessed on a number of measures including the Daily Diary Cards (Shearin and Linehan 1992), a two-page self report questionnaire designed to assess for various symptoms and behaviors, particularly self-destructive behaviors, on a daily basis.

In addition to investigating the relationship between attachment status as assessed on the AAI and treatment process and outcome for twenty patients in twice-weekly therapy, we have also been investigating the impact of the patients' attachment status on the therapeutic relationship through an interview adapted from the AAI (George et al. 1998), called the Patient–Therapist Adult Attachment Interview or PT–AAI (Diamond et al. 1999, George et al. 1998). The PT-AAI is designed to assess the patient's and therapist's state of mind with respect to attachment in the therapeutic relationship, or the conscious and unconscious rules that the individual has developed for organizing attachment related experiences, feelings, and thoughts, but within the context of the therapeutic rather than the parent–child relationship. The PT–AAI follows the same format and order of questions as does the AAI, with minor changes in the wording of questions to fit the context of the patient–therapist as opposed to parent–child relationship. The PT–AAI may be scored for attachment classification, using an adaptation of the five-way Adult Attachment Scoring and Classification System (Main and Goldwyn 1998), and for reflective function, using the Reflective Function Scale (Fonagy et al. 1997). (For a

Table 1. Measures

Adult Attachment Interview (AAI)
Semi-structured clinical interview
Scored for attachment classification and reflective function
Given at four months and one year
Patient-Therapist Adult Attachment Interview (PT-AAI)
Semi-Structured clinical interview adapted from AAI
Given at one year
Scored for attachment classification and reflective function
Diary Cards
Self-report questionnaire on symptoms, impulses, actions, and urges to self-harm
Given weekly

more comprehensive description of the PT–AAI, see Diamond et al. 2002, in press.) In developing the PT–AAI, we have been attempting to advance our understanding of how attachment status might affect both transference–countertransference dynamics (Dozier, Cue, and Barnett 1993, Dozier and Tyrrell 1998, Fonagy 1991, 1998, Holmes 1995, 1996, 1998, Sable 1992, Szajnberg and Crittenden 1997), and the quality and nature of the therapeutic alliance (Bordin 1994, Mackie 1981, Slade 1999).

The extension of attachment theory and research to the clinical arena has recently led to investigations of the ways in which attachment status may have an impact on many aspects of the therapeutic situation, including the configuration of the patient–therapist relationship. Indeed, the therapist is now seen as a prototypical example of an attachment figure in adulthood (Farber et al. 1995). Bowlby (1977) conceived of the therapeutic relationship at least in part as an attachment relationship, guided by the proclivity of humans throughout the life cycle to seek "proximity to some other differentiated and preferred individual . . . conceived as older or wiser," especially when the individual is "distressed, ill or afraid" (p. 792). Further, like all attachment relationships, the therapeutic one was thought by Bowlby (1969, 1973) to be inherently bidirectional with attachment-seeking behavior (proximity seeking, smiling, calling) tending to evoke corresponding adult attachment or caretaking behavior (soothing, holding, protecting) and hence, in Bowlby's view (1977, 1978, 1979), the attachment behavioral system contributes to the configuration of transference and countertransference dynamics. Patients inevitably bring to therapy expectations of the therapist that are consistent with their attachment histories, and indeed, the therapeutic relationship is uniquely suited to evoking and illuminating the patient's working models of attachment, which in the case of insecure states are likely to be multiple, contradictory and unintegrated, leading complex and sometimes chaotic transferences (Farber et al. 1995, Holmes 1996, Main 1991, 1995, 1999). But in emphasizing the importance of the therapist serving as a secure base—a reliable and trustworthy person with whom the patient can explore his representational models of self and others so as to reappraise these models on the basis of new relational experiences—Bowlby (1977) also made attachment an integral part of the treatment alliance.

Attachment status may also play a prominent role in the configuration of the countertransference in both the narrow and broad definitions

of the term (Racker 1968). For example, not only will the therapist's own states of mind with respect to early attachment relationships inevitably be activated in the therapeutic situation, but also the therapist's own feeling states may provide an index to the patient's particular type of attachment organization (Fonagy 1991, Szajnberg and Crittenden 1997). Particularly with the more severely disturbed patient, the therapist may be able to comprehend fully the patient's often complex and contradictory representational states with respect to attachment only by objectively sorting through his or her own welter of internal responses to the patient. Although our work on the relationship between attachment status and psychotherapeutic process is in its early stages, our observations suggest that attention to the patient's state of mind with respect to attachment may help the therapist to better engage some difficult–to–treat borderline patients in psychoanalytically–oriented psychotherapy. This is not to suggest that attachment status can be confounded with clinical diagnosis. Attachment status is going to have different presentations in patients with different levels of personality organization.

We now present two prototypical patients from our study, with a focus on how their representational states with respect to attachment as assessed on the AAI might have shaped their symptomatic presentation as well as aspects of the therapeutic process and outcome during the first year of psychotherapy, including the transference and countertransference dynamics.

Case Illustrations

Both patients were in their early thirties, selected for this paper because they had completed at least one year of TFP with the same therapist who was judged independently to be both adherent to the manualized therapy and competent to carry it out. Both patients were diagnosed with borderline personality organization (Kernberg 1975) and borderline personality disorder (American Psychiatric Association, *DSM-IV* 1994), and both had made at least one parasuicidal gesture within eight weeks of admission to the project. In addition, both had been hospitalized at least once, and had had a number of unsuccessful outpatient treatments. Further, both were considered treatment successes within the parameters of the research project in that they completed one year of therapy, showed diminution of symptoms, including self–injurious urges and behaviors, and improved psychosocial functioning after one year.

