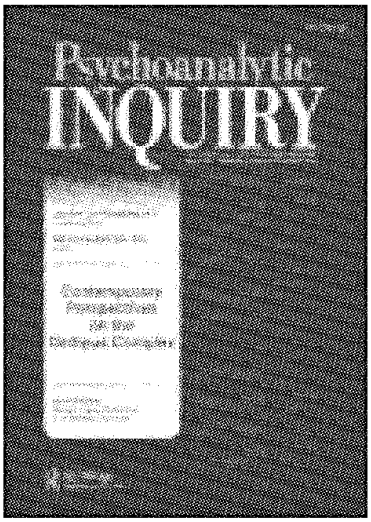

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Borderline conditions and attachment: A preliminary report

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Borderline Conditions and Attachment: A Preliminary Report

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In 1978 Bowlby posited that attachment theory would explain not only the creation and maintenance of strong affectional bonds in human beings, but also "the many forms of emotional distress and personality disturbance, including anxiety, anger, depression, and emotional detachment" (p. 5) that result from the disruption of those bonds. In the intervening years, attachment research and theory have indeed made substantial contributions to understanding the etiology, prognosis, and treatment of personality disorders and particularly borderline conditions, which are often characterized by extreme states of anxiety, anger, depression, and emotional emptiness. Certain crucial aspects of the object relations substrate of borderline personality, including the turbulent, polarized interpersonal relationships (West and Keeler, 1994); the alternation between protective shallowness and intense anger in relationships (Fonagy, 1991; Fonagy et al. 1995, 1996; West and Keller, 1994); and the chronic fears of abandonment and intolerance of aloneness (Gunderson, 1996), have

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been reconceptualized as sequelae of insecure attachment organization involving low levels of felt security and high levels of feared loss of attachment figures (Dozier, 1996). In addition, a number of empirical studies, using both interview and/or self-report attachment measures, have recently linked borderline disorders to a spectrum of insecure patterns of attachment, including the preoccupied, dismissing, unresolved for trauma, dependent, and negative/hostile attachment classifications (Sperling, Sharp, and Fishler, 1991; West et al., 1993; Adam, 1994; Diamond and Doane, 1994; Patrick et al., 1994; Adam, Keller, and West, 1995; Levy, Blatt and Shaver, 1995; Fonagy et al., 1996; Sack et al., 1996; Rosenstein and Horowitz, 1996; Saltzman, Saltzman, and Wolfson, 1997; Fonagy, 1998b).

As part of the Borderline Psychotherapy Research Project at New York Presbyterian Hospital–Cornell Medical College, headed by Drs. Otto Kernberg and John Clarkin, we have been attempting to assess intrapsychic structural change in psychodynamic psychotherapy by examining shifts in attachment status over the course of treatment with 20 borderline patients. These patients, who have been diagnosed with Borderline Personality Disorder (DSM-IV, 1994) and Borderline Personality Organization (Kernberg, 1975), are being treated with a manualized psychoanalytically oriented Transference-Focused Psychotherapy (TFP) by senior clinicians for a minimum of 1 year. We have been assessing the quality of attachment and object representation periodically during the course of treatment and the impact of both on the treatment process. The patient–therapist relationship as it evolves over the course of TFP is also being examined, with particular attention to the working through versus the persistence of insecure attachment patterns in the transference and to the development of reflective function, or the capacity to mentalize, in the patient–therapist dyad.

In designing our study, we were inspired by the growing body of research that indicates that attachment and object representation measures, particularly the Adult Attachment Interview (AAI) (George, Kaplan, and Main, 1985) and the Object Representation Inventory (ORI) (Blatt et al., 1988a), are theoretically grounded and empirically validated instruments for defining clinical phenomena, assessing the representational core of psychopathology, and evaluating structural change (Dozier, 1990; Gruen and Blatt, 1990; Diamond et al., 1992;

Blatt and Ford, 1994; Blatt et al., 1996; Fonagy et al., 1996; Main, 1995; Van IJzendoorn and Bakersmans-Kranenberg, 1996).

In this paper we present changes in attachment style and self and object representations of two of the 20 patients in the study over the course of 1 year in TFP. The two patients described in this paper were selected from the larger pool of 20 patients because they both completed at least one year of TFP with the same therapist. At the 1-year point Patient A continued treatment with her therapist, while Patient B chose to terminate treatment.

The Cornell Borderline Psychotherapy Research Project

The Cornell Borderline Psychotherapy Research group has been working for the past 20 years to study and systematize the psychoanalytically based treatment of borderline patients and has generated several volumes detailing the dynamic treatment of patients with borderline organization (Kernberg et al., 1989; Yeomans, Selzer and Clarkin, 1992; Clarkin, Yeomans, and Kernberg, 1999; Koenigsberg et al., in press). The research group has also explored a number of clinical issues with borderline patients, including factors related to early dropout (Yeomans et al., 1994), the impact of narcissistic features on the course of treatment for borderline patients (Horner and Diamond, 1996), and the impact of antisocial features on course of treatment (Clarkin et al., 1999).

Since the early 1980s approximately 40 borderline patients have been followed in twice-weekly TFP. Recently, the project has received National Institute of Mental Health funding (grant no: MH53705-02, Psychotherapy of Borderline Personality Disorder, Principal Investigator, John Clarkin, Ph.D.) to further refine the development of TFP with borderline patients, with a focus on assessing and refining therapist adherence to the manual and further evaluating the efficacy of TFP.[1] To this end the therapists' adherence to the manual and overall competence was assessed periodically through the course of treatment with 20 female borderline patients.

[1]Further, the effectiveness of TFP to diminish parasuicidal and impulsive behaviors is also being investigated. The project is using as a comparison group data from 10 patients in Dialectical Behavior Therapy (DBT), a form of cognitive-behavioral treatment developed by Linehan (1991, 1994).

Transference-Focused Psychotherapy

TFP is a modified psychodynamic treatment, the primary goal of which is to help borderline patients develop images of self and others that are integrated, multidimensional, and cohesive; to modify primitive defensive operations; and to resolve identity diffusion. TFP is designed to contain and work with the intense, chaotic transferences that borderline patients develop as a result of their split, polarized internal world. Thus, in TFP, the transference is the primary vehicle for the transformation of primitive (e.g., fragmented, split, polarized) to advanced (e.g., complex, differentiated, and integrated) object relations. TFP involves five major treatment phases: (1) a beginning phase that involves history taking and contract setting; (2) an early treatment phase that involves the identification of dominant object-relational patterns as they are lived out in transference; (3) a midphase that focuses on the integration of split, polarized, and part-object identifications via here-and-now transference interpretations; (4) an advanced phase that involves genetic interpretations that link current relational and transference patterns with early experiences; and (5) a termination phase.

Since the research reported in this paper encompasses the first year of treatment, we will focus our description on the first three phases of TFP. During these phases, the primary focus is on the predominant affect-laden themes that emerge in the relationship between borderline patients and their therapists in the here-and-now of the transference. These salient affective themes often emerge during the initial contract setting phase, which involves the clarification of the conditions of therapy, the delineation of the respective roles of patient and therapist, and most importantly, the development of strategies to contain acting out behaviors that would be potentially damaging to the patient, to others or to the patient's psychosocial stability. The interaction between therapist and patient in setting up the individualized treatment contract provides a first view of the patients' internal world of object relations (Yeomans et al., 1992).

During the second phase of TFP, the task is to identify the patient's repertoire of primitive, partial, and polarized representations of self and other as they emerge in the chaotic experiences, behaviors, and interactions with the therapist and to interpret such interactions in the

light of these primitive transferences. The challenge for the therapist is to be alert to the object relations activated in the patient at a particular moment—which aspects of her experience the patient experiences as part of the self, which as external to the self, and which are projected onto the therapist, with the goal of helping the patient to understand how these dispersed and contradictory images represent distinct aspects of the patient's representational world. The individual may show dramatic role reversals as she or he experiences both sides of the object-relational patterns in relation to the therapist. For example, the patient may alternate between experiencing the therapist as a threatening exploiter and the self as helpless victim, the therapist as an idealized rescuer and the self as special patient, or the therapist as helpless, ineffective treater with the self as an omnipotent savior. During the midphases of treatment, the main objective is to help the patient to integrate into conscious awareness his or her identifications with disparate aspects of the complementary relationships that are activated as dominant transference patterns. This awareness is fostered through interpretations that connect persecutory and idealized transferences, loving and hateful feelings towards the therapist. By the end of the first year of treatment, the increasing integration and modulation of the patients' object world is usually evident in his/her capacity to maintain the relationship with the therapist in spite of ongoing fluctuations between positive and negative affect states and between positive or idealized and negative or paranoid transferences. In sum, during the early to midphases of TFP, the therapist focuses his or her interpretations on the primitive behavior patterns and role reversals activated in the transference in the here-and-now interactions between patient and therapist. During this period, which usually spans the first year, the therapist is instructed to stay away from exploration of past relationships and to limit genetic interpretations that link unconscious meanings in the here-and-now with past unconscious meanings in the there-and-then. Premature genetic interpretations have been observed to foster regression in borderline patients (Kernberg et al., 1989) who tend to experience transference distortions as real and who thus have difficulty in the early stages of treatment understanding and integrating the linkages between current difficulties and early pathogenic relationships (Kernberg et al., 1989; Clarkin, Yeomans, and Kernberg, 1999). It should be noted that although TFP

stipulates a specific sequence of treatment phases and specific guidelines for phase appropriate interventions, the progression through these phases varies according to individual patient characteristics and the nature of the unique patient–therapist dyad. The patient's attachment status or current state of mind regarding early attachment relationships is a major patient characteristic which we have hypothesized will affect the course of TFP for borderline patients (Koenigsberg et al., in press).

