

Patient-therapist attachment in the treatment of borderline personality disorder

Diana Diamond, PhD
Chase Stovall-McClough, PhD
John F. Clarkin, PhD
Kenneth N. Levy, PhD

The authors report preliminary findings from a longitudinal study on the impact of attachment state of mind and reflective function on therapeutic process and outcome with borderline patients in Transference-Focused Psychotherapy (TFP). TFP is a manualized, psychoanalytically oriented treatment based on an object relations model of understanding patients with severe personality disorders. The attachment theory constructs of internal working models of attachment and mentalization or reflective function provide an important means of both conceptualizing borderline disorders and assessing therapeutic process and change. In the Personality Disorders Institute at New York Presbyterian Hospital-Weill Medical College of Cornell University, the authors have been using the Adult Attachment Interview (AAI) to assess changes in state of mind with respect to attachment and reflective function over the course of 1 year in borderline patients in TFP treatment. As part of the authors' investigations of the impact of patients' attachment status on the therapeutic process, they have adapted the AAI to

Presented at the conference, "Mentalization and Treatment Resistant Psychopathology: Implications for Clinical Services," held at The Menninger Clinic, Topeka, Kansas, January 2003.

Preparation of this article was supported in part by the International Psychoanalytical Association's Research Advisory Board (Grant No. 75159-00 01) and from the Research Foundation of the City of New York (RF-CUNY Research Fund, Grant No. 6269-1-0031). We gratefully acknowledge the assistance of Kristen Kelley, MA, Kim Kotov, PhD, Hilary Levine, PhD, and Martha Pierce, DSW in data collection and coding.

Dr. Diamond and Dr. Levy are with the City University of New York and the New York Presbyterian Hospital-Weill Medical College of Cornell University. Dr. Clarkin is with the New York Presbyterian Hospital-Weill Medical College of Cornell University. Dr. Stovall-McClough is with the New York University Child Study Center.

Correspondence may be addressed to Dr. Diamond at 50 Riverside Drive, Apartment 6A, New York, NY, 10024; e-mail: Dianadiam@aol.com. (Copyright © 2003 The Menninger Foundation)

evaluate states of mind with respect to attachment within the therapeutic relationship through an interview called the Patient-Therapist Adult Attachment Interview (PT-AAI). The AAI is given at 4 months and 1 year, and the PT-AAI is given to patients after 1 year of TFP, and both interviews are scored for attachment classification and reflective function. The authors present preliminary findings on change in both attachment classification and reflective function ratings at 4 months and 1 year for a subsample of 10 patients and therapists. They also present two cases that illustrate how the quality of mentalization or reflective function in the therapeutic dyad may be seen as a bidirectional process in that therapists' and patients' levels of reflective function are mutually and reciprocally influential. In one case, the patient's and therapist's reflective function mirrored each other directly and remained at a low or rudimentary level for the treatment year. Such a pattern of direct imitation does not necessarily promote intrapsychic change. In the second case, the patient moved from a rejecting or bizarre stance toward mentalization on the AAI to some rudimentary consideration of mental states after 1 year of treatment with a therapist who showed a full and nuanced awareness of mental states, but who adjusted his level of mentalization to that of the patient. These findings suggest that optimally the therapist ought to be one step ahead of the patient in the capacity for mentalization. (Bulletin of the Menninger Clinic, 67[3], 227-259)

I (first author) became interested in the applications of attachment theory and research to the intensive therapy of treatment-resistant with borderline personality disorder (BPD) patients when I was working with such patients in a hospital setting, the extended treatment division of New York Presbyterian Hospital, which was headed by Dr. Richard Munich. As a staff psychologist on the borderline unit, I came to realize that borderline patients were not homogeneous and, in fact, that they were distinguished by differences in their states of mind with respect to attachment as well as in their capacity to represent their own minds. For example, a patient I treated in three-times-a-week psychoanalytic psychotherapy for 8 years used to discuss fantasies and dreams of being a member of my family, would talk in vivid metaphors about taking out her heart and putting it in my hand, had impulses to strangle me with her purse strap in order to keep me from leaving her at the end of sessions, and, in the outpatient phase of therapy, would lurk in coffee shops near my office to see me as I was pass-

ing by. Another patient, also in three-times-a-week psychoanalytic psychotherapy for over 8 years, hardly dreamed about me at all, insisted that she had no feelings or fantasies about me, and until relatively late in the treatment would make secretive suicidal gestures, such as sequestering herself in a hotel room and taking a drug overdose (which mercifully she survived). I felt that sometimes I was the last to know the most important details of her life and the contents of her mind. Both patients could be considered treatment successes in that they both have been settled into productive work and long-term relationships and have shown major symptomatic improvement, particularly regarding self-destructive and depressive symptomatology. However, such clinical experiences teach us that attachments formed by borderline patients are not of one type; they may be characterized as much by dismissing devaluation of relationships as by cravings for contact. These experiences also raised the issue about how the capacity of patients and therapists to represent each other's internal worlds in mental state terms may in some sense be dependent on the dynamics of the therapeutic dyad.

At the Personality Disorders Institute of the Weill Medical College of Cornell University, we have been investigating attachment states of mind and reflective function in the therapeutic dyad in borderline patients over the course of 1 year of Transference Focused Psychotherapy (TFP; Clarkin, 2001). This research is part of an NIMH-funded treatment development study, headed by Drs. John Clarkin and Otto Kernberg, which is examining pre-post changes in attachment status, reflective function and symptomatology observed in the 1-year outpatient treatment of borderline patients in TFP. In this paper we will present preliminary findings on both attachment and reflective function ratings for a subsample of 10 patients in TFP, along with some illustrative case vignettes.

Transference-Focused psychotherapy

TFP is based on object relations theory (Kernberg, 1975, 1976) 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, Yeomans, & Kernberg, 1999). This intense focus on the transference functions to consolidate an attachment relationship to the therapist, to elicit and work through the insecure attachment representations that tend to characterize borderline pathology, and to improve the patients' capacity to represent the internal world of self and others. Fonagy and colleagues (Fonagy, Gergely, Jurist, & Target, 2002) have observed

that the majority of treatments for BPD, regardless of theoretical underpinnings, are characterized by the dual goals of building an attachment relationship with the therapist and improving the patients' capacity to think about self and others in mental state terms, defined as interpreting the behavior of oneself and others in terms of intentional mental states, such as desires, feelings, beliefs, and motivations (Allen, 2003). TFP fosters the building of an internal representation of minds of self and other (mentalization) by focusing on the differentiation and integration of representations of self and significant others, and by identifying the major affects linking such self-object dyads, thereby integrating dissociated or split-off affect states that are linked to these representations. The result is that affective experiences become enriched and modulated. In short, the major goal of TFP is to change the pathogenic object relations that lead to chronic affective, behavioral, and cognitive disturbance. Clinical researchers at the Personality Disorders Institute have described the tactics and techniques of TFP in three volumes of a treatment manual (Kernberg, Selzer, Koenigsberg, Carr, & Applebaum, 1989; Clarkin et al., 1998; Yeomans et al., 2002) and have delineated how complex treatment issues may be addressed in TFP as well as how it may be tailored to the needs of the individual patient (Koenigsberg et al., 2000). Recent outcome studies from the Personality Disorders Institute with 17 patients who completed 1 year of TFP indicated that borderline patients showed a significant reduction of suicide attempts and suicidal behaviors, a decrease in medical risk and severity of medical conditions following self-injurious behaviors, and a decrease in hospitalizations (Clarkin et al., 2001).

The integration of attachment concepts with TFP

Although the outcome data on TFP are promising, we know that not all borderline patients benefit equally from TFP. During the past 5 years, we have begun to investigate how characteristics such as the individual's state of mind with respect to early attachment relationships and capacity to reflect on mental states of self and others (Fonagy et al., 1995, 2002), might affect the patient's progression through the phases of TFP and reactions to the techniques of TFP. Bowlby (1988) fully intended that the concepts of attachment theory would illuminate our understanding of more severely disturbed, narcissistic, and borderline patients and their treatment. He hypothesized that just as the availability of a secure base in childhood facilitates the child's exploration of the external world, so does the therapist and the therapeutic situation serve as a secure base from which the patient can engage in self-exploration.

Bowlby (1975) wrote that the chief role of the clinician was to "provide the patient with a temporary attachment figure" (p. 291). Similarly, Fonagy and colleagues (2002) have hypothesized that the capacity to think about the self and others in mental state terms (i.e., to attribute intention, beliefs, and attitudes to significant others) is anchored in secure attachment relationships.