The first patient, whom I will call Adam, was the only child in a chaotic family, in which he remained enmeshed despite his marriage of several years duration. Adam described his relationship with his mother as "joined at the hip." His mother, whose career as a musician had been cut short by a chronic degenerative illness, depended on Adam for emotional and physical caretaking as a result of her physical deterioration and episodic depressions. Adam had a brother who died in a car accident at age 5, two years before the patient's birth. He thought his parents believed him to be the reincarnation of that child, and sometimes called him by the brother's name and dressed him in his clothes. He described his father, who was an intermittent drug abuser, as alternatively "cruel, seductive, and pathetic." The parents frequently separated and reunited during Adam's childhood, and both eroticized their relationship with him by engaging in a number of overt and covert sexualized interactions, such as masturbating in front of him. In addition, he recollects various bizarre and traumatic incidents from his childhood, including witnessing his father drowning his pets.

On the AAI, Adam received a primary attachment classification of Unresolved (U) and a secondary classification of Preoccupied (E) with specific subtypes of Fearfully Preoccupied with traumatic events (E3) and Angry, Conflicted (E2). As is the case for those with a primary classification of Unresolved, Adam's attachment interview showed evidence of a breakdown in discourse strategies and a loss of memory related to past traumatic experiences, as indicated in the following passage, in which he describes the violent behavior on the part of his father:

> "We kept getting . . . we kept getting replacement pets. And then when they would get full-grown and they were boring, my father didn't like them anymore and he'd get rid of them. But I—all I knew though when I was a

Table 2. Attachment Classification for Patients A and B

	ATTACHMENT CLASSIFICATION			
	AAI* Time 1	AAI* Time 2	PT-AAI + Patient	PT-AAI+ Therapist
ADAM	U/E3b/2	F5/U	F5	F5
BETH	DS2	F1	Ds3	F3

*Adult Attachment Interview (AAI)

+Patient-Therapist Adult Attachment Interview (PT-AAI)

kid is that they disappeared . . . And it wasn't until I was older, and I think I was like in fifth or sixth grade and I saw my dad killing my pet . . . that was pretty horrible . . . he um he strangled it . . . I forgot for like a couple of years before I remembered it . . . it was so upsetting . . . And then I wasn't like sure if I had seen it or not, and I thought you know I must've like made this up . . ."

Adam's memories of sexual and physical maltreatment in childhood remained unintegrated into his adult experience and functioning, as were his memories of loss. For example, he reported that his first experience with death was "hearing about my brother who had died . . . all the time. To the point that I thought I was my brother reincarnated . . . And I had to start seeing like, a child psychologist when I was 3 because I was going up to strangers in the grocery store and saying 'you know my brother died' and then they'd get nervous and like, laugh . . ." Aside from such isolated moments as those quoted here, when Adam became disorganized around past loss or abuse experiences, he was preoccupied with anger at attachment figures with whom he remained entangled, reflected in the five words he chose to describe his relationship with his mother: "intimate, neurotic, desperate, scared and confusing."

The clinical course for Adam during the first year of therapy was extremely tempestuous, and punctuated by ongoing urges toward self–mutilation. It was necessary to hospitalize him briefly on three occasions in the first six months of treatment. At one point he engaged in an affair that escalated into a murder–suicide pact that threatened his safety and that of his therapist. After this stormy beginning, however, he settled into the therapy, ceased self–destructive acting out, and became increasingly involved in and committed to his therapy, which he chose to continue when the research year ended. By the end of the first year of therapy, he was able to work at a job, which utilized some of his writing talents, and began to consider having a family of his own. At one year he was reclassified on the AAI with a secure state of mind with respect to attachment, although he was on the Preoccupied end of secure (F5), indicating that he continued to show some moderate angry preoccupations with attachment objects, but was coherent, contained, and even humorous about it. In addition, at one year he received a secondary classification of Unresolved.

As one might expect from a patient whose AAI was rated as Unresolved for trauma and Fearfully Preoccupied, Adam conveyed that initially he was

not "forthcoming" with the therapist, who he thought was uninterested in helping him and would forget about him between sessions. However, he said on the PT–AAI interview at one year that he gradually let go of the "sad, lame, tricky borderline part" of himself and that there was a gradual change of trusting him more." Asked to give five words that reflect his relationship with his therapist, Adam chose "reliable, dignified, important, mildly frustrating, and confusing." He was able to support his descriptions with semantic memories. Reflecting on what separations from his therapist were like for him, he said that while they were "stressful" and at times "seemingly endless," they became progressively easier for him to manage. When asked what he does when he's upset, he replied that he tends to talk about it a lot, but he no longer tries to kill himself—which, he states, he "got out of his system." Adam's description of how over the course of treatment the therapist came to serve as a secure base is reminiscent of how Bowlby (1988) conceptualized the relationship between therapist and patient: "I guess I feel a little more secure in general just because he has been so reliable as a steadying influence" . . . I kind of feel like I survive the unreliable things in day–to–day life better because there's something that's sort of steady. And just having one thing . . . that is kind of safe helps with all the things that aren't safe. The way a home would ideally feel when you're a kid . . ."