Attachment and Borderline Psychopathology

Since the mid-1980s a number of investigators (Main, Kaplan, and Cassidy, 1985; Hazan and Shaver, 1987; West et al., 1993; West and Sheldon, 1987; Sperling et al., 1991) independently began to apply Bowlby's (1969, 1973, 1980, 1988) and Ainsworth's (Ainsworth et al., 1978; Ainsworth, 1985) attachment theory and classifications to the study of adults in both clinical and nonclinical populations. Mary Main and her colleagues developed the Adult Attachment Interview (AAI), designed to assess an individual's state of mind with regard to attachment, and to provide a window into the internal working model of attachment derived from experiences with early attachment figures. The individual's overall state of mind or representational states with respect to attachment are assessed on the AAI through an analysis of discourse designed to capture both conscious and unconscious aspects of attachment representations. Main (1999) has recently adapted the term overall state of mind with respect to attachment to characterize the knowledge about early attachment relationships derived from the AAI for the following reasons. In describing the partially unconscious models and representations of self and other which are built up across the lifespan, Bowlby originally used both the terms "internal working model" (see especially Bowlby, 1973), and later (Bowlby, 1980) "representational models" and "representational)/psychological states" (an especially careful delineation of each of these usages can be found in Bretherton, 1992). In using each of these terms Bowlby leaves open the possibility that contradictory models of the same person, experience, or of the self may exist, especially in the case of insecure individuals, where one part of the internal working model (often less

experience-near) being more, the other (often more experience-near) being less readily accessible to consciousness.

In general, the term "internal working model" (IWM, taken from Craik, see Bretherton, 1992) can be readily and accurately used in reference to specific individuals or events, as, the internal working model of the self, the mother, the father, or particular specific experiences such as the death of a sibling. While representational state can also be used to refer to unitary models of individuals or experiences, it is necessary to use this term or a variant (e.g., plural) of it when referring to the assessment made during the Adult Attachment Interview. In this interview, an individual is assigned to an overall category (secure, dismissing, preoccupied, unresolved, or cannot classify) on the basis of discourse used during a discussion of their overall experiences with several attachment figures and with multiple attachment-related events. In this case, Main and her colleagues have selected the term "overall state of mind with respect to attachment" to describe what the interview assesses, arguing (in agreement with an earlier personal communication from Bowlby, Main to Diamond, 1999) that because of the multiple nature of the persons and experiences discussed, the term "internal working model" cannot be applied.

Main and colleagues (Main et al., 1985; Main and Goldwyn, 1998) originally identified three major overall states of mind with respect to early attachment experiences and relationships on the AAI. Individuals classified with *Secure/Autonomous* states of mind with respect to attachment as they appear in verbatim transcripts of the Adult Attachment Interview (AAI) are characterized by internally consistent and hence at least seemingly truthful portrayal of the relationships with parents in the present and in childhood, by well-organized, collaborative undefended discourse in which emotions are freely expressed, and by the ability to coherently and collaboratively discuss both positive and negative aspects of early attachment relationships on the AAI. Individuals classified with *Dismissing* states of mind regarding attachment tend to either devalue the importance of attachment relationships (rare) or more commonly to portray them in an idealized fashion with few corroborating concrete examples. They often insist that they have little memory for childhood events. Individuals classified with *Preoccupied* states of mind with respect to

attachment are relatively open and expressive about attachment-related feelings, but their interviews are confused, incoherent and chaotic, with, for example, long, grammatically entangled sentences, use of jargon and nonsense words, reversion to childlike speech, and confusion regarding past and present relationships. Individuals classified as having *Unresolved* states of mind show lapses in their monitoring of reasoning or discourse when discussing experiences of trauma and loss. These individuals may speak in a moderately coherent manner, but they make highly implausible statements regarding the causes and consequences of traumatic attachment-related events or become confused, fall silent, or suddenly utilize eulogistic speech. Because their interviews may have prominent features of either the secure, dismissing, or preoccupied attachment categories, individuals classified as Unresolved are given a corresponding secondary classification. Interviews that do not fall into one of the above three categories are given a *Cannot Classify* rating, signifying a more global breakdown in discourse and/or inconsistent use of attachment strategies, so that the AAI shows characteristics of several different attachment classifications. The first three categories parallel the attachment classifications originally identified in childhood (the secure, avoidant, and anxious-resistant) (Ainsworth et al., 1978), while the Unresolved for trauma or loss classification corresponds to the pattern of disorganized-disoriented attachment later described in infants (Main and Solomon, 1986; Main and Solomon, 1990; Main and Weston, 1981).

Hazan and Shaver (1987, 1990) have also investigated adult attachment, but with a focus on current romantic attachments rather than early parent–child attachment relationships. In contrast to Main and colleagues who have developed methods to assess internal working models or representational states with respect to attachment based on early attachment experiences that are both conscious and unconscious, Hazan and Shaver have focused on consciously held attachment styles in current romantic relationships. They have devised a brief self-report measure to assess romantic attachment. Following Ainsworth et al. (1978), they labeled the three types of adult attachment as secure, avoidant, and anxious-ambivalent. In subsequent research, Bartholomew (Bartholomew and Horowitz, 1991) noticed an incongruence between Hazan and Shaver's and Main's conceptions of

avoidant attachment. Individuals assessed as avoidant by Hazan and Shaver appeared to be predominantly fearful of relationships, whereas those assessed as avoidant by Main were predominantly dismissing of attachment. Based on this incongruence, Bartholomew developed a four-category interview and self-report classification of adult attachment that included secure and preoccupied (anxious-ambivalent/enmeshed) categories, but that divided the avoidant category into both dismissing and fearful-avoidant attachment classifications. Although one would expect that attachment styles assessed through self-report and internal working models of attachment assessed through interviews would show some overlap, in fact empirical research indicates that there is little correspondence between the two (Crowell, Treboux and Water, 1993; Bartholomew and Shaver 1998).

An accretion of studies, using both the interview (AAI) and self-report [Bartholomew Adult Attachment Questionnaire (BAQ)] measures, now links borderline pathology to a range of insecure attachment caregories including the preoccupied, dismissing, and unresolved for trauma attachment classifications (Patrick et al., 1994; Adam, 1994, 1995, Levy, Blatt, and Shaver, 1995; Fonagy et al., 1996). Initially, studies indicated that borderline patients may be distinguished from other clinical groups by their propensity to be classified as fearfully preoccupied with respect to attachment-related traumas (E3 on the AAI) (Patrick et al., 1994). Difficulties in forming, sustaining, and reciprocating attachment bonds have been seen in borderline samples to devolve from representational states that are characterized as internally entangled with and overwhelmed by representations of attachment figures, who are depicted in a chaotic, confusing, and often negatively tinged manner. Inconsistent maternal availability in the context of uneven promotion of child exploration have been shown to underlie insecure-ambivalent or preoccupied attachment (Cassidy and Berlin, 1994). Such factors curtail the separation-individuation process, which has long been postulated as the critical developmental period in the formation of borderline disorders (Kernberg, 1975; Cassidy and Berlin, 1994). Thus, there is convergent evidence from child and adult attachment research that the preoccupied/anxious-ambivalent states of mind with respect to attachment are associated with borderline pathology and may indeed

be one of the prototypical attachment classifications for borderline patients.

Recent research suggests that variations in attachment classification may discriminate among subtypes of borderlines. Some studies indicate that those with antisocial and/or narcissistic and paranoid features tend to be classified as dismissing, while those with histrionic, obsessive–compulsive, affective, or schizotypal features tend to be classified as preoccupied (Levy, Blatt and Shaver, 1995; Rosenstein and Horowitz, 1996). Finally, chronically self-injurious or parasuicidal borderline patients tend to be classified as unresolved with respect to potentially traumatic experiences on the AAI. There is increasing evidence that borderline patients, particularly those who have been hospitalized and/or are suicidal and/or chronically self-injurious (parasuicidal), have failed to integrate or resolve attachment traumata, particularly sexual and physical abuse by caretakers (Adam, 1994; Patrick et al., 1994; Adam et al., 1996; Fonagy et al., 1996; Fonagy, 1998b).

For example, in the Cassell Hospital study, which compares the attachment classifications on the AAI of 82 nonpsychotic inpatients and 85 case matched controls, Fonagy and colleagues found that the proportion of borderlines who were classified as fearfully preoccupied with past trauma was significant (Fonagy et al., 1996); however, what has consistently distinguished borderline patients from other clinical groups, in this and other studies, is the lack of resolution of trauma or unresolved status on the AAI (Patrick et al., 1994; Adam et al., 1995; Fonagy et al., 1996). Additionally, in a study of the long-term outcomes of 52 severely disturbed adolescents who were psychiatrically hospitalized at age 14 and reinterviewed at age 25, Allen, Hauser, and Borman-Spurriel (1996) found that 46 (or 88%) of the previously hospitalized subjects were classified with insecure states of mind with respect to attachment on the AAI as compared to half of the demographically matched high-school control sample (28, or 48%), with the lack of resolution of past trauma accounting for much of this insecurity. In recent meta-analytic studies of attachment status in clinical populations, adult attachment classification was strongly associated with clinical status, particularly when the unresolved attachment classification was used (Van IJzendoorn and Bakermans-Kranenburg, 1996).

However, it is important to note that although physical and sexual abuse have been repeatedly implicated as etiological factors in borderline disorders (Herman, Perry, and Kolk, 1989; Weston et al., 1990; Paris and Zweig-Frank, 1992; Stone et al., 1988), several studies suggest that a family climate of emotional violence and neglect, in conjunction with insecure attachment to primary caregivers, is more strongly associated with the development of Borderline Personality Disorder (BPD) than the specific trauma of physical and sexual abuse (Zanarini et al., 1989; Saltzman et al., 1997), which is associated with symptom severity in borderline patients (Briere and Zaidi, 1989; Shearer et al., 1990; Saltzman et al., 1997). Further research is needed to clarify the complex interconnections between intrafamilial abuse, family chaos, and insecure versus secure internal working models of attachment.

Reflective Function

The concept of reflective function (RF), or the capacity to think of others in mental state terms, has enhanced our understanding of the attachment substrate of borderline conditions and of the relationship between intrafamilial abuse and insecure attachment (Fonagy et al., 1995, 1996; Fonagy, 1998a). Defined as the capacity to comprehend and conceptualize mental processes such as feelings, beliefs, intentions, conflicts, motivations and other psychological states of self and other, RF may in fact serve as a mediating variable that ameliorates or exacerbates the impact of an abusive environment (Fonagy et al., 1995, 1996). Indeed, Fonagy and colleagues (Fonagy et al., 1996) found that the AAI's of borderline patients were distinguished from other psychiatric patients not only by significantly higher ratings on the lack of resolution of trauma scale of the AAI, but by significantly lower ratings on the RF scale. Further, the presence of adequate RF even in the context of an abusive or traumatic early history functions as a protective factor that mitigates against the transgenerational transmission of insecure attachment patterns.