The view that there may be an attachment substrate to the therapeutic relationship that is parallel to, but distinct from, the activation of libidinal or aggressive feelings both converges with and extends the object relations foundations of TFP (Diamond & Yeomans, 2003). Although those of us who have developed and elaborated on TFP have historically given 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, we have found it productive to explore the ways in which the attachment features of borderline pathology, particularly the insecure states of mind with respect to attachment that characterize borderline pathology, help to configure the transference and countertransference dynamics central to the techniques of TFP (Diamond et al., 1999, 2002; Koenigsberg et al., 2000). In addition, Bowlby's theories about the bidirectional nature of the attachment behavioral system has made our therapists and researchers more cognizant of the ways that attachment factors might influence the therapist as well as the patient. Like all attachment relationships, the therapeutic one was thought by Bowlby (1969/1982, 1973) to be inherently bi-directional, with attachment-seeking behaviors (proximity seeking, smiling, calling) tending to evoke corresponding adult attachment or caretaking behaviors (soothing, holding, protecting). In Bowlby's view (1978), the attachment behavioral system inevitably contributes to the configuration of transference and countertransference dynamics, for it is activated throughout the life cycle in situations where an individual who is ill and in distress seeks protection from or contact with someone deemed older or wiser.

Indeed, recent empirical and clinical investigations on the extension of attachment concepts into the clinical arena have shown that attachment status has been linked to (1) transference-countertransference dynamics (Fonagy, 1991; Gunderson, 1998; Holmes, 1995, 1996; Szajnberg & Crittenden, 1997), (2) the quality and nature of the therapeutic alliance (Dozier & Tyrrell, 1998; Dozier, Cue, & Barnett, 1993; Eagle, 2003; Mackie, 1981), and (3) patterns of patient-therapist narrative discourse (Fonagy, 2001; Slade, 1999). Although a comprehensive description of these investigations is beyond the scope of this article, we will highlight several recent studies that are particularly relevant to the current study.

Dozier and colleagues found that patients in supportive treatment who were classified as secure/autonomous with respect to attachment were more involved in and cooperative with treatment, whereas those with dismissing states of mind were more rejecting of help and superficial in their engagement with the therapist and those with unresolved/ preoccupied states of mind required more crisis intervention (Dozier, 1990). Dozier and colleagues have also found that clinicians with secure states of mind are more likely to challenge patients' own strategies for relating interpersonally and to intervene in greater depth, whereas clinicians with insecure states of mind are more likely to mirror the patients' interpersonal dynamics (Tyrrell, Dozier, Teague, & Fallo, 1999). They suggest that the best treatment outcomes and overall ratings of treatment alliance occur when patients and therapists' attachment state of mind are complementary rather than concordant. In this context, the therapist is more likely to challenge the patient's characteristic ways of regulating affect and distress in interpersonal contexts, leading to better therapeutic outcomes.

Another recent study by Eagle and colleagues (Parish & Eagle, 2003; Parish, 2000) provides additional empirical support for the centrality of attachment constructs to the therapeutic relationship. Using the Components of Attachment Questionnaire (CAQ; Parrish, 2000), Parish and Eagle (2003) identified nine major components of an attachment relationship as being present in the therapeutic relationship: (1) Proximity Seeking, (2) Separation Protest, (3) Secure Base, (4) Turning To for Comfort, Support, and Reassurance, (5) Stronger and Wiser, (6) Available and Responsive, (7) Strong Feelings, (8) Particularity, and (9) Evoking a Mental Representation. The components found to be the most strongly associated with the therapeutic relationship for patients were the components Stronger and Wiser and Available and Responsive. In addition, Eagle and colleagues found that the more intense the attachment to the therapist, the more positive the working alliance; they also found that the intensity of attachment varied among those with different states of mind, with dismissing patients having the lowest intensity of attachment to the therapist (Parish & Eagle, 2003).

The studies provide empirical affirmation for Bowlby's (1988) conceptualization that (1) the therapist is a prototypical attachment figure in adulthood, and that (2) patient's and therapist's attachment status may affect the treatment process and relationship. However, the majority of previous studies on attachment in the therapeutic relationship have been conducted with attachment measures that assess the state of mind with respect to attachment of patients and therapists vis-à-vis their own early attachment relationships and experiences,

rather than quality of attachment within the patient-therapist relationship itself.

Assessing patient-therapist attachment

As part of a larger longitudinal study assessing changes in attachment and symptomatology in borderline patients, we have adapted the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) to assess patients and therapists' states of mind with respect to attachment and reflective function in the therapeutic relationship. We have developed an instrument called the Patient-Therapist Adult Attachment Interview or PT-AAI (George, Kaplan, & Main, 1996; Diamond et al., 1999). The first 16 questions of the PT-AAI follow the same format and order as the AAI questions, with minor changes in the wording to fit the context of the patient-therapist relationship. For example, the AAI question, "Why do you think your parents behaved as they did during your childhood?" has been revised to read, "Why do you think your therapist/patient behaves the way he or she does as a therapist/patient?" Similarly, the AAI question, "Is there any particular thing you learned above all else from your childhood relationships?" has been revised to read, "Is there any particular thing you learned above all else from the therapeutic relationship?"

As is the case with the AAI, in the PT-AAI the individual is asked to describe the therapeutic relationship generally, to give five words to describe the therapist or patient, and to support these descriptors with specific examples or incidents. The interview also includes questions about the individual's response to separations from the patient or therapist, about what the individual did when he or she was upset, hurt, or ill in the course of therapy, and about times when the individual felt rejected or threatened by the patient or therapist in the course of treatment. In addition, speakers are asked why they think the patient/therapist acted the way he or she did in the course of treatment, and to evaluate the effects of psychotherapy. As with the AAI, the interview is designed to "surprise the unconscious" (George et al., 1996, p. 3) by allowing numerous opportunities for the interviewee to elaborate on, contradict, support, or fail to support previous statements or generalizations. We have also added 12 additional questions that further explore the particulars of the patient-therapist relationship. These additional questions are designed to further explore the patients' and therapists' experience and representation of the therapeutic relationship as well as their capacity to mentalize or reflect on that experience. Examples of additional questions include, "How do you think that

your patient/therapist feels about you?" and "Do you think of your therapist/patient outside of the therapy?"

As is the case with the AAI, the PT-AAI requires specialized training to administer and score.¹ The PT-AAI is transcribed verbatim for purposes of analysis, using the same transcription rules that apply to the AAI. An attachment classification for the patient and/or therapist is derived from the first 16 questions of the PT-AAI using an adaptation of the four-way Adult Attachment Scoring and Classification System (Diamond, Stovall-McClough, Clarkin, & Levy, 2003; Main & Goldwyn, 1998). The interviews are assigned one of four primary classifications: Secure/Autonomous, Preoccupied, Dismissing, or Cannot Classify. The Unresolved classification is not relevant for the patient-therapist attachment relationship because it assesses the lack of resolution of traumatic abuse and loss of attachment figures. The overall classifications are derived from two classes of subscale ratings: (1) Experience Scales that are based on the rater's inferences about the individual's experience of the therapist/patient; and (2) State of Mind Scales that assess the individual's organized states of mind with regard to attachment information.

The subscale ratings as well as the overall attachment classifications have been adapted to fit the context of the patient-therapist relationship by Diamond and colleagues (2003). Whereas revision of the State of Mind subscales has necessitated only minor changes in wording, revision of the subscales designed to assess the speaker's *experience of the relationship* has involved more substantial changes in conceptualization to fit the context of the patient-therapist relationship. For example, the AAI subscale for loving versus unloving behaviors between parent and child has been changed to the PT-AAI subscale of liking versus not-liking; that is, the extent to which the patient and therapist maintain positive feelings of concern, caring, and warmth despite the vicissitudes of the transference. Similarly, the AAI subscale for involving, or the extent to which the parent attempts to involve the child or to seek parenting from the child, has been revised to assess the extent to which patient and therapist seek attention or caretaking from each other in ways that go beyond the frame of the therapeutic relationship.

1. PT-AAI interviewers should be trained in the specific technique of interview administration by an individual who has taken the Adult Attachment Interview Training Institute certified by Mary Main and Erik Hesse. If the PT-AAI is to be coded for attachment classification based on the first 16 questions, it should be done so by those who have taken the AAI training institute and achieved reliability on a set of AAI transcripts (see Hesse, 1999).