The therapist reported on the PT–AAI that he was initially wary of Adam, and that he alternately felt uncomfortable, frightened, angry, exasperated, or threatened. At times he became flooded and confused, his disorganized responses echoing Adam's own response to his seductive, over–stimulating parents. Despite the tempestuous initial phases of the treatment, certain aspects of his presentation captivated the therapist. For example, he described him as "the most creative patient I've ever had," and stated, "I've had to be on guard because it would be easy to be sidetracked by that." He reported not being overly anxious about Adam's safety during separations, and said that when he thought about him when away, it was less with trepidation than with pleasure or curiosity about his communications. His engagement with this patient was evident in the five words he used to describe him at one year: "committed, stable, creative, interesting and enjoyable," although he had to increase his vigilance over the course of the year as the following statement from the PT–AAI indicates:

"He came in a few weeks ago and said he was writing a book. And he'd written a couple of chapters. And that book was about a well-intentioned therapist whose very own interventions that were meant to try and help the patient led to his suicide . . . not every patient is as clever as that in finding ways to, you know, communicate their combination of attachment and devaluation . . . so I never know what to expect, but it's often clever."

Interestingly enough, the PT–AAI's for Adam and his therapist were both rated as secure/autonomous (F5) at one year, again on the Preoccupied end of secure.

CLINICAL PROCESS:

Adam's dual attachment status of Unresolved and Preoccupied was evident in both the confused, fractured nature of his discourse in the sessions, and in the chaotic, self-destructive behaviors he exhibited during the contract-setting phase. In an initial contract-setting session, for instance, Adam began by telling the therapist that he had engaged in self-destructive behaviors and had contacted a former therapist three times over the weekend to tell her about his suicidality.

Adam: "I also burned my arm with a cigarette for the first time in two years . . . and I mean, I did my best to ruin my marriage . . . I called my wife's best friend, whom I was dating before my wife. I called . . . I had . . . I was furiously planning to call my mother . . . who's separated from my father right now, but it's back and forth. I was going to ask her if I could go home and like have an affair with her (laughs) . . . and it seemed like, I was like, that was going to be a normal thing to do, or necessary thing to do, you know."

Not derailed by the patient's somewhat shocking and scintillating utterances, the therapist focused on the identification and management of self-destructive behaviors.

Therapist: You see, this notion of "suicide" being the magic word is what we have to discuss . . . because it's clear that it has to do with the feelings you're experiencing and from the way that you are responded to.

Subsequently, Adam acknowledged that self-destructiveness functioned as a way of engaging his former psychiatrist. He talked about feeling that he got mixed messages from his former psychiatrist, who gave him his home number for emergency situations. But when he called him constantly in suicidal crises, he terminated his treatment and referred him to our project.

Reflecting on his relationship with him, Adam said, "I . . . feel rejected and it makes me angry and suicidal, but being treated nicely makes me encouraged and then it just gets confusing . . . I mean not that I want to be treated not nicely, but you know what I mean . . ." The patient and therapist then talked about emergencies and how to handle them in this treatment.

During the initial contract-setting sessions, the patient also articulated what is an essential problem for him: "I have hidden from people . . . people are dangerous," he told the therapist. Shortly thereafter he stated abruptly, "Feeling miserable . . . like to die," and lapsed into an unresponsive stance. "That does sound like a chronic feeling," replied the therapist, and stated that it must feel like he's in a state of constant emergency.

The foregoing clinical material, by necessity highly condensed, bears the imprint of the patient's unresolved attachment status, evident particularly in the lapses in his reasoning and discourse around the issue of abuse. Aspects of his discourse are also reminiscent of the collapse of behavioral and attentional strategies observed in disorganized/disoriented infants in the Strange Situation. Just as the disorganized infant will freeze or play dead upon reunion with the mother in the Strange Situation, so did this patient radically halt the flow of therapeutic dialogue through his abrupt reversals and statements such as "feeling miserable . . . like to die" or "want to be dead." Indeed, Adam's alternation in sessions between a playful, witty posture and one of frozen immobility was reminiscent of the rapidly shifting and contradictory postures observed in disorganized/disoriented infants—the childhood analogue for the Unresolved category in adulthood (Main and Morgan 1996).

Not surprisingly the experience of the therapist as a potentially fearful and dangerous object emerged quite quickly in the context of an early session where the patient talked about his mother's lack of concern for him, demonstrated most recently by the mother telling him that she no longer could afford to phone or visit the patient.

Therapist: Where do you imagine I'd fall on the concerned versus not concerned spectrum?

Adam: Well you're probably about where my parents are.

Therapist: Your parents who don't have enough money to phone you anymore.

Adam: And my dad who was wondering why I didn't just jump in front of a train, 'cause that would work (laughs). But uh, you're not that bad.

Therapist: Well, but it feels that way.

The foregoing clinical process bears the imprint of Adam's unresolved and preoccupied state of mind, which is reflected both in the abrupt breaks in the discourse and in the oscillations between extreme positive and negative views of self and others. Further, the clinical material shows the emergence, even in the initial contract–setting phase, of an internal working model of attachment that encompasses a view of others as cold and abusive, and a view of the self as helpless and abused.