Attachment and Therapeutic Process

Despite the evidence linking borderline disorders to the spectrum of insecure representational states with respect to attachment and to

deficits in reflective function (RF) there have been few investigations of the ways in which insecure attachment status affects the course of treatment with borderline patients. This dearth of attention to the clinical implications of attachment devolves from the idea held by many psychoanalytically oriented clinicians that a theory derived from systematic, laboratory-based observations of the development and maintenance of human affectional bonds in infancy and early childhood with normative samples cannot encompass or elucidate the complexities and nuances of patient–therapist transactions, particularly with severely disturbed patients (Hamilton, 1987). Although the clinical applications of attachment theory have recently begun to be explored theoretically and empirically (Dozier, 1990; Sable, 1992; Dozier, Cue, and Barnett, 1993; Farber, Lippert, and Nevas, 1995; Mallinckrodt, Gantt, and Coble, 1995; Gunderson, 1996; see Slade, 1995, for a review), the contributions of attachment theory to understanding therapeutic process with more severely disturbed patients have yet to be delineated.

The one exception is the research of Fonagy and colleagues (Fonagy et al., 1996), who reported on change in attachment status on the AAI for 35 nonpsychotic inpatients following 1 year of intensive psychodynamic psychotherapy. Although all 35 inpatients were classified with insecure states of mind with respect to attachment on their initial AAI, 14, or 40%, of the 35 inpatients showed a shift to a secure classification upon discharge.[2] In addition, the individual subscale ratings of the AAI at admission and at 1 year indicated that bland or idealized pictures of parents and a pattern of pervasive memory blockages were reduced by treatment (Fonagy et al., 1996).

In a later report from the same study, which compared the effectiveness of intensive and nonintensive psychoanalytic treatment for young adults with severe personality disorders, the AAI was useful in identifying those who benefitted from or dropped out of treatment early. All the patients who prematurely dropped out of treatment were from the preoccupied-entangled group and, in particular, the E2 subcategory characterized by vague, inchoate negativity (Fonagy et al., 1996), whereas individuals classified initially as dismissing were

[2] It should be noted that the raters in Fonagy et al.'s study had not been trained in the Cannot Classify (CC) category of AAI coding at the time the study was carried out.

more likely to show clinically significant improvements on the Global Assessment of Functioning (GAF) scale than were those clasified as preoccupied or secure.

Attachment and Structural Change

The above research suggests that the longitudinal assessment of attachment states in borderline patients over the course of treatment may provide a reliable and valid measure of intrapsychic change and particularly change in object relations that is hypothesized to occur in psychodynamic psychotherapy. Previous research and theoretical work on change in psychodynamic therapy has highlighted the centrality of shifts in internal object relations development for enduring therapeutic change (Wallerstein, 1986, 1988; Kernberg et al., 1989). Both attachment and object relations theorists posit that the structure (e.g., coherence and integration), as well as the content (e.g., malevolence/benevolence) of representations, influence expectations, feelings, behaviors, and relationship patterns.

Previous studies with both clinical and nonclinical populations have suggested that insecure representational states with respect to attachment are associated with a lower level of object relations (e.g., less integrated, differentiated, elaborated, articulated, and benevolent) assessed on both projective and self-report object relations measures (Sacks et al., 1995; Levine, Tuber, and Slade, 1995; Morrison et al., 1995; Rothstein, 1997; Levy, Blatt, and Shaver, 1998). More specifically, several recent studies suggest that individuals with insecure representational states with respect to attachment (as assessed in self-report and interviews measures e.g. the AAI) tend to have more malevolent self- and object representations as compared with the more benign self- and object images of individuals with secure representational states with respect to attachment on a variety of measures of self, and object representations, including the Object Representation Inventory (ORI) (Levy et al., 1998), the Rorschach (Rothstein, 1997), and the self-report SASBI circumflex model of interpersonal interaction (Morrison et al., 1995).

In our study, as an aspect of evaluating the efficacy of TFP and its capacity to promote intrapsychic change, we are investigating changes in representational structures of the borderline patients in our sample,

including changes in representational states with respect to attachment and reflective function (assessed with the AAI and in developmental levels of self- and object representations (assessed through the ORI (Blatt et al., 1981; Diamond et al., 1992) [discussed in greater detail in the methods section]. We hypothesized that attachment and object-representational measures may change differentially over the course of treatment, but together they are more likely to provide a comprehensive picture of those aspects of object relations (e.g., the expectations and images of self and other in primary dyadic relationships) that are expected to be reevoked and transferentially enacted in psychodynamic therapy with borderline patients.

Methods

Procedures

In the Cornell Borderline Psychotherapy Research Project, patients were given a number of self-report and interview measures designed to assess overall state of mind in relation to attachment and other aspects of their representational world.[3] At 4 months and 1 year, patients were given two attachment measures: the AAI, a semistructured indepth interview designed to elicit early attachment memories and experiences, and the BAQ, a self-report measure that focuses on current attachment patterns in romantic relationships. In addition, at 4 months and 1 year, patients were given the ORI, a projective technique designed to assess level and quality of self- and object representations through open-ended descriptions of mother, father, self, and therapist. Finally, at 1 year patients and therapists were given the Patient Therapist Relationship Interview (PTRI), a brief semistructured interview designed to explore the patient's and theorists' experience and representations of the therapeutic relationship and the treatment process at one year. Table 1 presents a summary of the measures used in the study. Each of these interviews and the scoring systems used in the study are described in greater detail below.

[3] In addition, on admission to the study, patients were given a number of additional assessment instruments including the SCID; SCID, Axis II; Parasuicide History Interview; Treatment History Interview, Brief Symptom Inventory, and Social Adjustment Scale—Life.

Table 1 Measures

Four Months	One Year
Patient	
Adult Attachment Interview (AAI)	Adult Attachment Interview (AAI)
Bartholomew Adult Attachment Questionnaire (BAQ)	Bartholomew Adult Attachment Questionnaire (BAQ)
Object Representation Inventory (ORI)	Object Representation Inventory (ORI)
	Patient–Therapist Relationship Interview (PTRI)
Therapist	
	Patient–Therapist Relationship Interview (PTRI)

Subjects

The subjects are two patients in the Cornell Borderline Psychotherapy Research Project at the New York Presbyterian Hospital–Cornell Medical Center. The larger group of 20 female subjects, from which our two subjects were selected, ranged in age between 18 and 45 years. All of the subjects had had at least two incidents of parasuicidal behaviors (Linehan et al., 1991) during the past 5 years, with one incident during the 8 weeks prior to admission to the study. Subjects met at least five out of nine criteria for BPD on the SCID-II and did not meet DSM-IV criteria for schizophrenia, bipolar disorder, substance dependence, or mental retardation. All patients are being treated with manualized TFP by five experienced therapists with psychoanalytic and/or postdoctoral training (two patients per therapist) for a minimum of 1 year.

The two patients selected for this pilot study are Caucasian individuals in their late twenties who had had a number of previous hospitalizations for self-destructive and parasuicidal behaviors prior to their admission to the study. Although both were diagnosed with BPD (DSM-IV, 1994) and Borderline Personality Organization (BPO) (Kernberg, 1975) at the beginning of the study, they varied somewhat in their clinical presentation. Adam was assessed to have prominent narcissistic and antisocial features, whereas Beth was diagnosed only with BPD and BPO. Adam was married when he entered the study, and Beth married in the course of the first year of treatment. In addition, both patients were employed during their 1-year treatment.

Both Adam and Beth were in treatment with the same therapist. The therapist was a senior female clinician with over 10 years' experience as a therapist and researcher in the Cornell Borderline Psychotherapy Project. The therapist selected for this study was judged in independent supervisory ratings to be both competent in TFP and adherent to the TFP manual.

Adult Attachment Measures

Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985)

The Adult Attachment Interview is a semi-structured clinical interview designed to elicit thoughts, feelings and memories about early attachment experiences and to assess the individual's state of mind or internal working model with regard to early attachment relationships. The interview consists of 17 questions asked in set order with standardized probes. Individuals are asked to describe their relationship with each person during childhood, choosing 5 words to describe each relationship and supporting these descriptors with specific memories. To elicit attachment related information they are asked how their parents responded to them when they were in physical or emotional distress (e.g., during times when they were upset, injured, and sick as children). They are also asked about memories of separations, loss, experiences of rejection, and times when they might have felt threatened, including, but not limited to, those involving physical and sexual abuse. The interview requires that they reflect on relationship influences on current functioning and on their parent's motivations. Thus they are asked why they think their parents acted the way they did and how they think their early expereince with their parents have shaped their adult personality. The technique has been described as having the effect of "surprising the unconscious" (George et al., 1985) and allowing numerous opportunities for the interviewee to elaborate on, contradict, or fail to support previous statements. The AAI is rated for both attachment classification and for reflective function according to the following procedures.

The AAI is transcribed verbatim and trained coders first score the transcripts to assess the nature of early experiences with attachment figures and current state of mind regarding attachment using subscales that cluster in three areas: (1) those that are based on the rater's *inferences* about the individual's experiences of parents in childhood

(e.g., the extent to which parents were loving, rejecting, neglecting, involving, and role reversing); (2) those that assess the individual's style of discourse (e.g., coherence of transcript, idealization, insistence on lack of recall, active anger, lack of resolution of loss and trauma, and overall coherence of thought); and (3) those that assess the individual's overall state of mind with respect to attachment (e.g., degree of derogation of attachment). Subscales are generally rated from 1 to 9 (1 = absent or very low to 9 = high levels of the quality present). Several additional scales rate the extent to which subjects are unresolved with regard to loss or trauma.

These subscale ratings, particularly the state of mind subscales, are then used to assign individuals to one of five primary attachment classifications. The adult classifications of secure/autonomous, dismissive, preoccupied, and unresolved parallel the infant classifications of secure, anxious-avoidant, anxious-resistant, and disorganized-disoriented (Main et al., 1985).

Within each of the primary attachment classifications, subclassifications are also made. For example, there are three subtypes within the preoccupied classification (E1—passive stance according to ill-defined experiences of childhood; E2—current anger regarding past experiences in childhood; and E3—preoccupation with traumatic events in childhood). Recent research has indicated that the four-category attachment classification system may be inadequate to classify clinical populations (Hesse, 1996; Crittendon, 1995), which has led to the development of a fifth Cannot Classify (CC) category. Hesse (1996) reports that approximately 40 percent of clinical samples cannot be classified under the four-category attachment system, compared with 18–20 percent of normative subjects.