On the basis of the subscale scores, individuals are assigned to one of the following four categories designed to capture the overall quality of the patient-therapist attachment relationship:

1. *Secure (F)*. Patients and therapists are classified as secure/autonomous when their interviews show that they value the therapeutic relationship and regard attachment-related experiences within the therapeutic relationship as influential. *Patients* rated as secure/autonomous are likely to present a believable picture of a therapist serving as a secure base during treatment, or if the therapist did not provide a secure base during treatment, these subjects are still moderately to highly coherent regarding the relationship. *Therapists* are given a secure/autonomous rating when they are able to provide a believable and coherent picture of the relationship with the patient and demonstrate an open capacity for reflection and thoughtfulness regarding difficult aspects of the relationship, including countertransference reactions. Therapists with secure states of mind also have a strong confidence in their ability to act as a secure base for their patient.
2. *Dismissing (D)*. Patients and therapists are classified as dismissing when their interviews suggest they are cut off from attachment-related feelings and experiences within the therapeutic relationship. The interviews are characterized by attempts to limit the influence of and feeling about the therapeutic relationship through idealization, devaluation, or disavowal of the relationship. There may also be a disavowal of any imperfection in the patient or therapist in the face of contradictory or unsupportive evidence, or a derogation of the therapeutic relationship, or psychotherapy in general. In these interviews, there are often assertions of independence from or noninvolvement with the patient or therapist. *Patients* classified with dismissing states of mind with respect to the therapist may present a picture of the therapeutic relationship that is moderate to strongly idealized in that global positive descriptions of the therapy and the therapeutic relationship are not backed up with specific examples or memories of positive experiences (comfort, support, concern, caring, etc.) from the patient or therapist. Similarly, *therapists* are classified with dismissing states of mind with respect to the patient when they portray the therapeutic relationship and experience as uniformly positive without convincing specific illustrations. Therapists and patients classified as dismissing acknowledge difficulties with the patient or the treatment, but they do so in a cool, off-hand, or matter-of-fact manner that shows little emotional depth or involvement.

3. *Preoccupied (E)*. Therapists and patients who are classified as preoccupied share an excessive involvement in and preoccupation with the therapeutic relationship beyond what is normative for psychotherapy. Their narratives tend to be confused, unobjective, incoherent, and preoccupied with the therapeutic relationship and/or by past experiences of therapy. Those with preoccupied states of mind usually show a weak and confused sense of personal identity, and they tend to organize their affective life around the therapeutic relationship and the therapeutic interactions. In extreme cases, a *patient's* preoccupation with the therapeutic relationship can be expressed through dramatic self-destructive and destructive actions designed to elicit the therapist's care and concern or to punish the therapist for imagined slights. *Therapists* classified as preoccupied are over involved with the patient and his or her progress, sometimes conveying a sense of immersion in the emotional life of the patient beyond the norm for clinicians of most theoretical persuasions. The preoccupied therapist may express the belief that his or her professional reputation depends on the outcome and fate of the treatment, or he or she may report excessive mental preoccupation with the patient and his or her progress.
4. *Cannot Classify (CC)*. Interviews are categorized as Cannot Classify when the patient or therapist shows evidence of two or more different discourse strategies (Dismissing and Preoccupied), or suddenly and dramatically changes discourse strategy in mid-interview.

Assessing reflective function in the patient-therapist relationship

The PT-AAI is also scored for reflective function using the Reflective Function Scale (Fonagy, Steele, Steele, & Target, 1997), which operationalizes the concept of mentalization. Mentalization refers to the individual's capacity to think about others in mental state terms (Fonagy et al., 1996, 2002). The Reflective Function Scale ranges from -1 (negative RF, in which interviews are totally barren and/or rejecting of mentalization, or grossly distorting of the mental states of others) to 9 (exceptional RF, in which interviews show unusually complex, elaborated, and original reasoning about mental states). The midpoint of the scale is 5, or ordinary RF, which indicates that individuals hold a model of the mind of others that is fairly coherent, if somewhat one-dimensional, naïve, or simplistic (Fonagy, Steele, Steele, & Target, 1997).

There is now an accretion of studies from the developmental and clinical domains that have established the centrality of mentalization in the attainment and maintenance of attachment security, both in parent-child

and patient-therapist relationships (Fonagy et al., 1996; Slade, 2002). Mentalization is thought to result from the child's internalization of the caretaker's ability to represent the child's mental processes coherently and accurately, and to mirror the child's affective states in ways that are both marked or differentiated, and contingent and accurate (see Fonagy et al., 2002). According to Fonagy and colleagues, mentalization is an essential aspect of secure attachment, whereas insecure attachment can involve distortions or deficits in the capacity to represent the internal worlds of self and other. Significantly, Fonagy and colleagues (1996) found that the AAIs of borderline patients were distinguished from other psychiatric patients not only by insecure and unresolved attachment classifications on the AAI, but also by significantly lower ratings on the RF scale. Further investigations by Fonagy and colleagues (1991) have suggested that the capacity for mentalization may, in fact, serve as a mediating variable that ameliorates or exacerbates the psychological impact of early trauma (Fonagy et al., 1995, 1996). Other investigations, both empirical and clinical, have shown that the capacity to reflect on the intentions and motivations of the other serves as a protective factor that mitigates the negative effects of an abusive or traumatic early history and that guards against the transgenerational transmission of insecure attachment patterns (Slade, 2002). In our ongoing research and clinical investigations of the efficacy of TFP, we are finding that therapists' and patients' capacity for mentalization is a significant contributor to treatment process and outcome in TFP (Diamond et al., 1999; Koenigsberg et al., 2000).

The PT-AAI is designed to further explore the reflective function factors that might contribute to the transference-countertransference dynamic central to TFP, and the ways that they may vary depending on the dynamics of the specific patient-therapist dyad. We have completed an initial study in which patients in TFP are given the PT-AAI with respect to their state of mind about the therapist after 1 year of treatment. At the same time, therapists are also given the PT-AAI regarding their state of mind about the patient. In addition, the traditional AAI is given to patients at 4 months and after 1 year of TFP. Both the PT-AAI and AAI are rated for attachment classifications and reflective function. Attachment and reflective function ratings were provided by raters who were blind to all identifying information about the patients and therapists, and who were trained to reliability by Main and Hesse in the AAI classifications and by Fonagy and Target in RF ratings.

The five therapists in the study were all clinicians with postdoctoral and or psychoanalytic training who had substantial experience as therapists and researchers in the Personality Disorders Institute. All therapists participated in a weekly peer supervision meeting led by senior clinicians in the project. All therapists were monitored for their adher-

Table 1. *Attachment and symptomatology measures*

Adult Attachment Interview (AAI)

Given at 4 months and 1 year to patients

Semistructured clinical interview

Scored for state of mind with respect to attachment and reflective function

Patient-Therapist Adult Attachment Interview (PT-AAI)

Given at 1 year to patients and therapists

Semistructured clinical interview adapted from AAI

Scored for state of mind with respect to attachment and reflective function

ence to and competence in TFP. A complete description of the sample characteristics, assessment, and scoring procedures for the larger study of which these patients are a part is beyond the scope of this article and can be found elsewhere (Clarkin et al., 2001; Diamond et al., 1999, 2002).

Preliminary research findings

Demographics

We have completed preliminary analyses of attachment and reflective function ratings for the AAI and the PT-AAI on a sample of 10 patients. The average age of the patients was 30.4 (range 23-38 years). Nine of the patients were white, and one was of mixed race. All patients were diagnosed with borderline personality organization (Kernberg, 1975) and borderline personality disorder (American Psychiatric Association, 1994). All had made at least one parasuicidal gesture (severe self-injurious gesture) within 8 weeks of admission to our research project.

AAI

Table 2 shows our preliminary findings regarding the AAI ratings at 4 months and 1 year. Six of the 10 patients were classified as primarily unresolved with respect to loss and/or trauma (U) at 4 months. Four of those six lost their primary unresolved status and shifted to an organized insecure or secure state of mind at 1 year.* This finding is consistent with the larger sample of which these patients are a part (Levy, 2002).

*It should be noted that one of these cases had a provisional rating on the AAI at time 2 because she did not complete the interview, although she did respond to the majority of questions.