The Dismissing Patient

The second patient, whom I will call Beth, was from a family that she depicted as cold, conflictual, and combative with embattled parents who were minimally attentive and affectionate. She reported having few memories of her parents, who, for their part, often forgot to pick her up at school. Her father, who was severely depressed and alcoholic, was often absent for weeks at a time, and when present, was sporadically violent, on one occasion smashing a car into the house.

Beth had a barren and constricted manner of expressing herself on the AAI, and initially received a primary classification of dismissing of attachment (D), with the specific subtype of devaluing of attachment (Ds2). She could recall few memories of her childhood, depicted her parents in a uniformly detached fashion, and tended to minimize the significance of feelings linked to early attachment experiences. The words that came to mind in describing her relationship with her mother were "cold, sometimes warm, not very motherly, calm and sparse," but she could provide only the barest specific memories to back up her generalizations. Instead, she kept reiterating that the family environment was "just cold . . . It was empty . . . not much furniture . . . everything was slate and stone, and she (mother) just never did anything to make it warm. It was like, really cold. . . . there was nothing warm . . . it was just cold . . ." The patient stated that as a child she used to retreat to an attic hideaway where she comforted herself in isolation. The five words she chose to describe her childhood relationship with her father, "tumultuous, scaring, loud, violent and [I] felt guilty," were more vivid and specific and showed some capacity to portray problematic aspects of her history, but generally she tended to distance herself from attachment experiences and associated affects. Further, she discounted their impact on her current functioning and development, as indicated in the following response to the question of how, having lived with her father's episodic threats

and acts of violence, might influence her now as an adult: "I'm sure it must but I don't know how really. I mean, I'm sure if, you know, if you have a great, you know, perfectly adjusted childhood it probably helps you as a result. But I don't know specifically how it affects me . . ."

Beth's clinical course was relatively smooth and uneventful, despite the fact that she had been referred to the study after a near–lethal suicide attempt. When she entered the project she was employed in a white collar job that was below her capacities and was also vacillating indecisively between several relationships. During the treatment year, she made no further suicide attempts or gestures, was not rehospitalized, committed herself to one relationship, and married in the course of treatment—all of which could be seen as the results of diminution of identity diffusion and improvement in object relations. Indeed at one year, Beth was reclassified with a secure state of mind with respect to attachment, although she remained on the dismissing end of secure. Her classification of (F1) indicated that she had re–evaluated and "set aside" early disappointing attachment relationships and redirected her attention to new experiences and relationships.

Although Beth dutifully participated in one year of treatment, her engagement with her therapist was somewhat limited and self-protective. Just as she described growing up in a cold and stark environment on the AAI, so did Beth experience the treatment relationship as somewhat distant and uninvolved. On the PT–AAI, she described her therapist as "professional, controlled, understanding, and concerned" about her, but said that their relationship was "not that personal." The few episodic memories that she offers to illustrate these five descriptions were rather lame and unconvincing. She also minimized the significance of separations from the therapist and reported not feeling anything when informed about an upcoming vacation, but stated, "Maybe there was once or twice when I got depressed when he was away and I said to myself that I couldn't wait till he came back . . . but I didn't really miss him greatly when he left . . ." When asked how the therapist responded when she was upset, she added, "He'd . . . give me an idea of why I was feeling the way I was feeling . . . um I didn't get that upset this year . . ." She did report that the therapy definitely helped her and made her "realize more about myself . . . why I do things and why I feel the way I feel, and you know, where it comes from . . ." However, other statements indicated that the therapeutic explorations challenged her tendency to distance herself from the affective experience of relationships—

which undoubtedly contributed to her decision to terminate after one year when the research year ended. For example, she stated, "I didn't want him or anybody to know I was angry . . . consciously, I didn't know I didn't want anybody to know, if you know what I mean. But he'd say or start digging into things and find out why I was angry and then I'd realize something really made me mad, but I didn't want to be mad. With my parents, for example, I didn't want to be angry with them."

In the above statement there is also a sense of heightened anxiety and insecurity that has been associated with a shift from dismissing to secure attachment organization (Hazan and Shaver 1994).

On the PT–AAI, the therapist was somewhat unilateral in describing his relationship with Beth as evidenced in the five words he chose to describe it: "distant, rigid, formal, cold and superficial." He reported feelings of rejection and exclusion from her life, and freely acknowledged his frustration with her tendency to "close off to what I was saying and dismiss it in a devaluing way." He stated: "I don't think she ever wanted me to see everything going on inside of her, so she would be well behaved and withholding at the same time . . . it was hard. to figure out how to get to the deeper levels . . . we did make some progress with that . . ." The therapist reported that he rarely thought about Beth outside of the treatment situation, and that he had no fantasies about her. Acknowledging that he felt rejected and disappointed by Beth's decision to leave treatment after one year, he understood it as Beth's way of turning the tables on others by whom she felt "chronically dismissed." The therapist stated, "She seemed to have an identification with narcissistic, cold, rejecting parents," and felt that she treated him "with the same narcissistic indifference that she felt she was the object of." Interestingly enough, on the PT–AAI, whereas the therapist was classified with a secure state of mind with respect to Beth (F3), she was classified with a dismissing state of mind with respect to the therapist (Ds3), which closely approximated her original state of mind with respect to her early attachment relationships (Ds2).