In the current study, the AAIs were scored by two separate raters, one who scored the 4- month interviews and the other the 1 year interviews. Both raters were blind to all identifying characteristics of the subjects including diagnosis, the nature and purpose of the study, and the time of the interviews (e.g., 4 months or 1 year). Both raters were trained to code the AAI in workshops conducted by Main and Hesse and had achieved reliability on an extensive set of training transcripts. Both raters had also been trained in the most recent five-way attachment classification system which includes the Cannot Classify (CC) category.

Another set of raters, who were also blind to all identifying characteristics of the subjects including diagnosis, as well as to the nature and purpose of the study, rated the AAI for RF. These raters had received training in the application of the Reflective Function Manual, version 4.1 (Fonagy et al., 1997), by the authors of the manual. Briefly, the Reflective Function Scale is a clinical scale that ranges from −1 (negative RF, in which interviews are overly concrete, totally barren of mentalization, or grossly distorting of the mental states of others) to 9 (exceptional RF, in which interviews show unusually complex, elaborate, or 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 or simplistic. A more comprehensive description of the scale, its theoretical underpinnings, rating procedures, reliability, and validity can be found in The Reflective Functioning Manual, Version 4.1 (Fonagy et al., 1997).

Patient–Therapist Relationship Interview (PTRI)

This interview is designed to explore patients' and therapists' experience and representation of the therapeutic relationship and the therapeutic process. The format of the PTRI in part parallels that of the AAI described above. Like the AAI, this interview requires patients and therapists to describe their relationship generally and then more specifically by choosing five adjectives. Patients and therapists are also asked how they manage and respond to separations from each other, how they respond to felt experiences of rejection from the other, whether each has ever felt threatened by the other in the course of the treatment. In addition, patients and therapists are asked how the therapeutic experience has affected them, whether they consider themselves changed as a result of this experience, and what they have learned from their therapeutic work. This interview also evaluates the quality of the patients' and therapists' level of reflective function (RF) vis-a-vis the therapeutic relationship or the capacity to mentalize about the relationship (e.g., to evaluate the motivations, thoughts, feelings, and intentions of the other). To this end it includes questions which evaluate the extent to which each can formulate a coherent understanding of the therapeutic interactions. The interview evaluates the quality of the therapist's understanding of the patient as well as the

extent to which the patient has internalized the therapist's understanding of him or her, and been helped by such understanding in other interpersonal contexts. The PTRI was scored with the Reflective Function (RF) Scale (Fonagy et al., 1997).

Bartholomew's Four-Category Adult Attachment Questionnaire (BAQ; Bartholomew and Horowitz, 1989)

The BAQ is a brief self-report attachment questionnaire that asks subjects to choose one of four vignettes that best characterizes them in current close romantic relationships. Subjects are then asked to rate in Likert-type format the degree to which each vignette matches their style of relating. In several studies Bartholomew's self-report measure has been shown to be both reliable and valid (Bartholomew and Horowitz, 1991; Brennan, Shaver, and Tobey, 1991) Horowitz, Rosenberg, and Bartholomew, 1993; Levy, Blatt, and Shaver, 1998). Bartholomew's four-category measure overlaps with that of Main but distinguishes between two different avoidant-attachment styles: (1) a fearful-avoidant style characterized by a desire for, but a conscious fear of intimacy, and (2) a dismissing-avoidant style characterized by a defensive denial of the need and/or desire for relatedness. Recent research indicates that this distinction between fearful and dismissing avoidant has become increasingly significant in differentiating between the level of object relation development (Levy et al., 1998), romantic attachment (Brennan et al., 1991), personality style (Bartholomew and Horowitz, 1991), and treatment outcome (Horowitz et al., 1993).

The Object Representation Inventory (ORI; Blatt et al., 1981)

The ORI is an open-ended technique that elicits narrative descriptions of self and significant others. Subjects are asked to describe, without interruption, mother, father, self, and therapist. Blatt and his colleagues have developed a number of scales to score various aspects of these descriptions (Blatt et al., 1981; Diamond et al., 1994; Blatt, Bers, and Stein, 1985; Diamond et al., 1994).

Differentiation-Relatedness Scale of Self- and Object Representations (Diamond et al., 1994)

The ORIs were rated for the degree of self–other differentiation and relatedness on a 10-point scale, as illustrated in Table 2. Scale points 1

Table 2 Self-Other Differentiation and Relatedness Scale Points

1.	Self–other boundary confusion (physical)
2.	Self–other boundary confusion (intellectual/affective)
3.	Self–other mirroring
4.	Self–other idealization or denigration
5.	Semidifferentiated self and other (rapprochement)
6.	Emergent constancy of self and other
7.	Consolidated and constant (stable) sense of self and other
8.	Cohesive, individuated, and empathically related self and other
9.	Reciprocally related, integrative, unfolding self and other
10.	Intersubjective (constructive) self and other

and 2 indicate a lack of basic differentiation between self and other; scale point 3 indicates a definition of self through mirroring by others; scale point 4 indicates extremes of self–other idealization or denigration; scale point 5 indicates oscillation between polarized positive and negative aspects of self and other; scale points 6 and 7 encompass an emergent differentiated and integrated representation of self and others with increasing tolerance for ambiguity; scale points 8 and 9 indicate a sense of self and others as empathically interrelated in reciprocal mutually enriching interactions; and finally, scale point 10 involves a reflective sense that descriptions represent continuously unfolding constructions of self and other.

Previous research with adult samples, both clinical and nonclinical, supports the construct and predictive validity of this measure (Diamond et al., 1990, Stayner, 1994; Blatt et al., 1996; Levy et al., 1998) as well as its independence from age, intelligence, length of hospitalization, and age of onset of psychiatric disorder (Stayner, 1994). Particularly relevant to the present study, Blatt and colleagues (Blatt et al., 1996) found that changes in the level of differentiation and relatedness of representations of mother, father, self, and therapist predicted independent assessments of clinical functioning and therapeutic change over a 2-year period (Blatt et al., 1996).

For the present study, and consistent with earlier reports (Stayner, 1994), an intraclass correlation coefficient (ICC) = .96 was obtained for ratings of self–other differentiation and relatedness between two judges on an independent sample of 30 protocols and on a subsample of 30 protocols from the current study. Once reliability was established between the two raters, disagreements were resolved by consensus.

Results

We will provide a case-focused presentation of changes in the two patients' attachment classification, reflective function, and object-representational measures over the course of 1 year. Qualitative data from the interviews are presented to show how these measures may enrich our clinical understanding of treatment response in borderline patients.[4] An overview and summary of the two patients' attachment classification, specific subtype, and subscale ratings[5] at time 1 and time 2 on the AAI are presented in Table 3, as are the BAQ self-report ratings on current romantic attachment. A summary of the RF ratings on the AAI and the PTRI are also presented in Table 3. Table 3 also includes the ORI self–other differentiation and relatedness ratings.

Adam: The Patient with the Unresolved/Preoccupied State of Mind with Respect to Attachment

Adam was from a chaotic family with a mother whom he described as erratic and seductive and a father whom he described as inconsistent and cruel. His mother had a chronic degenerative physical illness with an accompanying mood disorder, and depended on the patient for emotional and physical caretaking. Adam had a brother who was killed in a car accident two years before his birth. His parents dressed him in his brother's clothing and he thought the parents believed that he might represent the reincarnation of that child. Adam described his relationship with his mother as one of being like Siamese twins. He stated that because of her impairments and previous losses his mother, who had had to relinquish her own career as a musician, lived vicariously through the Adam. Although he had demonstrated promise as a

[4] In the following presentation and discussion of the results, all identifying information has been changed to protect patients' confidentiality. Quotes have been altered in content but not linguistic structure to protect research participants.

[5] We have presented the AAI subscale ratings in Table 3 but will not discuss these extensively in the text because of space constraints. However, the interested reader will note that both patients showed increases in subscale ratings of overall coherence of the transcript and metacognitive reasoning. In addition, the patient initially rated as dismissing of attachment showed a decrease in the degree of derogation of attachment figures and of attachment relationships overall, whereas the patient rated initially as preoccupied with attachment showed a decrease in involving anger toward her parents at 1 year. These results are consistent with the expected outcome of psychoanalytic therapy.

Table 3 Adult Attachment Interview (AAI) and Self-Report Attachment Classification and Scale Ratings

	Adam		Beth	
	Time 1	**Time 2**	**Time 1**	**Time 2**
AAI Classification	E3b/2/U	F5/U	Ds2	F1a
Primary	Unresolved	Secure	Dismissing	Secure
Secondary	Preoccupied (Fearfully preoccupied by traumatic events; angry/ conflicted)	Unresolved	(Devaluing of attachment)	(Somewhat setting aside of attachment; reevaluating and redirection of personal life)

AAI Subscale Ratings

Scales For Experience of Parents

	M	F	M	F	M	F	M	F
Loving	1	2.5	1.5	2.5	3	3	2	1
Rejecting	8	5	5	3	6.5	6	7	5
Involving/ Reversing	8	6	8.5	7	1	5	(5)(1)	(7)(1)
Pressure to Achieve	4	1	1	1	1	1	1	1
Neglecting	1	1	1	(5)	1	1	1	8

Scales for State of Mind Respecting Parents

Idealizing	1	1	1	1	1	1	3.5	1
Involving Anger	6	2	4	1	1	1	2	2
Derogation	1	1	4	1	6	6	1	3

Scales for Overall State of Mind Regarding Attachment

Overall Derogation of Attachment	1	4	6	3
Lack of Recall	4	1.5	5.5	5
Meta-cognition	1	4	1	3
Passivity	4	3.5	3	3
Fear of Loss	N/A	N/A	N/A	N/A
Highest Score URL	4.5	3	2	1
Highest Score URT	6	5	N/A	N/A
Coherence of Transcript	4	7	3.5	5
Coherence of Mind	4	4.5	3.5	5

Table 3 Continued

	Adam				Beth			
	Time 1	Time 2			Time 1	Time 2		
Reflective Function Ratings								
			(Patient)	(Therapist)			(Patient)	(Therapist)
	(AAI)	(AAI)	(PTRI)	(PTRI)	(AAI)	(AAI)	(PTRI)	(PTRI)
	3	5	4	6	3	3	3	3
Bartholomew Adult Attachment Self-Report Questionnaire Raings (BAQ)								
Self-report Classification	Fearful Avoidant		Fearful Avoidant		Dismissing Avoidant		Secure	
BAQ Self-Report Ratings								
Secure	2		2		2		1	
Fearful	6		7		4		4	
Preoccupied	5		2		2		1	
Dismissing	3		4		5		5	
Object Representation Inventory (ORI)								
Self–Other differentiation and Relatedness Scores								
Self	4		6		5		3	
Therapist	5		7.5		5		5	
Mother	4.5		5		4.5		5.5	
Father	5		7		4		5	

musician and composer, he was unable to work consistently because of his psychological difficulties. The parents had a distant relationship, lived on different floors of the house, and both turned to Adam for companionship. Both parents eroticized their relationship with the patient by sleeping in the same bed with him, and engaging in other overt and covert sexualized interactions. In addition, he recollects fragments of bizarre and violent incidents from his childhood, including seeing his pet bird drowned in front of him by his father.