Table 2. *Adult Attachment Interview (AAI) Classification for 10 Patients*

Patients	AAI Time 1 (4 months)	AAI Time 2 (1 year)
1	DS2 Devaluing of Attachment	F1 Setting aside of attachment
2	U/E1/E2 Unresolved Passively preoccupied Angry/Conflicted	U/CC/E3/E2/Ds3 Cannot Classify Unresolved Fearfully preoccupied with traumatic events Angry/conflicted Restricted in feeling
3	E3 Fearfully preoccupied with traumatic events Loss of memory	CC/Ds1/E2 Cannot Classify Dismissing Fearfully preoccupied with traumatic events
4	U/E3/E2 Unresolved Angry/conflicted Angrily Preoccupied	F5/U Secure/Autonomous Somewhat resentful/Conflicted Unresolved
5	U/Ds2/Ds3 Unresolved Dismissing/devaluing Restricting in feeling	CC/U/Ds2/E3 Cannot Classify Unresolved Dismissing/devaluing Fearfully preoccupied with traumatic events
6	U/E2/E3 Unresolved Angrily Preoccupied Fearfully Preoccupied	U/E2/E3 Unresolved Angrily Preoccupied Fearfully Preoccupied
7	U/CC/DS2/E2 Unresolved Dismissing Angrily Preoccupied	DS1/DS2*
8	U/Ds3/Ds2 Unresolved/Dismissing	Ds3/U Dismissing/Unresolved
9	F4 Secure	F4/F2 Secure
10	Ds3/Ds1 Dismissing Restricted in feeling	Ds1 Dismissing

* This code is provisional because the patient did not complete the interview.

PT-AAI

Table 3 shows the PT-AAI ratings for the 10 patients at 1 year. Our major finding is that in all but one case, the patients' attachment state of mind with respect to the therapist on the PT-AAI is concordant with one or more aspects of the attachment state of mind with respect to the parents on the AAI at 4 months and/or 1 year. For example, if the patient showed a secure, dismissing, or preoccupied attachment state of mind with respect to childhood attachment relationships on the AAI, he or she was likely to show a parallel attachment classification(s) with respect to therapist on the PT-AAI. These findings suggest that the PT-AAI in combination with the AAI given over the course of therapy may be useful in tracking aspects of the transference as it unfolds over time, particularly in identifying the specific attachment states of mind with respect to parents that are recapitulated with the therapist.

In TFP, the therapist's countertransference feelings and fantasies are thought to be one of the most important sources of information about the patient's early attachment relationships. Thus we are particularly interested in ratings that are sensitive to countertransference dynamics. However, as the data presented in Table 3 indicate, the attachment ratings of the therapists regarding their relationship with the patients are not particularly revealing of countertransference nuances. All 10 therapists were rated with secure states of mind, although their ratings span the dismissive to preoccupied range of the secure category (F1 to F5). It should be noted that a secure classification in the AAI scoring system can be characterized as more dismissing (e.g., somewhat emotionally constricted albeit coherent [F1] to prototypically secure [F3]) to more preoccupied (e.g., somewhat angry, conflicted, or resentful, although coherently so [F5]).

The reflective function ratings on the 10 patients and therapists suggest a somewhat more complex picture. Table 4 presents the reflective function ratings of patient and therapists on the AAI and PT-AAI. In columns 2 and 3 of this table, we see that all but one of the patients improved in their capacity for mentalization regarding the relationship with parents over the first year of TFP as measured by the AAI, although in most cases the improvement was somewhat minimal (Mean change in RF = 1.05.)² The therapists' ratings (column 5 of Table 4), in all cases but one, exceeded that of the patient.

Table 5 shows that 4 out of the 10 patients moved into a higher RF category, for example, shifting from low or questionable RF to ordi-

2. The median is 1, indicating that there are no extreme values affecting the measure of central tendency.

Table 3. *Patient-Therapist Adult Attachment Interview (PT-AAI) classification for 10 patients and therapists after 1 year of TFP*

Patient	Patient PT-AAI	Therapist T-AAI
1	Ds3 Restricted in feeling Incomplete dismissal	F3 Secure/Autonomous
2	E3 Fearfully preoccupied by traumatic events	F5 Secure/Autonomous Somewhat resentful/conflicted
3	Ds2 Devaluing of attachment	F3 Secure/Autonomous
4	F5 Secure/Autonomous Somewhat resentful/ Conflictual	F5 Secure/Autonomous Somewhat resentful Conflictual
5	E2 Angry/Conflicted	F1 Secure/Autonomous Somewhat restricting of attachment
6	F5 Somewhat resentful/ Conflicted	F1 Somewhat setting aside of attachment
7	CC/DS1/DS2/E2/E3 Cannot Classify Dismissing Angrily Preoccupied Fearfully Preoccupied	F5 Somewhat resentful/ conflictual
8	DS2/DS3 Dismissing/devaluing Restricting of feeling	F5 Somewhat resentful/ conflictual vis-à-vis attachment
9	F2 Secure Somewhat restricting of attachment	F4 Secure Somewhat preoccupied with attachment
10	DS3 Dismissing Restricting in feeling	F2 Secure Somewhat restricting of attachment

Table 4. *Adult Attachment Interview (AAI) and Patient-Therapist Adult Attachment Interview (PT-AAI) reflective function ratings (RF) for 10 patients and therapists after 1-year of TFP*

Patient	Patient AAI1	Patient AAI2	Patient PT-AAI2	Therapist PT-AAI2	Difference*
1	3	3	3	3	0
2	3.5	4.5	4	8	4
3	5.5	6.5	5	7	2
4	3	5	4	6	2
5	4	4.5	4.5	6.5	2
6	4	5.5	6	4.5	-1.5
7	-1	1	3	7	4
8	2	2.5	3	6	3
9	5	5.5	3	5.5	2.5
10	3.5	5	3.5	4	.5

*This column shows the difference between therapist PT-AAI and patient PT-AAI.

nary RF over the course of 1 year of TFP. Table 5 also presents the mean scores of the patients' AAI and the PT-AAI RF ratings at Time 1 and Time 2. Interestingly enough, the patients' mean RF score on the PT-AAI (3.9) falls between the patients' mean RF score on the AAI at Time 1 (3.25) and the mean RF score on the AAI at Time 2 (4.3). Further data analyses indicated that there is a strong relationship between the patients' RF on the AAI at Time 1 and Time 2 ($r = .92, p < .003$) and a marginally significant relationship between the patients' RF on the AAI at Time 1 and the patients' RF with respect to the therapist on the PT-AAI at Time 2 ($r = .48, p < .06$).

Most interestingly, an examination of patients 1, 4, and 7, each of whom had the same therapist, shows that the reflective function ratings of the therapist vary with the individual patient. There are several possible interpretations of these findings, including: (1) The therapist's RF rating is picking up a countertransference factor that might curtail or enhance his or her capacity to mentalize; (2) The therapist's RF may be modified by that of the patient so that it comes to mirror that of the patient, or vice versa; or (3) The RF might be coconstructed such that each patient and therapist contributes to the creation of a unique interpersonal climate that may allow RF to flourish or wither for both participants. A more in-depth exploration of patient-therapist RF ratings in two of these cases is presented in the following section and suggests that all three of these explanations may be at work. In the first case (7), the same therapist showed a full and marked awareness of the mental states

Table 5. *Change in Adult Attachment Interview (AAI) reflective function ratings (RF) for 10 patients after 1-year of TFP*

Patient	Patient AAI1	Patient AAI2	Change**	Change Cat	Patient PT-AAI2
1*	3.0	3.0	0.0	0.0	3.0
2	3.5	4.5	+1.0	0.0	4.0
3	5.5	6.5	+1.0	0.0	5.0
4*	3.0	5.0	+2.0	1.0	4.0
5	4.0	4.5	+0.5	0.0	4.5
6	4.0	5.5	+1.5	1.0	6.0
7*	-1.0	1.0	+2.0	1.0	3.0
8	2.0	2.5	+0.5	0.0	3.0
9	5.0	5.5	+0.5	0.0	3.0
10	3.5	5.0	+1.5	1.0	3.5
Mean	3.25	4.30	+1.05		3.90

*Cases that show change in reflective function (RF) category. **This column shows the change in reflective function (RF) category from time 1 to time 2.

of the patient on the PT-AAI, but there were some indications that he adjusted his RF to that of his patient, who moved from actively repudiating mental states at the beginning of treatment to a rudimentary capacity to comprehend mental states at 1 year. In the second case (1), the RFs of patient and therapist mirror each other directly, and both showed a somewhat rudimentary and limited capacity to intuit each other's mental states on the PT-AAI at 1 year, indicating that patients' and therapists' RFs were entrained but not productively so.