Clinical Process

At the beginning of the therapy, Beth presented as the quintessential avoidant patient who had split off her wish for intimacy, comfort, and contact, and her anger about separation. During the contract-setting phase when core problems are defined, Beth's dismissing stance was evident in the problem

that she identified as primary: "I don't like being around other people, I don't know if that . . . I haven't had many successful relationships . . ."

Therapist: . . . I think problem number one that would come up in the therapy might be your keeping some of what you're thinking or what you're feeling to yourself. Do you agree?
Beth: It's possible. I don't know. I mean I've tried to say what I'm feeling . . .
Therapist: Oh, but there's some obstacle there. Because your former therapist said that you'd been having suicidal thoughts a long time before you discussed them. Is that correct?
Beth: Yes.

The therapist responded to the patient's laconic answers and minimization of affect by filling in what he imagined the patient is feeling.

Therapist: But it's not so much depression, you say, it's more loss?
Beth: Ah, hah.
Therapist: Or feeling empty.
Beth: . . . It seems very comforting to me [the idea of suicide]. That's the problem, I think . . . Even when I feel like this I don't like crying . . . when I'm depressed . . . I just want it to stop . . .
Therapist: So the world is a pretty bleak place?
Beth: Yeah.
Therapist: It doesn't offer much comfort.
Beth: Yeah.

This initial session culminated with the therapist identifying the major affective themes and translating them into an object relational context or dyad. He stated, "We have two things to look at. One has to do with the way that you experience yourself . . . as being worthless, and the other has to do with how you see the world, which is cold and very uncomforting." One is reminded here of Beth's description on the AAI of the emotional climate of her family as "just cold." Indeed, in a subsequent session the patient elaborated further on the conviction that expressing feelings could not possibly lead to help or affective responsiveness on the part of caretakers, stating, ". . . I knew it wasn't normal to kill yourself, but I didn't know it wasn't normal to be that depressed . . . it was like that in my house when I grew up, you know, it was normal to be depressed and nobody would pay any attention to it . . ."

The initial therapeutic explorations during the contract-setting phase revealed that Beth holds back feelings, not only out of her conviction that

they will be discounted or ignored, as was the case in her family of origin, but also because she feared that they would be ridiculed. For example, she revealed that she had never told her boyfriend, to whom she had recently become engaged, about the extent of her depression, because she was afraid that he would "laugh at" her. One is reminded here of the observations that avoidant infants are mocked or ridiculed by their caretakers when they attempt to evoke attachment–related behaviors (Main and Weston 1982). Thus, Beth's dismissing state of mind with respect to attachment was found to pervade both the content and the structure of the therapeutic discourse.

Change on the AAI

At one year, both patients were classified as Secure/autonomous (F) on the AAI, although Adam remained on the preoccupied end of the secure spectrum (F5), while Beth was on the dismissing end (F1). In addition, Adam continued to be rated with a secondary classification of unresolved for trauma (U). Although both achieved a primary secure status, the two patients showed interesting differential patterns of change on the AAI subscales.

Both patients showed an increase in subscale ratings of overall *coherence of transcript*, that is, in the capacity to tell their story collaboratively and consistently, and in *metacognitive monitoring*, or the capacity to monitor and reflect on processes of thinking and recall as one tells the story. However, Adam's *perception of his parents as rejecting, his involving anger toward them, and his lack of recall of early attachment experiences* all diminished, while Beth showed a decrease in *the dismissing derogation of attachment relationships* and experiences overall, but an increase in her view of the *parents as role–reversing* or overly demanding that she be responsible for their emotional and physical well–being. These findings on the AAI subscales suggest that the trajectory of change toward security may differ for patients with different attachment organization.

We were surprised that Adam and Beth were judged by independent blind raters to have shifted their primary attachment classification from insecure to secure after only one year of therapy, given the severity of their pathology and our experience that it generally takes years of treatment before such patients make substantial long–term changes. We want to emphasize that a secure state of mind with respect to attachment is not necessarily synonymous with secure attachment overall. We may surmise that

the shift to secure status for these two patients indicates a change in the organization and coherence of their verbal discourse, and in the capacity to use such discourse to cope with and coherently verbalize impulses and affects that heretofore were expressed through self-destructive acting out. If one assumes that acting out involves the inability to symbolize or reflect on the internal states of self and other, and that it represents "discharge to ward off psychic reality" (Green 1993, p. 77), then the capacity to demonstrate a secure state of mind on AAI shows some increased capacity to tolerate and represent psychic reality coherently. The findings on the ways in which changes in attachment classification were paralleled by a decrease in levels of self–reported symptomatology and particularly in self–injurious impulses and actions that will be presented in the following section, provide support for the above formulation.

Changes in Self-Report Symptomatology

The changes in attachment organization, as well as the attachment classifications themselves of the two patients, were reflected in the trajectory of their symptoms, and particularly in their suicidal impulses and actions over the course of the first year as reported on the daily diary cards. Patients were asked to report their level of "urge" to engage in various self-destructive behaviors on a 0 to 5 Likert–type scale (that ranged from O or absent, to 5 or constant, intense), and to respond yes or no regarding whether they had actually engaged in self–injurious behaviors, including impulses and actions to self–harm, and the "urge to quit treatment." Adam, who was classified as Unresolved and Preoccupied on the AAI, showed chaotic and episodic levels of urge to self–harm throughout the treatment as evident in the figure that summarizes his diary cards from the initial phase of treatment (weeks 1 and 6).