Attachment Ratings (AAI). As shown in Table 3, at time 1, Adam received a primary attachment classification of unresolved for trauma (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, his attachment interview showed evidence of a global breakdown in discourse strategy when discussing attachment-

related traumas and of some memory loss for early traumatic experiences. For example, he experienced a dramatic loss of memory related to past traumatic experiences and was unable to complete sentences related to the violent and sexualized behavior of his parents.

> We kept getting . . . we kept getting replacement birds. 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 through when I was a kid is that they disappeared. I didn't know—I mean they said they were taking them to the vet to have them put asleep. 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 bird . . . that was pretty horrible . . . he um he drowned it . . . I forgot for like a couple of years before I remembered it. . . . I forgot all about it—it was so sort of upsetting and it wasn't till like a couple of years later and I remembered I'd seen it. And then I wasn't like sure if I had or not, and I thought you know I must've like made this up. . . .

For individuals with a classification of unresolved, attachment-related traumas and losses continue to remain unintegrated into current experience and functioning. It should be noted that the unresolved classification on the AAI encompasses not only episodes of sexual and physical abuse, but also other acts that exceed cultural norms, including chronic seductiveness, cruelty or neglect, exposure to parental sexual activities, bodily functions, or maltreatment of other family members or pets.

Adam not only demonstrated a high degree of disorganization and incoherence when discussing past attachment-related traumas, but he also indicated that these fearful experiences were currently affecting his mental processes overall, leading to a secondary classification of preoccupied. Adam showed an angry preoccupation with early attachment-related experiences and oscillated in a somewhat confused and chaotic manner between polarized positive and negative evaluations of early attachment objects. When asked to give five words to describe his relationship with his mother, he chose "intimate, neurotic, desperate, scared and confusing." His descriptors of his father were equally polarized: "distant, inadequate, cruel, more like a peer, and I

worried about him." Adam's involvement with his parents was characterized by role-reversal, or caretaking of impaired, erratic parents, and he expressed much anger and conflict over such parentification in the family, as the following passage elaborating on the word "intimate" indicates:

> Um . . . Well . . . Well . . . she was very sort of inappropriate . . . Ah, that would have been a good one. Sexually, I mean she um, uh, you know, did everything in front of me...she took baths with me and was always complaining about things. I don't know. Ah, she urinated on the floor if she couldn't get to the bathroom in time and ah—I always you know—I—it was my job to—clean the bathrooms. So I was kind of involved in that . . . so the bathroom was gross . . . And I had to clean it up.

As can be seen from Table 3, after 1 year of treatment, Adam was reclassified as having a secure state of mind regarding attachment on the AAI. Interestingly enough, he received a subclassification of F5, indicating that, overall, he presented as coherent and autonomous. However, he remained at the preoccupied end of the secure continuum, which means that he continued to show some instances of resentment, anger and conflict vis-a-vis the parents (although at a much decreased level as evidenced by the diminution of subscale ratings of involved anger toward the parents). At one year, the five words he chose to describe his relationship with his mother were "intense, unstable, frightening, but also nice and larger than life." Regarding his relationship with his father, he said, "he was distant, but friendly, I worried about him, I felt protective of him, I was fond of him, but I also resented him in some ways." Adam's descriptions of parents on the AAI thus became less hostile, more reflective and more integrated. Although he remained moderately entangled with and angry at attachment figures, Adam showed a high degree of coherence, insight, and humor about his continued preoccupation with his parents. Furthermore, although he was not totally forgiving of his parents' imperfections, he showed a greater degree of acceptance and understanding of them, as the following response to the question, "Why do you think your parents parented you the way they did during your childhood indicates?"

> I think because they were—scared and—messed up themselves and had had horrible childhoods themselves . . . and as much as I—I'm furious at them for things, I really do think that they just couldn't do any differently . . . My mom at least just wasn't—she wasn't physically well enough to care for me—she was so sick that it made her unable to see like the grey areas. . . . And that's what prevented her from learning how to be a better parent when—even after she read the books. . . .

Although overall his transcript was judged to be coherent, when discussing past attachment- related traumas, he continued to show lapses in the meta-cognitive monitoring of reasoning, leading to a secondary classification of unresolved. An example of the persistence of such breaks in discourse and lapses into incoherence is provided by the following passage where Adam talks about doubting his own mind and memory about past traumatic incidents:

> Well—I—always feel like—whenever I talk about it—I feel sort of like either—I'm not remembering things correctly or I'm not remembering enough or I'm somehow exaggerating, even though I'm not really . . . but so I still feel I mean it just seems like I don't know what was real and—I don't know. It has this sort of bizarre-like ghost quality to it or something.

In such statements, Adam gave a haunted impression, suggestive of continuing lack of resolution about early traumatic experiences. However, such lack of resolution and the lapses into incoherence and disorganization that it entails were less evident at time 2. Further, the lapses in discourse strategy were limited to the discussion of specific early traumatic events and did not permeate other discourse contexts, as was the case at time 1. Hence, his unresolved for trauma classification shifted from primary to secondary at time 2.

In sum, at time 2, Adam showed a decrease in his perception of his parents (especially his mother) as rejecting, in the degree of involving anger at both parents and in insistence on lack of recall of early attachment experiences. In addition, Adam showed an increase in derogation of attachment relationships overall, in metacognitive monitoring, and in overall coherence of the transcript (but not

coherence of mind, which is expected given his continued secondary Unresolved status)—as indicated on the AAI subscale ratings reported in Table 3.

Reflective Function (RF) Ratings

At time 1 Adam showed only rudimentary indications of RF on the AAI and was given a rating of low, or questionable, RF (scale point 3) as reported in Table 3. Although he showed some awareness and consideration of the mental states of others, Patient A failed to elaborate on these understandings. Further, despite these strivings to understand the internal world of attachment figures, there were indications that much of the material he related on the AAI was so overwhelmingly powerful and unmanageable for him that he needed to distance himself from her comprehension of others.

By contrast, after 1 year of treatment, Adam's reflective function improved considerably, and he was found to have an ordinary level of understanding of his rather traumatic circumstances (scale point 5). At 1 year, he demonstrated a model of the mind of attachment figures that is easily understood and well-integrated, even if it is simple or one-dimensional (that is, restricted to one aspect of full reflective capacities). At time 2, Adam demonstrated genuine empathic sensitivity to others in his description of early attachment experiences and an appropriate level of affect about his chaotic early environment.

The improvement in RF vis-à-vis the early experience with the parents on the AAI at 1 year is parallelled by the RF ratings of the PTRI. In discussing his relationship with his therapist, Adam was found to have an ordinary level of RF (scale point 4, between ordinary and low), consistent with the AAI ratings at time 2. In reflecting on her relationship with Adam, the therapist showed a relatively high level of reflectiveness about her therapeutic experience with Adam, as shown by the rating of 6 (between ordinary and marked RF).

Self-Report Attachment Ratings (BAQ)

As shown in Table 3, on the Bartholomew Adult Attachment Self-Report Questionnaire at time 1 and time 2, Adam classified himself as fearful-avoidant, which is discrepant with his AAI attachment rating of unresolved/preoccupied (Time 1) and secure/autonomous/unresolved (Time 2). Those who rate themselves as fearful-avoidant

express the fear of being hurt in intimate attachments although they express the desire for closeness and intimacy. Thus Adam did not experience subjectively, in the context of a close romantic relationship, the change in attachment organization vis-a-vis the parents seen on the AAI.

Self and Object Representation Ratings

For Adam, the changes on the AAI in both attachment classification and RF (but not self-report attachment style) are paralleled by changes on the ORI. Table 3 presents the ratings of descriptions of mother, father, self, and therapist on the ORI Self–Other Differentiation and Relatedness Scale for the two patients at 4 months and 1 year. Adam's initial self- and object descriptions were characterized by either extreme unilateral idealization or denigration of self or other (scale point 4) or by unintegrated oscillations between positive and negative views of the other, between opposing, extreme relational and affective polarities, such as overwhelming closeness versus unbridgeable distance, invasive control versus total abandonment, intense rage versus idealizing love (scale point 5). For example, at time 1, Adam's self-description has a pervasive negative valence typical of scale point 4.

> Well I could give you my diagnosis. . . . I think I must be really angry. . . . I'm definitely scared . . . and I sort of . . . I feel very un . . . sort of stuck. . . . Because on the one hand I have lots of interests and things, but at the same time I don't seem to have any . . . ability or . . . at least not confidence in my abilities to go through with any of them . . . I'm pretty miserable really. I don't really know how to elaborate on it.

At time 1, Adam's description of his therapist showed the preoccupation with regulation of closeness and distance, control and connection in relationships characteristic of scale point 5. Adam, for example, states, at time 1:

> I like her . . . it's different from any other sort of treatment I've been in. I'm just used to people crossing more lines. . . . I worry that she doesn't see who I am . . . I mean my good qualities . . .

> and that she's only going to see me as a stereotypical borderline ... you know ... she assumes I know less than I do ... I don't really need that ...

At time 2 (1 year), Adam's self- and object descriptions showed some unevenness, but in general, there was movement toward higher stages of self–other differentiation and relatedness with rapprochement-like polarization and oscillation replaced by more integrated, modulated, and nuanced self- and object descriptions. In the self-description, there was tentative movement toward a more individuated and cohesive sense of self, achieved in part by trial identifications, positive self-assertion, and the expression of opinions denoting a shift toward consolidating a coherent identity (scale point 6).

> Well I think that lately anyway like in the last nine months, I'm an honest person. I always wanted to be. I just had a hard time. And I am very opinionated too opinionated.... I still get angry too easily about strange things that just sort of escalate. And I feel actually ... happier than I ever used to. Like just sort of in a consistently content way.

Adam's description of his therapist particularly showed, not only increased modulation and integration, but also an increased appreciation for the unique qualities of the other and the specific context that may have shaped the other. Further, he shows some rudimentary understanding that one's sense of self and other is a continually unfolding, narrative process (scale point 8).