Case 1

History and AAI

The first patient, Nicole, was one of three children from an arranged and loveless marriage, and her personal history was one of unrelenting loss, abuse, and neglect. She was the product of an arranged marriage with a Greek father and a Greek-American mother whose family advertised for a mate for their daughter. The mother developed a severe degenerative illness after the patient was born and was hospitalized on numerous occasions for both emotional and physical disorders. Nicole remembers her mother being "angry all the time" and describes her as alternately neglectful and abusive toward her. When Nicole was 3 years old, the father left the family (which included the patient and two older brothers) for another woman, whom he married and who discouraged

all contact with his children. Nicole's mother's physical condition subsequently deteriorated, and she became a paraplegic and was hospitalized until her death, which occurred when Nicole was 13. Nicole and her siblings were shuffled among their relatives and were cared for mostly by grandparents and aunts because their father refused to care for them consistently. Nicole had many hospitalizations starting in adolescence for eating disorders as well as self-destructive and antisocial behaviors. She married in her early 20s and had a son with her first husband. About 6 years prior to the current treatment, she engaged in a yearlong affair with a therapist, after which she became repulsed by sex and divorced her first husband. She remarried but almost immediately began an affair with her son's teacher, which led to a pregnancy and an abortion. Her suicidality and destructive behaviors escalated, including intentionally smashing her car into her husband's car. She was eventually hospitalized for the third time and subsequently referred to the borderline project when she was in her late 20s.

Not surprisingly, the course of treatment for Nicole was not only extremely stormy from the beginning, but was also filled with dramatic and self-destructive enactments, including drinking, assaults on others, and overdosing on medications. She often acted out within the sessions in a sexually aggressive manner, sometimes attempting to climb in the therapist's lap, undress him, or undress herself during session. On one occasion, she surreptitiously tried to cut herself in a session and then began beating her therapist on the chest with her fists when he tried to intervene, indicating that there was little differentiation between aggression toward self and others. These incidents coincided with a growing attachment to the therapist after a period of denying any attachment, which she found frightening and intolerable. In the course of the first year of treatment, she experienced paranoid regressions and at times saw the therapist as "the devil." She even hallucinated the presence of the devil in her bedroom. By the end of the first year, however, she began to respond well to the structure of the therapy and her acting out gradually diminished, although there were periodic crises, which interrupted the therapy. Such crises included an overdose on medications two days in a row. Over the course of treatment, Nicole ceased such self-destructive behaviors and began to explore a number of difficult issues, including her excruciating history of loss and abuse, her guilt about her past affairs and abortion, and her sense of herself as irrevocably bad and evil.

On the initial AAI, Nicole was given a primary classification of Unresolved with respect to loss and trauma (U) and a secondary classification of Cannot Classify (U/CC/Ds2/I:2) because she oscillated between dismissing and preoccupied strategies. With respect to the unresolved

classification, she alternated between acknowledging and denying the childhood abuse by her mother, and at times appeared to trick herself regarding the experience stating, "I wasn't there." Her speech surrounding the discussion of the abuse became incoherent and fragmented, and she ultimately lapsed into a mute, frozen state reminiscent of the freezing or trancelike behaviors of infants judged disoriented/disorganized in the Strange Situation. Overall, 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 by inchoate traumatic pain, thus earning her a Cannot Classify classification.

Nicole had the lowest RF rating of any patient in the sample on the AAI. In response to attempts on the part of the interviewer to engage her in reflection on the AAI at 4 months, particularly in the questions about early abuse and loss of her mother, Nicole became either hostile or evasive, leading to an RF rating of -1, or negative RF. She either refused to respond to questions that usually elicit reflection on mental states, or she engaged in bizarre, self-destructive gestures such as scratching herself. In the few instances in which she spoke in RF terms, she gave unintegrated and bizarre responses.

After 1 year of treatment, Nicole did not complete the AAI and hence we were only able to derive a provisional attachment classification. Because the majority of the interview was completed, we were able to derive a reflective function rating from the second AAI interview. Nicole was found to show a 2-point increase on the RF scale (from -1 to 1 on the RF scale) at 1 year. Although she did not actually repudiate the demand RF questions as she had at Time 1, she showed very little explicit understanding of mental states underlying the behavior of self or other. The few reflective statements in the interview were found to have a paranoid flavor and a misattribution/projection of her feeling rather than an exploration of feeling. There were indications that her contemplation of the minds of others who had abused her was almost intolerable. At one point, for example, she stated, "My mother hated me, she hated me," and then said, "This is . . . killing me." The increase in the reflective function score at 1 year was attributed to her reflections on her relationship with her grandmother, who qualified for purposes of the interview as a major attachment figure in her early life, and for whom she provided several adjectives (*warm and she loved me a lot, and she was good to me*) that were backed up by vivid examples. For example, she was able to substantiate these words with specific memories of her grandmother kissing her, rocking her to sleep, and reading her stories. The RF rater commented, "The subject is clearly traumatized by her

childhood relationships. The relationship with the grandmother seems to be her only form of attachment.”

PT-AAI

Although the AAI at 1 year was rated as lacking in reflective function (RF = 1), Nicole showed some limited capacity for consideration of mental states, albeit at a rudimentary level, leading to a rating of low or questionable RF on the PT-AAI (RF = 3). Interestingly, this was due in part to her tendency to rehash the therapist's interpretations in ways that were often simplistic and naive but that revealed some rudimentary capacity to contemplate mental states. For instance, she described herself as someone who “pushes away attachments and is afraid of being close.” Although she did at times repudiate some of the direct questions regarding her feelings about the therapist and their understanding of each other, she was able to discuss how the backdrop of the therapeutic relationship allowed her to decrease her self-destructiveness and reflect on her behavior. It was clear from the interview that she was beginning to draw on the therapist to neutralize her rage, and that the therapist was becoming real to her even if she did not acknowledge this directly.

The change in her capacity to manage her feelings was evident in the following statement from the PT-AAI interview in which she described her thoughts, feelings, and behavior during a recent argument with her husband:

Like, I'm able to like think. So then sometimes I can, um, like diffuse the situation . . . it's not often but it's getting better . . . I didn't like, I, I didn't touch, like, usually I would punch him, kick him, or throw things . . . But, I didn't. I mean, I was going, like, I wanted to but, I just didn't . . .

Although Nicole showed improvement in her capacity for mentalization on the AAI and PT-AAI at 1 year, her PT-AAI, like her initial AAI, was rated as Cannot Classify because she was alternately dismissing, devaluing, angrily preoccupied, or fearfully preoccupied (CC/Ds1/Ds2/E2/E3) in the description of her relationship with her therapist. In sum, although she re-created directly the multiple unintegrated attachment states of mind with respect to the therapist, she did not recapitulate her inability to contemplate the mind and intentions of early attachment figures at 1 year, but instead showed improvement in mentalization.

The PT-AAI interview with the therapist showed somewhat inconsistent reflective function in that at times the therapists' responses were extremely rich, evocative, and coherent, indicating the containing func-

tion he likely displayed for the patient, whereas at other times he appeared to retreat from a full exploration of the patient's feelings, thoughts, and intentions. The therapist began his interview by comparing the treatment to Shakespeare's play, *The Taming of the Shrew*. He stated that more than any other, this "fiery" patient "pulls for a kind of involvement." The five words he gave to describe Nicole were "intense, ambivalent, scary, gratifying, and fun" words that capture his contradictory and complex countertransference feelings toward a patient with clear oscillatory tendencies in the transference, as evident in her Cannot Classify 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 humorous fashion, his interview was rated as Secure/Autonomous (F5), albeit on the preoccupied end of secure.

The therapist's interview received an RF score of 7, or marked RF, indicating a fully developed, vivid, and integrated awareness of the mental states underlying his patient's problematic behaviors. For example, when asked why he believed the patient acted the way she did and how she felt about him, he described the complex admixture of idealization and paranoid distortion that characterized the transference:

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 basically 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 there's been this mixture of idealization, thinking that the only way somebody could care about her is if she offered herself sexually, and then a certain amount of sexual aggression towards 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.

Although the therapist had clearly thought about the patient in complex terms, he appeared to be limited by his tendency to create an objective, intellectualized persona from which to relate to her, perhaps in order to be able to stay with her in therapy. For example, in reflecting on what he has learned from the experience with this patient, the therapist stated that he had never seen such a "clear-cut case of a paranoid transference" but then observed that his work with the patient had changed, having made him much more aware of "how much you, the therapist, matter to the patient," and how "difficult it can be for the patient that you do matter to her." It seems that the intellectualized under-

standing of the patient might have held the therapist back from fully attributing mind and intention to his patient, but this may have been necessary because the contents of her mind were probably at times overwhelming to him.