These figures present a summary of the daily diary cards for each week, as seen on the horizontal axis, with the vertical axis representing the intensity and frequency of the self–injurious actions and urges. The amplitude of these urges appeared to decrease over the treatment year, as is evident in the next figure that summarizes Adam's diary cards from the latter stages (weeks 21 and 37) of treatment.

Adam endorsed significant urges to harm himself and to quit the treatment. Beth, who was classified as Dismissing on the AAI, reported gener-

ally lower levels of urges to harm herself throughout the treatment year, with occasional spikes, as is evident in the following two figures.

In sum, for both patients there was a decrease in the number and intensity of self–destructive urges and actions during the course of the first year of therapy, although this decrease was much more dramatic for Adam than for Beth.

Conclusion

Given the substantial evidence offered by attachment researchers of the lawful predictability through the life cycle and across generations of internal working models of attachment (Main, Kaplan, and Cassidy 1985), it is not surprising that aspects of the treatment experience and relationship are initially assimilated to their Procrustean bed. Knowledge of the patient's attachment status may function as a guide for understanding the differences in patients' symptomatic presentation, in the way they change, and in aspects of the treatment process itself, including the transference–countertransference dynamics. Our findings show that two patients with the same diagnosis and level of personality organization, but with very different states of mind with respect to attachment, engaged the therapist's subjectivity in vastly different ways. The patient's state of mind with respect to attachment, and the therapist's response to it may be thought to constitute a "third term," or "analytic third" (Ogden 1994) that reflects the "unique dialectic generated by (between) the separate subjectivities" (p. 4) of patient and therapist. Although he was coherent and collaborative in his account of Beth's treatment, the therapist readily acknowledged that he responded to the dismissiveness of Beth by pursuing her elusive affects, which in turn may have led to a replication of her dismissing state of mind with respect to early attachment figures in the therapeutic relationship, reflected in the dismissing classification (Ds3) of Beth's PT–AAI at one year. By contrast, the Unresolved/Preoccupied state of mind of Adam, found a fuller, richer, and more nuanced resonance in the therapist, evident in his PT-AAI classification of F5, which showed some preoccupation with the patient, albeit expressed with humor, containment, and coherence. The therapist readily tolerated even Adam's most heinous projections and near–violent enactments, along with the welter of pleasurable and frightening feelings he evoked in him, and was able to contain and use them to therapeutic

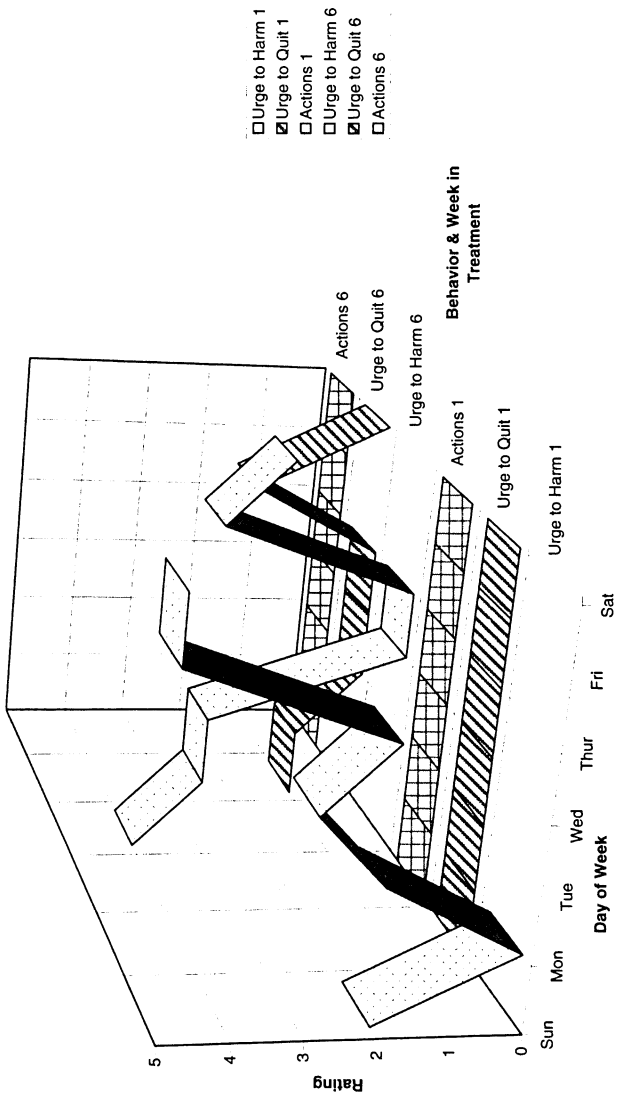


Figure 1.