> How can I describe her? ... It's just going to be everything is something I'm attributing to her. But she seems to be a very decent person and ... I think she's you know sincere and is helping me very much ... I mean I've been ... very helped by this therapy. I think she is really interested in helping me ... but not to the point where it's, you know at all strange, like it was with a past therapist.... I just—guess I just mean I like I trust her, is all.

In sum, for Adam, the shift in the internal working model of attachment from preoccupied to secure is accompanied by a corresponding

shift in the developmental level of self and object representations from rapprochement-like polarization and oscillations to increased cohesion, integration, and modulation.

Beth: The Patient with the Dismissing State of Mind with Respect to Attachment

Patient B was from a family that she depicted as cold and conflictual with embattled parents who were minimally attentive and affectionate. She reported having few memories of her parents and stated that they intermittently forgot to pick her up from school. Her father was an alcoholic and a compulsive gambler, who was often absent for weeks at a time and when present, was sporadically violent. Her mother was alternately affectionate and rejecting. She describes her family environment as follows: "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.

Attachment Ratings (AAI)

As shown in Table 3, at time 1, Beth received a primary attachment classification of dismissing (D) with the specific subtype of devaluing of attachment (D2). Her subclassification of D2 captured her tendency to depict her parents in a derogatory, detached fashion; to minimize the significance of feelings and affects linked to early attachment experiences; and to downplay the importance of attachment relationships in general; and to focus on and overvalue personal autonomy and strengths. The words that came to mind in describing her relationship with her mother were "cold, sometimes warm, not very motherly, calm and sparse." Choosing five words which came to mind about her childhood relationship with her father, she said, "It is was tumultuous, scary, loud, yelling, violent, and that she felt guilty." Although Beth did show some capacity to portray the negative or problematic aspects of her early experiences with her parents as indicated in the foregoing adjectives, she was unable to recall or depict specific instances or memories to back up her statements. For example, when asked to

elaborate on the word "cold" in relation to her mother she replied vaguely, "I can't remember . . . it's just a feeling. I don't even remember that much of it. It's strange but I don't remember my interactions with her really well. There's very little I really remember." Not surprisingly, Beth showed little comprehension of the ways in which childhood experiences might affect her current functioning. For example, in the context of talking about how certain childhood experiences such as her father's episodic threats of violence influence her now as an adult, she said, "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 but, you know, I'm sure it does."

At 1 year, Beth was judged to have a secure state of mind regarding attachment on the AAI. However, her subclassification of F1A, which indicated some ongoing setting aside of attachment relationships in response to harsh early experiences, placed her at the more dismissing pole of the secure category. While still somewhat constricted, her discourse was more coherent and collaborative, and she had greater access to her childhood memories. She was also relatively balanced in her portrayal of parents, about whom she had developed more understanding and perspective. For example, the five words she used to describe her childhood relationship with her mother were, "loving, safe, cold, protective and controlling". Regarding her relationship with her father, she said, "it was tumultuous, I was always wanting to make him feel better, he was cold, angry and sad."

At 1 year, however, she continued to resort to claiming a lack of memory for key events, although she did not block or avoid questions altogether, and in fact appeared to get to the heart of things more often than not. Indeed, she was often very clear, simple, concise and coherent in expressing her feelings about attachment relationships and experiences, as the following passage indicates:

> I always felt rejected. I always felt like nobody really cared about me—they didn't know I was there . . . I just felt like I was . . . an incidental thing . . . cause my father was so drunk all the time and I felt that part of the reason he drank was because he had to

> support his family ... I guess I felt like they would've been better off without me ... I know from being very young I was always, you know, went off by myself ...

At 1 year, as the following passage indicates, Beth was not only generally coherent in terms of her overall experience and responses, but was also able to convincingly discuss her understanding of the factors that led her parents to behave the way they did.

> I think they did the best they knew how ... my mother was one of 10 children and to her we had a good life compared to what she had. She had a bad life ... her father used to run away ... and she didn't have enough to eat or even a room when she was growing up ... So for us to even have a bedroom ... even though she never had any idea of how to make it warm ... or some place a child would want to be in, to her it was just nice that ... we had it.

Thus, at 1 year, Beth showed an increase in metacognitive monitoring, coherence of mind, and overall coherence of the transcript; a decrease in the degree of derogation of attachment relationships and of attachment figures overall; and an increase of her tendency to see the parents as role-reversing (changes that are reflected in the AAI subscales reported in Table 3).

Reflective Function Ratings (RF)

As was the case with Adam, at time 1 Beth showed a limited degree of RF on the AAI, as indicated by her rating of low or questionable RF (scale point 3). Although she demonstrated some intellectual sense of the importance of attachment on the AAI, there was little evidence of the affective experience of attachment in the interview. In addition, her reflective function degenerated into peculiar and idiosyncratic formulations around issues of loss. In contrast to Adam, Beth showed no change in RF on either the AAI or the PTRI, both of which continued to be categorized with low RF at 1 year. Interestingly, on the PTRI, the therapist was also categorized with low or questionable RF vis-à-vis his experience with Beth at 1 year.

Self-Report Attachment Ratings (BAQ)

As shown in Table 3, Beth classified herself as dismissing-avoidant on the BAQ at both time 1 and time 2, a rating that matched her initial AAI classification of dismissing but was discrepant with her 1 year AAI rating of secure. Thus patient B saw herself as profoundly uncomfortable with closeness and dependency and as overly invested in self-sufficiency and autonomy in close romantic relationships at both 4 months and 1 year.

Self- and Object Representation Ratings (ORI)

The shift in Beth's attachment status to secure on the AAI at 1 year, which parallels that of Adam, was not accompanied by shifts in the self-report attachment style, in the level of RF or in the level of differentiation-relatedness of self- and object representations. As shown in Table 3, Beth's (like Adam's) self- and object descriptions at time 1 showed the unintegrated oscillation between positive and negative aspects of the other, as the following passage from Beth's maternal description indicates (scale point 5):

> She was . . . cold . . . but sometimes she was you know warm. I mean sometimes she was warm. . . . I guess, you know . . . I don't know how to put it in a word but not very motherly. . . . Why I think she was cold.

Beth's therapist description at time 1 also reflects concern with themes of boundaries, distance, and control and, in addition, demonstrates a defensive concreteness characteristic of rapprochement functioning (scale point 5).

> I don't know anything about her really. . . . She keeps a distance better than many other therapists I've had . . . like, maybe more impartial . . . more matter-of-fact kind of . . . just more like a Doctor. . . . If I died or something I don't think she'd cry . . . doesn't let herself get too involved. . . . She's a nice woman . . . she's very polite and nice and she's courteous.

Beth showed some shifts in ratings of self- and object descriptions at 1 year, but there is little evidence of substantial change along the

dimensions of differentiation and relatedness in her representations. Although in general her self- and object descriptions were less unilaterally polarized in a negative direction and showed more oscillations between positive and negative aspects of self and other, in fact, her self-description at 1 year indicated a more tenuous sense of self and more reliance on others to maintain stability and consolidation. At 1 year Beth described herself as

> a big jumble of mixed emotions.... Like all those loose ends are inside me for some reason.... I mean I tend to get a little depressed sometimes I guess ... not really that much makes me happy.... I don't know anything you know about what I am or what I want.... It's just like not that much here ... there's not that much in me.

Similarly, the therapist description remained at a defensively concrete level.

> She's different from any therapist I've ever had.... I think she's smart. She usually knows a lot, ... by the book, like not emotional ... more like a real doctor.... I don't know anything about her at all.... She doesn't get involved at all personally—I think ... just more like what a psychiatrist is supposed to be like.... She never goes over ... never, you know.... There's nothing outside our sessions really.... She just never gets emotional.

In the above description, it appears that Beth was defensively engaged in trying to block the flow of representing her therapist in a more vivid and connected way. In short, Beth's self- and object representations continue to show a defensive concreteness, lack of cohesion, and ambivalent oscillation characteristic of rapprochement functioning throughout treatment despite her shift to secure states of mind regarding attachment on the AAI at 1 year.

Discussion

The preliminary research findings presented in this paper suggest that measures of attachment, reflective function, and object representation

assess distinct dimensions of intrapsychic change with borderline patients. Although our report is based on two patients, our findings contribute to an understanding of the representational core of borderline conditions, lend support to the clinical significance of attachment research and theory, and illuminate the relationship between representational states with respect to attachment and self- and object representations. Our major findings are as follows. First, the state of mind with respect to attachment both patients changed from insecure to secure on the AAI after 1 year of TFP.[6] Further, just as both patients were initially classified with different insecure states of mind on the AAI, so were they both classified with different variants or subtypes of secure states of mind at 1 year, subtypes which showed some continuity with their initial attachment classifications.

Second, the shift to security in internal working models or representational states of attachment was paralleled by shifts to higher levels of differentiation and relatedness in self- and object descriptions for Adams, but not for Beth. This finding suggests that representational states with respect to attachment as measured on the AAI and psychoanalytic notions of self- and object representations as measured on the ORI are overlapping but not synonymous with each other and may access somewhat different clinical processes and knowledge structures. In Main's scoring system for the AAI, the quality of attachment relationships are assessed, not on the contents of the attachment history, but rather "on the basis of procedures used by individual to create an attachment-related narrative" (Fonagy, 1998, p. 348). The ORI self–other differentiation and relatedness scoring system, on the other hand, tends to focus on the prominent themes in the content of the patient's narratives about self and others. Thus, whereas the AAI accesses implicit relational structures based on procedural, as well as declarative or autobiographical, memories, the ORI elicits primarily autobiographical memories.

Given that internal working models of attachment are thought to be based on implicit relational procedures that are relatively resistant to change (Lyons-Ruth, 1999) and that by definition personality-

[6]Main (1996, 1999) and Fonagy (1999) have recently stated that there may be multiple internal working models of attachment with different attachment figures that are relatively independent of each other and that one attachment classification may not necessarily encompass the multifaceted nature of the internal world.

disordered patients have chronic and pervasive impairments in the ways in which they relate to others, it is somewhat surprising that both patients were judged to have moved from insecure to secure attachment status after 1 year of psychodynamic therapy.