Interestingly, the RF rater observed, "How can anyone have fun with a Hannibal Lecter (patient) especially when you are a Jodie Foster (therapist)?" Her description of the patient as Hannibal Lecter involved a recognition that the paranoid transference may also be seen as the externalization in the therapeutic relationship of an alien part of the self on the part of the patient, representing the abusing, rejecting other, who is felt to colonize the self, and hence must be projected onto others (Fonagy, 2001). In an uncanny coincidence, when this was discussed with the therapist, he reported that in a previous session (which occurred after the PT-AAI interview), Nicole had said, "I wish you were Hannibal Lecter so I wouldn't be attached to you, only there's something likable even about him and in the end the Jody Foster character ran off with him." This convergence of the rater's fantasy about the therapeutic relationship with that of the patient qualifies as one of the "uncanny" coincidences noted by Freud (1919/1955b, 1941/1955a) in and out of the consulting room. Such coincidences demonstrate the power of the unconscious dimensions of mental life, and particularly the ways in which things that are frightening and familiar are often repressed, so that they return as grotesque or alien. In addition, the parallel between the current patient-therapist relationship and that of the filmic portrayal of a sadistic therapist and his frightened patient (transposed in this case to the fantasy of the sadistic patient and the frightened therapist) contributes to our understanding of the therapist's tendency to curtail his RF vis-à-vis the patient. We might hypothesize that were the therapist to contemplate the full range of the patient's motivations and intentions with regard to her relationship with him, the severity of her aggressive and erotic feelings and impulses toward him would be unbearable. It is also possible that the integration of such frightening fantasies about the patient-therapist relationship (consciously expressed on the part of the patient, but unconsciously conveyed through the PT-AAI on the part of the therapist) may be an indication that the therapist's capacity for mentalization can be only so far ahead of the patient in order for the patient to make use of it.

Case Summary

In this case, we see a complex profile in which patient's and therapist's RFs become entrained to each other in the course of treatment. The patient initially showed a rejecting and bizarre stance toward mentalization on the AAI, but moved toward some rudimentary, if lim-

ited and simplistic, consideration of mental states after 1 year of treatment. In this case, the therapist showed a full and nuanced awareness of the mental states of the patient. Some of the exceptional and original reflective statements that were made in his PT-AAI interview at 1 year, however, were tempered by overobjectified explanations and descriptions of the relationship, suggesting that perhaps he was held back from a full appreciation of the patient's mind. We suggest that this may have been an adaptive, and even therapeutic, stance (Diamond & Yeomans, 2003).

Case 2

History and AAI

Carol was from a family that she depicted during the AAI as "just cold . . . our whole house was kind of that way . . . nothing warm or inviting about it . . . We never had a family room. . . . It was empty . . . not much furniture Everything was slate and stone." Her parents were embattled and minimally attentive or affectionate. She reported having few memories of them, but she recollects that they sometimes forgot to pick her up from school. She described her mother as a somewhat perfunctory and instrumental caretaker, and her father as a severely depressed alcoholic who was often absent for weeks at a time and, when present, was sporadically violent, on one occasion driving a car into the house. Carol stated that as a child she felt that she was not really important and that no one would care if she were not there. Her truncated and constricted manner of expressing herself on the AAI, together with her slight tendency to idealize her parents and early experiences with them for which she had only limited recall, led to a primary classification of Dismissing (Ds), with the specific subtype of Devaluing of attachment (Ds2). Although she readily acknowledged the shortcomings in her parents, she minimized the significance of attachment relationships and associated feelings overall, focusing instead on her personal strengths and autonomy. The words that came to her mind when she described her relationship with her mother were "cold, sometimes warm, not very motherly, calm and sparse," and she could provide only the barest memories to illustrate her generalizations. Like most dismissing speakers, she tended to distance herself from attachment experiences and affects and to discount their impact on her current functioning, 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."

As indicated from this statement, Carol showed a limited capacity for reflecting on the mental states of self or other, as evidenced by her rating of low or questionable RF (scale point 3). She showed only a rudimentary capacity to understand that her behavior or that of others was a reflection of underlying, dynamic intentions or emotions. Additionally, although she demonstrated some intellectual sense of the importance of attachment on the AAI, her capacity to understand, explore, or symbolically represent the mental states of attachment figures remained superficial, canned, and somewhat stereotyped.

Carol'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 she 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 result of a significant diminution in identity diffusion and improvement in object relations. Indeed, at 1 year Carol 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 consciously reevaluated and "set aside" early disappointing attachment relationships and redirected her attention to new experiences and relationships. However, Carol showed no change in her capacity to attribute mind and intention to attachment figures, and hence she was again categorized with low or perfunctory RF on the AAI at 1 year (RF = 3). For example, when asked to reflect on the motivations behind her parents' rejecting behavior reported on the AAI, she stated, "I don't think it was intentional. I don't know . . . I think they just . . . didn't know it. They didn't know any better . . . I think they think they loved us and they did a great job."

PT-AAI

Carol's superficial, limited, and self-protective stance also characterized her engagement with her therapist, although she dutifully participated in 1 year of treatment. Carol's evaluation of her therapist and the treatment on the PT-AAI suggests that she struggled to deactivate or dismiss her emotions and thoughts regarding the relationship, just as she had with her parents on the AAI. On the PT-AAI, she described her therapist as "professional," "controlled," "understanding," and "concerned" about her, but she said that their relationship was "not that

personal.” The few episodic memories that she offered to illustrate these five words were rather vague and unconvincing. She 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.” Carol also tended to play down negative qualities with “upbeat” statements and to emphasize her personal strengths. For example, 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.” In general, she minimized the impact of the relationship on her functioning, and she showed little insight into why her therapist did therapy the way he did.

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 1 year when the research requirement ended. In a slightly reflective statement, she said:

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.

Just as Carol minimized the importance of attachment relationships on the AAI and PT-AAI, so did she show deficits in her capacity to read the mental states of self and others, leading to a rating of low or questionable RF on both the AAI and PT-AAI at 1 year. The patient stated that she had had difficulty comprehending the therapist’s understanding of her, as evidenced by her response when asked to reflect on her therapist’s view of her:

I don't really know if I know what his view of me was—particularly. Except . . . there's a title . . . something like . . . Borderline Personality maybe people categorize it who know about it . . . categories you sometimes to fall into . . . some of the patterns of a person with Borderline Personality . . . you know he pointed out things to me, and they happened to be some things maybe that might coincide with that, but, um, I really didn't see myself like that.

Interestingly, the therapist was also categorized with low or questionable RF vis-à-vis his experience with Carol at one year. On the PT-AAI, the therapist was somewhat unilateral in describing his relationship with Carol, 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 he freely acknowledged his frustration with her tendency to "close off to what I was saying and dismiss it in a devaluing way."

The therapist reported that he had difficulty staying emotionally engaged with Carol, had no fantasies about her, and rarely thought about her outside of sessions. He stated, "She was always in perfect attendance and always on time," but her "body language communicated a kind of defensiveness, a wall she didn't want me to get beyond." His attempts to reflect on her intentions and contents of mind were somewhat intellectualized and formulaic, as his response to the question "Why do you think she behaves the way she does in therapy?" indicates:

She seemed to have . . . an identification with narcissistic, cold, rejecting parents who left her feeling very tenuous about her claim on . . . you know, just being alive . . . and so she walled herself off in an isolated but protected state and simultaneously, without much awareness, treated people with the very narcissistic indifference that she felt she was the object of.

Such seemingly insightful passages as this one were unintegrated with other passages, indicating that Carol's mental states were opaque to the therapist, who acknowledged that the patient didn't "internalize my understanding too much." Hence the therapist was rated with low RF (3) of the over-analytical hyperactive type, a rating that contrasts markedly with his secure classification on the PT-AAI, because attachment security involves the creation of a coherent and integrated narrative about the relationship. On the PT-AAI, the therapist described Carol in a somewhat unilateral way as "distant, rigid, formal, cold, and superficial." Remarkably, these five words overlapped considerably with the five words Carol used to describe her parents on the AAI, indicating that a projective process was at work wherein the therapist had come to mirror directly her internal world in ways that did not contain or modify it. Not surprisingly, Carol chose not to continue with the therapist at the end of the research year, despite their symptomatic change.

Case Summary

In this case, the patient and therapist's RF ratings mirror each other directly (both had ratings of 3, or low RF). Although at first glance the

consistency between the therapist's and patient's ability to reflect on the relationship might suggest that the therapist was accurately mirroring the patient's experience, we know from findings by Fonagy et al., (2002), that such a pattern of direct imitation or mirroring does not necessarily lead to containment and modulation of affect. Hence we might say that mirroring that is too parallel, that is unmarked, is not conducive to the development of the self as a psychological organization that facilitates participation in a network of relationships (Fonagy et al., 2002). That was certainly the case with Carol and her therapist.