Figure 2.
Urges & Actions to Self-Harm: Late Treatment Phase Subject A

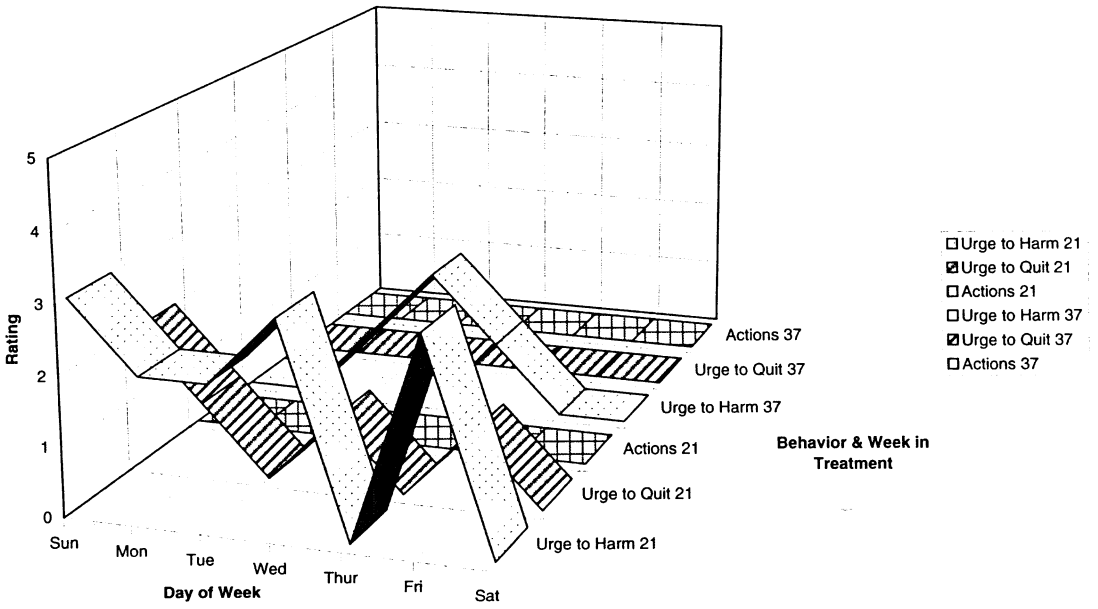
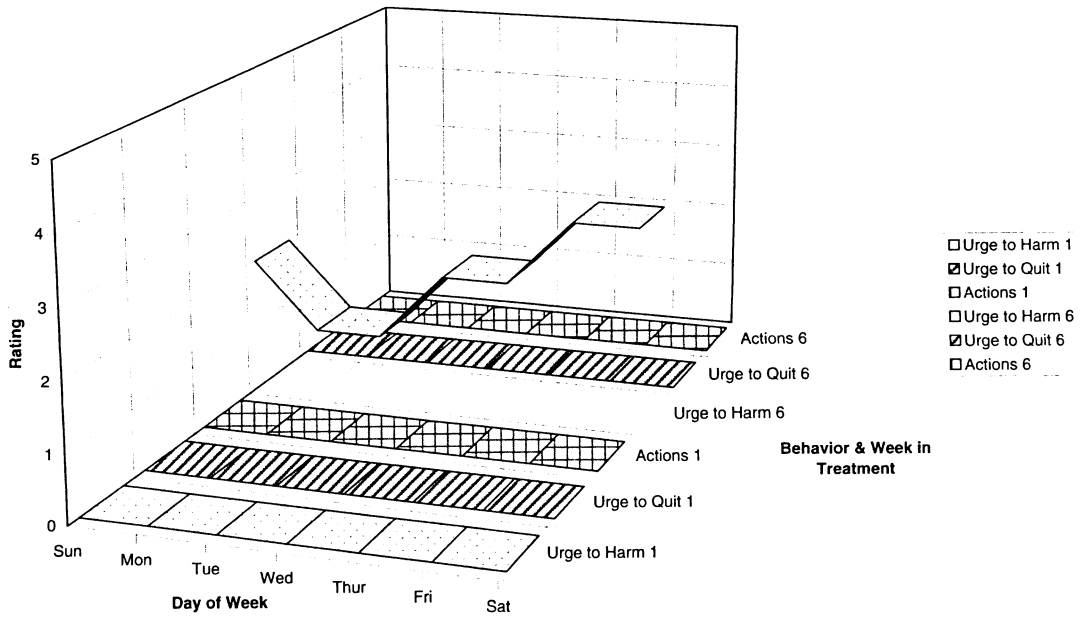


Figure 3.
Urges & Actions to Self-Harm: Early Treatment Phase Subject B



advantage. Bion (1962, 1967) describes the model of the container and the contained in which the therapist contains, metabolizes, and detoxifies the patient's projected affects, impulses, and internal states, and presents them to the patient in more tolerable form to be re-experienced and re-internalized.

The shift to secure states of mind in these borderline patients after a year of intensive therapy suggests that the therapeutic relationship may function either as a container of insecure attachment (in the case of Adam, whose state of mind with respect to the therapist and the parents was secure after one year) and/or as a funnel for insecure attachment (in the case of Beth, whose state of mind with respect to the therapist after one year replicated her state of mind with respect to the parents at four months). Main (1999) has suggested that this shift to security for the two borderline patients in the course of a year's treatment in which the major focus was on the here–and–now of the transference, rather than the there–and–then of the patient's attachment history, means that "the patients learned to discuss that history coherently and collaboratively as a simple result of learning new implicit procedures for interactions in a different context" (p. 870). In other words, by not focusing on a review of explicit or autobiographical memory as do some dynamic treatments, but on the evolving transference relationship with the therapist, TFP creates the conditions for a revision of the implicit emotional memory of attachment. Main's formulation is consistent with the recent emphasis on non–interpretive mechanisms of change in psychoanalytic therapy, and particularly on shifts in implicit relational knowing resulting from heightened affective exchanges or moments of mutual recognition between therapist and patient (Lyons-Ruth 1999, Stern et al. 1998). In TFP, however, the mutative factors are thought to be both the experience *and* interpretation of the transference relationship with the therapist.