The findings on the shift to secure states of mind with respect to attachment for both patients at 1 year are especially significant given the paucity of the secure attachment classification among clinical groups. Previous research suggests that in nonclinical low-risk samples, 56 percent are rated secure, 16 percent dismissive, 10 percent preoccupied, and 18 percent unresolved for trauma or cannot classify (Main, 1996). In clinical populations, on the other hand, few individuals (approximately 8–14 percent) are classified as secure, and both unresolved and cannot classify status are predominant (Patrick et al., 1994; Allen, Hauser, and Borman-Spurrell, 1996; Crittendon, 1996; Fonagy et al., 1996; Van IJzendoorn and Bakersmans-Kranenburg, 1996).

However, it is important to note that there are different subtypes of security so that even individuals judged to have secure states of mind with respect to attachment may have dismissing or preoccupied traits. Although both patients were judged to have secure states of mind at 1 year, Adam remained somewhat angry and conflicted about attachment figures, even while he was generally more understanding of his continuing involvement with them. Beth continued to downplay the significance of attachment relationships although overall she presented as more valuing and understanding of attachment figures. Thus, we noted some continuity in characteristics or attitudes toward attachment figures and attachment relationships in general, even as Adam and Beth shifted from insecure to secure status on the AAI. These findings point toward the importance of considering security of attachment as a dimensional, as well as categorical, rating (Main, 1999; Fonagy, 1999).

The dimensional view of attachment security is enhanced by a consideration of the various continuous subscale ratings of the AAI.

Although both patients were reclassified as secure at 1 year, they were found to change differentially as indicated by the different patterns of change on the AAI subscales. Thus the patient initially classified as unresolved/preoccupied (Adam), at 1 year, showed a decrease in the degree of preoccupying/involving anger toward the

parents and in his valuation of attachment relationships, while the patient initially rated as dismissing of attachment (Beth), at 1 year, showed a decrease in devaluation of attachment relationships and an increase in subscales that reflected recognition and expression of negative affect about attachment experiences such as the view of parents as involving or role-reversing. These divergent results appear on the AAI subscales in which the dismissing patient showed increased recognition and tolerance for negative aspects of early attachment experiences and the unresolved/preoccupied patient showed a decrease in negative affect and in negative aspects of attachment representations. These findings are consistent with the direction of change one would expect in psychoanalytic therapy with patients with such different states of mind with respect to attachment.

In further evaluating this shift to secure states of mind on the AAI it is important to consider not only the specific dimensions of change in the two patients, but also what a classification of secure attachment entails. Security on the AAI is characterized by seemingly honest and open portrayals of both childhood and current relationships with parents; by a well-organized, undefended discourse style in which emotions are freely expressed; and by a high degree of coherence exhibited in the discussion of attachment relationships regardless of how positively or negatively these experiences are portrayed. Both patients were indeed found to have increased coherence of their transcript and increased capacity for metacognitive monitoring at 1 year. For borderline patients, self-destructive enactments often function as a primary mode of communication early in treatment, and identity diffusion often clouds their capacity to communicate coherently and openly even after such acting out behaviors have ceased. Thus, a change in the organization and coherence of their verbal discourse in 1 year is highly significant.

Following attachment researchers (Main, 1995), we have hypothesized that the individual's dominant discourse characteristics provide a window into representational states with respect to attachment. Our preliminary findings contribute to the growing conviction that the AAI has promise as an instrument to assess aspects of intrapsychic change, involving both the nature of representational states with respect to attachment and the organization and coherence of language and discourse used to describe such attachment representations (Fonagy et

al., 1996; Main, 1995; Fonagy, 1999). We have of course considered the possibility that the secure classification on the AAI for the two patients represent an artifact of TFP, rather than a valid shift in attachment organization. However, the here-and-now emphasis of TFP makes it unlikely that subjects were reclassified with secure states of mind with respect to attachment at 1 year primarily because they have learned to talk about their early attachment experiences openly and coherently. While the AAI focuses on an exploration of early attachment relationships and experiences, TFP specifically deemphasizes the exploration of early experiences with parents or caretakers during the first year of treatment. Instead, the emphasis is on the containment of acting out (parasuicidal) behaviors and on the identification and recapitulation of dominant object-relational patterns, as they are experienced and expressed in the here-and-now of the transference relationship. Thus, it is more likely that the analysis and working through of the transference, integral to TFP, catalyzes change in the patients' representational states or internal working models of attachment which allows them to represent more coherently their early relationships with their parents. In addition, the patients' secure states of mind with respect to attachment at 1 year may represent a partial internalization of a secure therapeutic relationship, but remains contingent on the continuance of that relationship. This interpretation is consistent with Blatt and colleagues' (Blatt et al., 1997) findings that change in developmental level of representations in severely disturbed patients occurs first in descriptions of the therapist and that these changes in turn appear to catalyze shifts in parental representations.

Consistent with our belief that changes in attachment organization are not simply an artifact of TFP, the patient with the trauma history, who was initially classified as unresolved for trauma, continued to receive a secondary attachment classification of unresolved at 1 year, indicating that she continued to talk about past traumatic events in a conflicted and incoherent way. The persistence of the unresolved classification at 1 year might be expected for a patient in TFP for the following reason. As discussed above, during the first year of treatment, TFP is designed to diminish and change parasuicidal behaviors by clarifying the dominant object-relational paradigms that might fuel them (such as the dual experience of self as victim and victimizer)

through the here-and-now experience of the transference, rather than through an exploration of *past* traumas that might contribute to self-destructive object-relational scenarios and behaviors. Thus, the persistence of lack of resolution of past traumatic experiences in the context of a shift to security in the representational states with respect to attachment is consistent with the goals and structure of TFP during the first year and reinforces our preferred explanation that the shift to secure states of mind is a specific result of the treatment.

The finding that two patients with diverse attachment classifications undergoing the same type of therapy with the same therapist achieved a similar shift in attachment status after 1 year suggests that TFP may be a powerful conduit of intrapsychic change with a heterogeneous group of borderline patients. However, before we can definitively state that such intrapsychic change has occurred, more extensive research (currently in process) is necessary to assess whether changes in representational states with respect to attachment are associated with changes in behavior and symptoms, both in the therapeutic relationship and in other interpersonal contexts. It is possible that the increase in coherence and flexibility of thinking and attention that led to these patients' AAIs being rated as secure at 1 year is not only the result of the new attachment relationship to the therapist, but is also dependent on the structure and support provided by relationship and is not as yet generalizable to other interpersonal contexts.

However, our findings also indicate that patients with different types of insecure states of mind with respect to attachment will form quite different attachment relationships to the therapist. For example, we found that, in a standardized psychodynamic treatment with the same therapist, RF, or the capacity to mentalize the experience of the other, increased substantially for Adam but not for Beth after 1 year, despite the shift to secure states of mind in both patients. Further, the level of RF in the patients' reflections on his or her experience with the therapist closely paralleled that in the therapist's reflections on her experiences with the patient. These findings, in conjunction with the finding that the therapist showed a richer, fuller, and more nuanced level of awareness about her therapeutic experience with Adam than she did with Beth, indicate that different relationships may in fact bring into focus or ascendance different attachment representations for

both patient and therapist. Thus attachment, even in the therapeutic situation, appears to be a reciprocal or bidirectional process, influenced by patient, therapist, and their interaction. Although of course it is impossible to generalize too definitively about the course of therapy with patients with different states of mind with respect to attachment from such a limited sample, our findings may have some implications for the treatment of borderline patients with different attachment classifications.

Implications for Treatment of Preoccupied Patients

A number of clinical researchers (Dozier, 1990; Fonagy et al., 1996; Gunderson, 1996; Slade, 1999) have noted that patients with preoccupied or unresolved attachment status may be less suited or responsive to exploratory psychodynamic therapy than are patients with other attachment classifications. Fonagy and colleagues (Fonagy et al., 1996), for example, found that patients with preoccupied states of mind with respect to attachment on the AAI were less likely to show clinically significant improvements on the Global Assessment of Functioning (GAF) scale after 1 year of psychodynamic inpatient treatment and were more likely to drop out of the treatment than were patients with dismissing states of mind with respect to attachment on the AAI. These findings raise questions about whether individuals with preoccupied states of mind lack the representational stability, affect organization and tolerance necessary for an exploratory psychodynamic treatment.

Interestingly enough, in our study Adam, who was classified as unresolved/preoccupied at time 1, not only showed significant change after 1 year of treatment but was sufficiently engaged in his therapy so that he chose to continue past the 1 year research requirement. The patient's responses on the Patient-Therapist Relationship Interview (PTRI) provide us with his perspective on what worked for him in treatment. Not surprisingly, Adam describes himself as having been quite wary and distrustful of his therapist in the beginning, but over the course of 1 year, his sense of trust in her and the process increased to the point where he felt he could stop playing games and be more himself, as the following excerpt from the PTRI indicates:

> At first I had the sense that she would forget who I was in between sessions. . . . And then of course, because I was paranoid about those type of things, I was the worst way I could be. . . . I was sort of not as forthcoming as I might have been and I would try to be tricky because I thought it was somehow defending myself against something.

He notes that, over time, he could relinquish the part of himself which had served to protect him from the disappointing, inconsistent relationships he had come to expect.

Over the course of 1 year, Adam had begun to introject aspects of the therapist and to identify with her in ways that seemed to have helped modify his preoccupied state of mind. He states,

> I guess I feel a little more secure in general just because she has been so reliable as a steadying influence almost or something. I kind of feel like I survive the unreliable things in day to day life better 'cause there's something that is sort of steady. And just having . . . something 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.

In attachment terms, it appears as if he is coming to use his therapist as a secure base (Bowlby, 1988). In therapeutic work with borderline patients, it is often striking how long it takes to work through the attachment patterns where the potentially helpful other is portrayed as both unpredictable and intrusive. It is usually well into the first year of treatment before such patients can use the therapist as a secure base of any sort.

Our findings suggest that the high degree of structure and predictability of TFP may provide the containment necessary to hold individuals with preoccupied and unresolved states of mind with respect to attachment in treatment. The initial treatment contact in TFP, which specifically spells out therapists' and patients' roles and responsibilities, helps to anchor patients with preoccupied states of mind and provides a safe harbor when the actual therapeutic relationship is threatened by their often highly conflictual, polarized, and contradictory object relations. Further, the immediate and intense

focus on the transference is designed to mobilize, define, and contain the chaotic, contradictory self- and object representations that patients with preoccupied representational states tend to immediately project into any interpersonal situation and that often lead to premature dropout. The structure of TFP also may help to keep the therapist from getting overly entangled with the borderline patient. As the therapist remarked, "He's the most creative patient I've ever had, and I've had to be on guard 'cause it could be easy to "underestimate his pathology because of that." In short, in offering more structure and containment than most psychodynamic treatments, TFP may be an exploratory psychodynamic treatment particularly suitable for the patient whose state of mind regarding attachment is preoccupied or unresolved.