Conclusion

These findings, although preliminary, suggest that when we evaluate mentalization in the therapeutic relationship, we ought to consider the profile of patient's and therapist's reflective functions in relation to each other, rather than the discrete, individual scores. Just as the infant, through myriad transactions with others, learns both general schemes and highly singular ways of being with another that are unique to each relationship, so it is possible that each patient-therapist dyad may generate its own unique patterns of reflective function regardless of the individual mentalizing capacities of each member. Infant researchers such as Tronick and his colleagues (Tronick, 2000, 2001) pay considerable attention to the power of such singular interactional processes to shaping the internal world of the infant. Our clinical vignettes illustrate that in order for the patient to use the therapeutic relationship as a scaffold from which to develop the capacity to understand self and other in terms of mental states, patient's and therapist's RF must be complementary, neither too discrepant nor too parallel.

Studies of infant development have indicated that infants move quite quickly (after 4 months) from a preference for perfect contingent mirroring responses to noncontingent marked mirroring responses (Fonagy et al., 2002). On the basis of these findings, we might hypothesize, similar to Fonagy and colleagues (2002), that the therapist catalyzes mentalization through contingent but marked (or dissimilar) mirroring of the patient's affective states. Such responses to the patient's experiences "mark" the occurrence, separating it from both the patient's immediate experience of it and the therapist's reaction to it. Through such differentiated mirroring, therapists invite reflection in ways that are not possible with more direct mirroring of affective states (Fonagy et al., 2002). In short, if the therapist directly reflects the patient's level of mentalization, then he or she cannot catalyze development of mentalization in the patient. In her psychoanalytic investigations, Kantrowitz (2002) has similarly observed that the thera-

pist's character, by which she means cognitive style, defensive patterns, and characteristic object relational patterns, may in fact impede the analytic process if it is either too similar to or different from that of the patient.

The quality of mentalization in the therapeutic arena may be seen as a bidirectional process in that the therapist's and patient's capacities for reflective function are mutually and reciprocally influential. Just as the therapist's capacity to understand and reflect on the patient's internal experience or lack of it may expand or curtail the patient's capacity to explore minds of self and other, so also may the patient's capacity to understand the nature and functioning of mental states enhance or inhibit the therapist's mentalizing capacities. Our preliminary findings from the PT-AAI suggest that reflective function assesses transference and countertransference aspects of the therapeutic relationship by capturing the patient's and the therapist's capacities to represent each other in mental state terms, which then may be linked to the patient's capacity to reflect on the mind of parents or primary caretakers as evidenced on the AAI.

In addition, a consideration of RF profiles of different patient-therapist dyads on the PT-AAI suggests that the instrument captures aspects of the therapeutic relationship that fall under the rubric of Vygotsky's concept of the zone of proximal development (ZPD; Vygotsky, 1978). The ZPD is a developmental concept that refers to a set of dynamically unfolding processes through which latent or embryonic developmental functions and capacities are brought to fruition. The ZPD has recently been adapted to the clinical situation by Wilson and Weinstein (1996), who have defined it as "the processes that beget the differences between an analysand's ability to advantageously make use of the dyadic nature of the clinical situation as contrasted with solitary introspection or self analysis in order to acquire insight and capacities that promote self knowledge and self regulation" (p. 171). The ZPD refers to a set of interactive and dynamic processes through which one member of the dyad who possesses more advanced or developed cognitive and emotional skills (such as the capacity for mentalization) provides the scaffold for the evolution of embryonic potentials in the individual with less developed skills and capacities such that they become part of the internal property of the child. Inherent in the concept of the ZPD is the idea that the analyst flexibly navigates being ahead of, with, and even occasionally behind the patient, depending on which position might best promote the patient's capacity for mentalization at any particular stage in treatment. Hence it is not surprising that our therapists' RF ratings range from low or questionable RF to highly marked or superior RF, because we may hypothesize that they are re-

sponding to the patient's potential or capacity for mentalization at any given moment in treatment.

We might hypothesize that the fluctuations in the therapists' RF ratings at 1 year varies as a function not only of his or her own capacity for mentalization, but also of his or her sensitivity to patients' fluctuations in RF. This conceptualization of our findings is strengthened by the fact that the majority of these patients showed slight increases in reflective function, along with major improvements in behavior, symptomatology, and attachment status (with shifts from Unresolved/Disorganized to Organized attachment classifications for the majority of patients over the course of 1 year of TFP). Interestingly enough, the two patients who showed the least change in attachment measures after 1 year were the patients whose therapists were either substantially ahead or substantially behind their patients in reflective function. In one case, the therapist had an exceptional, intricate, and original way of depicting her patient's mental states on the PT-AAI (RF = 8), whereas her patient's reflective function remained somewhat rudimentary and stereotyped (RF = 4) throughout the treatment. In the second case, the therapist showed a somewhat banal or superficial capacity for reflective function (RF = 4.5), whereas the patient showed a quite explicit and at times sophisticated grasp of mental states of self and other (RF = 6) at the 1-year point. These findings suggest that, optimally, the therapist ought to be one step ahead of the patient in the development of the capacity for mentalization, just as in language development the mother introduces the child to semantics and syntax that are only months (rather than years) ahead of the child's current language capacities.

These findings also suggest that multiple repeated measures of reflective function over the course of therapy may provide an index of the extent to which therapist and patient are working in the zone of proximal development; that is, the extent to which an optimal analytic space, in which interpretations may be assimilated and used by the patient and in which objects may be used for internalization and growth as well as repetition, has been established in different therapeutic dyads and is operative at any given moment in the treatment. Our data thus suggest that reflective function is not a static intrapsychic concept, but instead may be the result of an unfolding transaction between patient and therapist that is itself in dynamic flux over the course of therapy.

Our findings on the importance and variability in mentalization among different patient-therapist dyads also highlight the importance of integrating multiple measures in investigating the impact of attachment concepts in the therapeutic relationship. The investigations of Fonagy and colleagues (Allen, 2003; Fonagy et al., 2002; Fonagy, Red-

fern, & Charman, 1997; Meins, Fernyhough, Russel, & Clarke-Carter, 1998) have demonstrated that attachment and mentalization are intricately linked in the process of development in that mothers of securely attached children are more likely to foster mentalization in their children by using mental state terms, by responding sensitively to their children's level of understanding of the minds of self and others, and by conceiving of their children as individuals with minds. Although the interaction between mentalization and attachment has been well established in studies of early parent-child interactions (Fonagy et al., 1997; Fonagy et al., 2002; Mein et al., 1998), there has been little investigation into the ways in which mentalization and attachment may converge or diverge in other social relationships beyond infancy and childhood, such as the therapeutic relationship. Our findings suggest that mentalization and attachment are overlapping but not synonymous, and that, in fact, improvements in mentalization may precede, lag behind, or coincide with the shift to secure states of mind with respect to attachment. Hence we might hypothesize that just as secure attachment provides a safe anchor that allows for the exploration of the minds of self and other, so might the capacity for mentalization lay the groundwork for the development of secure attachment relationships.

References

- Allen, J. G. (2003). Mentalizing. *Bulletin of the Menninger Clinic*, 67, 91-112.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington DC: Author.
- Bordin, E.S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L.S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 13-37). New York: Wiley.
- Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation*. New York: Basic Books.
- Bowlby, J. (1975). *Attachment theory, separation anxiety, and mourning*. In D. A. Hamburg & K. H. Brodie (Eds.), *American handbook of psychiatry* (2nd ed. pp. 292-309).
- Bowlby, J. (1978). *Attachment theory and its therapeutic implications*. Chicago: University of Chicago Press.
- Bowlby, J. (1975). Attachment theory, separation anxiety, and mourning. In D. A. Hamburg & K. H. Brodie (Eds.), *American handbook of psychiatry* (2nd ed., pp. 292-309).
- Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss, sadness and depression*. New York: Basic Books.
- Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books. (Original work published 1969)
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.
- Clarkin, J.F., Foelsch, P.A., Levy, K.N., Hull, J.W., Delaney, J.C., & Kernberg, O.F. (2001). The development of a psychoanalytic treatment for patients with