It is clear from the clinical process material that the attachment status of both patients helped to configure the therapeutic process during the first year of TFP. This was particularly the case during the early phases, which involve the identification of problems that could interfere with the patient's safety or the therapy, and the setting up of an individualized treatment contract. The clinical vignettes from the initial contract setting phase for Adam and Beth illustrate that attachment status helped to shape both the types of problems identified as salient, and the nature of the interaction between patient and therapist, providing a first view of the patient's internalized world

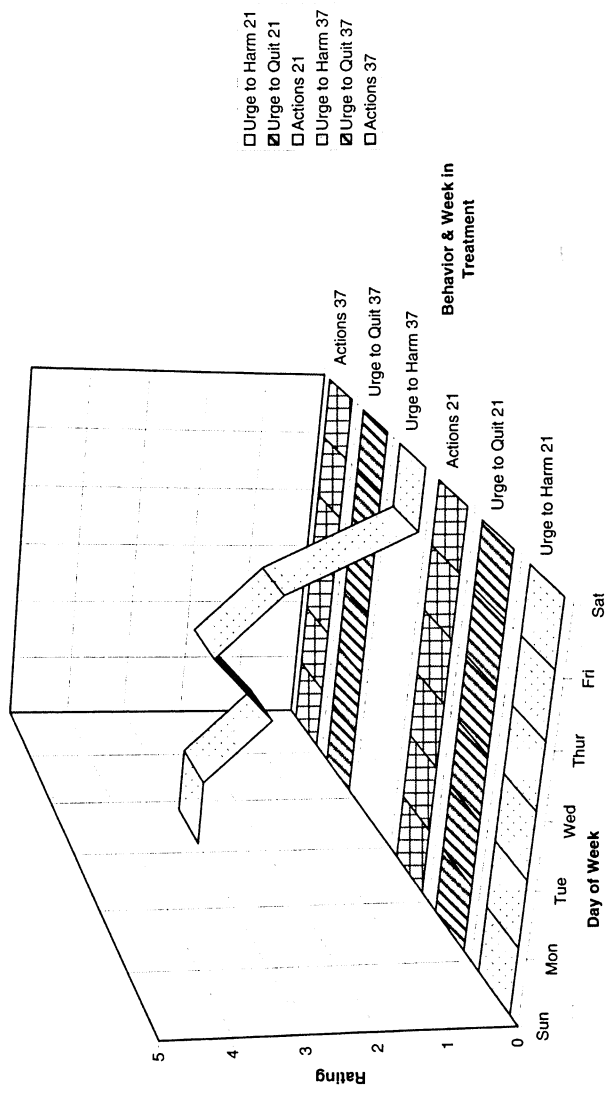


Figure 4.
Urges & Actions to Self-Harm: Late Treatment Phase Subject B

of object relations (Yeomans et al. 1992), including the patient's internal working model of attachment. For example, Beth, like many dismissing individuals, became disorganized when confronted with emotional issues in therapy, which challenged her characteristic defensive foreclosure of feeling states. Although Beth dutifully participated in the one-year treatment course and at one year was judged to have shifted from a dismissing to a secure attachment state of mind, the quality of her engagement remained somewhat limited and self-protective, and she tended to retreat from the help that was offered as has been found to be the case with dismissing patients in treatment (Dozier et al. 1993, Dozier and Tyrell 1998). There are indications that although the treatment was successful in changing suicidal behaviors and in shifting her state of mind with respect to attachment toward security, Beth remained somewhat disengaged throughout the course of therapy and induced similar feelings of disengagement in her therapist.

By contrast, the immediate and intense focus on the transference in TFP quite quickly mobilized Adam's chaotic, contradictory, and polarized self and object representations. As is typical of those with Unresolved/Preoccupied states of mind with respect to attachment, he often experienced the therapist as dangerous or unreliable. Yet, although he vacillated between experiencing the therapist as potentially helpful and as unpredictable and intrusive through much of the treatment year, at one year he was able to exhibit secure base behaviors (Bowlby 1973) with regard to the therapist, e.g., missing him during separations, but tolerating separation without undue distress and being easily soothed on reunions. Our findings suggest that the high degree of structure and predictability of Transference–Focused Psychotherapy (TFP) may provide the containment necessary to hold preoccupied and unresolved individuals in treatment. Previously, we have hypothesized that the initial treatment contact in TFP, which specifically spells out therapists' and patients' roles and responsibilities, helps to anchor preoccupied patients, whose highly conflictual, polarized, and contradictory object relations predispose them to chronic negative therapeutic reactions or to high rates of dropout (Diamond et al., 1999, Fonagy et al. 1995, 1996).

In sum, our findings suggest that the patient's state of mind with respect to attachment may function as an important factor in the therapeutic process and outcome, shaping the nature and quality of the therapeutic

discourse and the configuration of transference and countertransference dynamics. However, just as in the course of development the causal relationships discovered by attachment research are not simple and linear, but rather the result of goodness of fit between the individual's inner organization and the evolving multifaceted contexts in which it evolves, so too attachment status does not necessarily lead to one particular transference-countertransference dynamic or pattern, but rather a multiplicity of transference and countertransference possibilities dependent on the goodness of fit in the therapeutic dyad.

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