Implications for Treatment of Dismissing Patients

Our findings also have implications for the understanding and treatment of patients with dismissing states of mind with respect to attachment who have been found in previous studies to fare better in long-term psychodynamic treatment than do those with preoccupied states of mind (Fonagy et al., 1996). Consistent with previous research findings, for example, Beth dutifully participated in the 1 year treatment course and at 1 year was judged to have shifted from a dismissing to a secure state of mind with respect to attachment. The quality of her engagement, however, remained somewhat limited and self-protective. Dozier (1990) found that patients classified with dismissing states of mind on the AAI are often resistant to treatment, have difficulty asking for help, and retreat from the help that is offered. There are indications that, although the treatment was successful in changing the patient's suicidal behaviors and in changing her state of mind with respect to attachment, Beth remained somewhat disengaged throughout the course of therapy and induced similar feelings of disengagement in her therapist.

For example, on the Patient-Therapist Relationship Interview (PTRI), Beth states that she remained unsure through the course of treatment about whether her therapist was truly emotionally engaged with her or whether she was "just doing her job as a therapist." She seemed unable to represent her as a vivid enduring object in her internal world. For instance, she was relatively certain that the thera-

pist did not think about her outside of sessions. Similarly, she minimized the therapist's significance to her during separations. "Maybe there was once or twice when she was away that I said to myself that I couldn't wait for her to come back, but I never really missed her." Another example of the patient's dismissive state of mind involved her coming in one morning and announcing, to her therapist's surprise, that she was getting married that afternoon. Although the therapist had known of her engagement, she reflected that "usually a person's a little more . . . just a little more is made of their marriage . . . So that more than anything else encapsulated the way she was so . . . out of touch with affect." Consistent with Dozier's (1990) findings that the patient with dismissing states of mind often evokes countertransference feelings of being excluded from the patients' life, Beth's therapist stated,

> I don't think she ever wanted me to see everything going on inside of her, so she would be well-behaved but also withholding at the same time . . . It was hard for me to try and keep in mind . . . or figure out how to get at the deeper levels, because she'd go on about manifest level issues, problems with her job . . . and I was always looking for an angle to get deeper in . . . which of course I could find—we did make some progress with that . . . but on the whole I'd say the relationship was formal, distant. . . . She would kind of close off to what I was saying—and dismiss it in a devaluing way.

These statements are reminiscent of Horowitz's (1994) speculations that a dismissing attachment organization may powerfully curtail the therapist's engagement with the patient.

At the end of the 1 year research phase when Beth was given the option of continuing treatment at her own expense, she chose instead to terminate. Reflecting on the reasons for Beth's decision to terminate after 1 year, her therapist reported that she was surprised that; despite her statements that it was the most helpful and real therapy she had had, "she would drop it the way she did." The therapist stated that she felt that Beth treated her "with the same narcissistic indifference that she felt she was the object of." Her therapist noted how, on the last day of her therapy, the patient showed very little affect, thanked

her for being helpful, and left without any manifest indication of it being difficult saying goodbye to someone with whom she had worked intensively. Data from the PTRI with these two therapeutic dyads speak to the power of attachment status to shape the nature of the therapeutic relationship even, as in this case, when the therapist was judged independently to be highly competent.

One limitation of the current research is that we did not investigate the therapists' state of mind with respect to attachment. Recently Dozier and colleagues (Dozier and Tyrrell, 1998) have found that although secure states of mind in the therapist are more likely to promote good clinical outcomes, therapists who are classified as secure have the best clinical outcomes with patients whose attachment classification contrasts rather than compliments where the therapist falls on the secure continuum. For example, therapists classified on the dismissing side of the secure spectrum have better clinical outcomes with preoccupied patients, while therapists classified on the preoccupied side of the secure continuum have better clinical outcomes with dismissing patients.

Mental Representation and Attachment

Our findings from the ORI elucidate other aspects of the patient's representational schemata that supplement our understanding of their representational states with respect to attachment and how they are activated in the therapeutic situation. We assume that an individual's images of self and others are derived in part from their early attachment history (Horowitz, 1994; Levy et al., 1998). However, our findings suggest that there are aspects of the representational world that may not be captured by a single overall attachment classification (Diamond and Blatt, 1994; Levy et al., 1998) as we have already seen through a consideration of the complex patterning of the various continuous AAI subscale ratings for the two patients.[7] Although both

[7]Main (1999) has recently proposed that as applied to the AAI the term "internal working model of attachment" may be somewhat misleading because it can readily be mistaken to imply unitary internal models and does not take into account the multiple, often contradictory, working models of attachment that are found in the AAI transcripts of all insecure (particularly preoccupied and unresolved) individuals (see Main, 1991, for explication), Main (1999) and Hesse (1999) currently prefer the terms "state of mind with respect to atttachment," which comes close to Bowlby's "representational states" (Bowlby, 1980) to depict the knowledge

patients were classified with secure states of mind with respect to attachment at 1 year and their AAIs were characterized by moderate to high levels of coherency, the level of differentiation and relatedness in their self- and object representations varied considerably. For example, Adam showed consistent changes in the quality of his self- and object representations, which were characterized by increased integration and modulation of positive and negative aspects of self and other, increased empathy and reflectiveness in relationships with others, and increased solidity and consistency in sense of self. By contrast, Beth's self- and object representations remained at the rapprochement level with a focus on issues of control, autonomy, and unintegrated oscillations between positive and negative aspects of others. Notably, her self-description showed indications of regression to a more undifferentiated vague and amorphous sense of self at 1 year.

Consistent with our findings, Dozier and colleagues (1996) found that dismissing individuals often become disorganized when they are confronted with emotional issues in therapy. For example in reflecting on her experience in therapy, Beth stated

> She [the therapist] would start digging into things and find out why I was angry, and then I would 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 at them.

It appears as if therapy challenged her defensive foreclosure of her feeling states and left her feeling like "a big jumble of mixed emotions," as she indicated in her self-description at 1 year. In discussing how her view of herself changed as a result of therapy, she stated,

> If anything, there are more things I don't like about myself now, 'cause I don't like the way I do. . . . I hate to say for the worse but maybe it added things that I didn't know about myself that I didn't like about myself to my list of things that I didn't like

about the multiple representations of the various early attachment relationships derived from the AAI.

> about myself if you know what I mean, so I don't think it really improved the way that I see myself . . . so I guess change then yes, but it maybe made it worse. . . . It made me more aware of what I don't like about myself.

It should be noted that at one year, the patterning of Beth's scores on the continuous AAI subscales, and particularly the increase in her view of her parents (particularly the mother) as clinging, role reversing and demanding of care is consistent with the rapprochement dynamics evident on the ORI. These findings also suggest that particularly with some severely disturbed individuals, a dismissing state of mind regarding attachment may be consistent with rigid maladaptive defenses which are challenged in the course of treatment.

In sum, in our study a consideration of the ORI and reflective function ratings together with the various continuous subscale ratings for Adam and Beth over the course of the one year of TFP, fine-tunes our view of change in the representational world provided by a consideration of their shifts in overall attachment classification.

Our research findings contribute to the growing body of studies that are identifying the quality of mental representations or schemas (Horowitz, 1994; Levy et al., 1998) that are associated with different attachment categories. In his studies of representational schemas and attachment status of recently widowed subjects, Horowitz (1994) found that the mental representations of individuals with dismissing states of mind with respect to attachment, who avoid intimate engagement with others, tend to be impoverished, "vague and lacking in the type of interassociated elements that make for well-defined schemas" (Horowitz, 1994, p. 12). Horowitz speculates that the vague nature of representations of self and others in dismissing individuals in turn may fail to evoke vivid representational schemas in the other, which makes it difficult for others, including the therapist, to visualize or evoke the individual's representational world. Conversely, Horowitz (1994) surmises that the rich, if chaotic and contradictory, self- and object representations of individuals classified as preoccupied may be more readily and vividly mentalized or represented by others, including the therapist. The variability of previous research on treatment response of individuals with dismissing and preoccupied representational states with respect to attachment suggests that

perhaps the insecure attachment categories encompass individuals with different levels of object relations development. Further, additional measures of the level and quality and self- and object representations may provide an index to the different treatment responses of those with the same attachment classification. More extensive research with larger samples is necessary to explore the relationship between attachment classification and nature and quality of self- and object representations.

Comparison of Interview and Self-Report Attachment Measures

As in previous research (Bartholomew and Shaver, 1997), we were interested in observing whether self-report and interview ratings of attachment would coincide. In our study, we found that self-report attachment measures did not consistently converge with interview ratings of attachment, nor did they as readily reflect change in attachment organization. At 1 year when Adam and Beth were classified as secure on the AAI, they continued to rate themselves as fearful-avoidant and dismissing-avoidant, respectively, on the BAQ, indicating that their experience of themselves in current attachment relationships continued to be insecure. This finding is consistent with other research studies that suggest that borderline patients may continue to experience themselves as impaired in spheres of both work and love long after they show objective changes in a number of relational and occupational dimensions (Edel, Joy, and Yehuda, 1990; Stone, personal communication, 1997). Consequently, interview measures of attachment, which assess representational states with respect to attachment through discourse analysis designed to assess unconscious processes, may in fact be more robust indicators of intrapsychic change than are self-report measures, which assess consciously held attachment style in current significant relationships. However, further research is needed to explore the respective contributions of both modes of measuring attachment.

Conclusion

In sum, the attachment, reflective function, and ORI differentiation-relatedness ratings assessed important dimensions related to thera-

peutic process and outcome for Patients A and B. Our research findings suggest that intrapsychic change in intensive psychodynamic transference-focused therapy (TFP) is best evaluated through combined assessments of changes in attachment status, reflective function, quality of self- and object representations, and patient–therapist accounts of their experience of the therapeutic relationship and therapeutic process. An assessment of change in attachment representational states with respect to attachment on the AAI, which emphasizes the coherence of discourse and language used to describe attachment relationships (Main, 1996), was complemented in this study by an evaluation of shifts in the nature and quality of the multiple representations of self and attachment figures on the ORI and of shifts in Reflective function or the capacity to develop well-integrated and articulated models of the mind of significant others. All three sets of ratings together captured aspects of psychological structure and functioning that forecast the fate and determine the course of psychodynamic treatment.

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