- borderline personality disorder: A preliminary study of behavioral change. *Journal of Personality Disorders*, 15, 487-495.
- Clarkin, J.F., Yeomans, F., & Kernberg, O.F. (1999). *Transference-focused psychodynamic therapy for borderline personality disorder patients*. New York: Wiley.
- Diamond, D., Clarkin, J., Levine, H., Levy, K., Foelsch, P., & Yeomans, F. (1999). Borderline conditions and attachment: A preliminary report. *Psychoanalytic Inquiry*, 19, 831-884.
- Diamond, D., Clarkin, J., Levy, K., Levine, H., & Kotov, & Stovall-McClough, C. (1999). *The patient therapist adult attachment interview (PT-AAI)*. Unpublished manuscript, The City University of New York, Department of Psychology.
- Diamond, D., Clarkin, J.F., Stovall-McClough, C., Levy, K.N., Foelsch, P., Levine, H., Yeomans, F. (2002). Patient-therapist attachment: Impact on the therapeutic process and outcome. In M. Cortina & M. Marone (Eds.), *Attachment theory and the psychoanalytic process* (pp. 127-178). London: Whurr Press.
- Diamond, D., Stovall-McClough, C., Clarkin, J., & Levy, K. (2003). Patient-therapist adult attachment scoring and classification systems, The City University of New York, Department of Psychology, New York.
- Diamond, D., & Yeomans, F. (2003). The impact of attachment on transference-focused psychotherapy, and the impact of transference-focused psychotherapy on attachment with borderline patients. Manuscript submitted for publication.
- Dozier, M. (1990). Attachment organization and treatment use for adults with serious psychopathological disorders. *Development and Psychopathology*, 2, 47-60.
- Dozier, M., Lomax, L. & Tyrrell, C. (1996). *Psychotherapy's challenge for adults using deactivating attachment strategies*. Unpublished manuscript, University of Delaware, Newark, DE.
- Dozier, M., Cuc, K., & Barnett, L. (1993). Clinicians as caregivers: Role of attachment organization in treatment. *Journal of Consulting and Clinical Psychology*, 62, 793-800.
- Dozier, M., & Tyrrell, C. (1998). The role of attachment in the therapeutic relationship. In J. A. Simpson and W.S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 221-248). New York: Guilford.
- Eagle, M. (2003). Clinical implications of attachment theory. *Psychoanalytic Inquiry*, 23, 12-27.
- Fonagy, P. (1991). Thinking about thinking. *International Journal of Psychoanalysis*, 72, 639-656.
- Fonagy, P., Steele, H., & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organization of infant mother attachment at one year of age. *Child Development*, 62, 891-905.
- Fonagy, P. (2001). *Attachment theory and psychoanalysis*. New York: Other Press.
- Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.
- Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., Target, M., & Gerber, A. (1996). The relation of attachment status, psychiatric classification and response to psychotherapy. *Journal of Consulting and Clinical Psychology*, 64, 22-31.
- Fonagy, P., Redfern, S., & Charman, T. (1997). The relationship between belief desire reasoning and a projective measure of attachment security (SAT). *British Journal of Developmental Psychology*, 15, 51-61.
- Fonagy, P., Steele, M., Steele, H., Leigh, T., Kennedy, R., Mattoon, G., & Target, M.

- (1995). Attachment, the reflective self and borderline states: The predictive specificity of the Adult Attachment Interview and pathological emotional development. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental and clinical perspectives* (pp. 233-279). Hillsdale, NJ: Analytic Press.
- Fonagy, P., Steele, M., Steele, H., & Target, M. (1997). *Reflective-functioning manual: Version 4.1. For application to the adult attachment interviews*. Unpublished manuscript, University College London.
- Freud, S. (1955a). Psycho-analysis and telepathy. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works* of Sigmund Freud (Vol. 18, pp. 173-193). London: Hogarth Press. (Original work published 1941)
- Freud, S. (1955b). The "uncanny." In *[as above]* (Vol. 17, pp. 217-256). London: Hogarth Press. (Original work published 1919)
- George, C., Kaplan, N., & Main, M. (1996). *The Berkeley Adult Attachment Interview*. Unpublished manuscript, University of California, Berkeley, Department of Psychology. (Original work written 1985)
- Gunderson, J. (1990). The borderline patient's intolerance of aloneness: Insecure attachments and therapist's availability. *American Journal of Psychiatry*, 153, 752-758.
- Hesse, E. (1999). The Adult Attachment Interview. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 395-433). New York: Guilford.
- Holmes, J. (1995). Something there is that doesn't love a wall: John Bowlby, attachment theory and psychoanalysis. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental and clinical perspectives* (pp. 19-43). Hillsdale, NJ: Analytic Press.
- Holmes, J. (1996). *Attachment, intimacy and autonomy: Using attachment theory in adult psychotherapy*. Northvale, NJ: Aronson.
- Kantrowitz, J.L. (2002). The external observer and the lens of the patient-analyst match. *International Journal of Psychoanalysis*, 83, 339-350.
- Kernberg, O.F. (1975). *Borderline Conditions and Pathological Narcissism*. New York: Aronson.
- Kernberg, O. F. (1976). *Object relations theory and clinical psychoanalysis*. New York: Aronson.
- Kernberg, O.F., Selzer, M.A., Koenigsberg, H.W., Carr, A.C., & Appelbaum, A.H. (1989). *Psychodynamic psychotherapy of borderline patients*. New York: Basic Books.
- Koenigsberg, H.W., Kernberg, O.F., Stone, M. H., Appelbaum, A.H., Ycomans, F.E., & Diamond, D. (2000). *Borderline patients: Extending the limits of treatability*. New York: Basic Books.
- Levy, K. N. (2002, May). *Change in attachment organization during the long-term treatment of patients with borderline personality disorder*. Invited panelist, "Integrative Treatments for Borderline Personality Disorder," XVIII Annual Conference of the Society for the Exploration of Psychotherapy Integration, San Francisco, CA.
- Mackie, A.J. (1981). Attachment theory: Its relevance to the therapeutic alliance. *British Journal of Medical Psychology*, 54, 201-212.
- Main, M. (1991). Metacognitive knowledge, metacognitive monitoring, and singular (coherent) vs. multiple (incoherent) models of attachment: Findings and directions for future research. In C.M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.) *Attachment across the life cycle*. London: Routledge, pp.127-159.

- Main, M. (1999). Attachment theory: Eighteen points with suggestions for future studies [epilogue]. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 845-887). New York: Guilford.
- Main, M., & Goldwyn, R. (1998). *Adult attachment scoring and classifications system*. Unpublished scoring manual, University of California, Berkeley, Department of Psychology.
- Meins, S., Fernyhough, C., Russel, J., & Clarke-Carter, D. (1998). Security of attachment as a predictor of symbolic and mentalizing ability: A longitudinal study. *Social Development, 7*, 1-3.
- Parish, M. (2000). The nature of the patient's tie to the therapist. (Doctoral dissertation, Adelphi University, 1999). *Dissertation Abstracts International, 60*, 6378-B.
- Parish, M., & Eagle, M. (2003). Attachment to the therapist. *Psychoanalytic Psychology, 20*, 271-286.
- Racker, H. (1968). *Transference and countertransference*. London: Maresfield Library.
- Slade, A. (1999). Attachment theory and research: Implications for theory and practice of individual psychotherapy. In J. & Cassidy, P. Shaver (Eds.), *Handbook of attachment theory and research* (pp. 575-594). New York: Guilford.
- Slade, A. (2002, July). *Keeping the baby in mind: Research and clinical implications of parental reflective functioning*. Paper presented at the meetings of the World Association of Infant Mental Health, Amsterdam, the Netherlands.
- Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2001, April). *Maternal reflective functioning: Considering the transmission gap*. Paper presented at the biennial meetings of the Society for Research in Child Development, Minneapolis, MN.
- Szajnberg, N.M., & Crittenden, P.M. (1997). The transference refracted through the lens of attachment. *Journal of the American Academy of Psychoanalysis, 25*, 409-438.
- Tronick, E. (2000, December). *The implicit organization: Thickness and specificity of infant-adult relationships*. Paper presented at the conference, "Attachment: Current Developments in Research, Theory and Application," sponsored by the Center for Attachment Studies of the Derner Institute of Advanced Psychological Studies at Adelphi University.
- Tronick, E. (2001). Emotional connections and dyadic consciousness in infant-mother and patient-therapist interactions. *Psychoanalytic Dialogues, 11*, 187-194.
- Tyrell, C.L., Dozier, M., Teague, G.B., & Fallot, R.D. (1999). Effective treatment relationships for persons with serious psychiatric disorders: The importance of attachment state of mind. *Journal of Consulting and Clinical Psychology, 67*, 725-733.
- Vygotsky, L. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.
- Wilson, A., & Weinstein, L. (1996). The transference and the zone of proximal development. *Journal of the American Psychoanalytic Association, 44*, 167-198.
- Yeomans, F.E., Clarkin, J.F., & Kernberg, O.F. (2002). *A primer of transference focused psychotherapy for the borderline patient*. Northvale, NJ: Jason Aronson.