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A

**Intrapsychic and Symptomatic Change in Patients
with Borderline Psychopathology**

by

Hilary A. Levine

A dissertation submitted to the Graduate Faculty in Psychology in partial
fulfillment of the requirements for the degree of Doctor of Philosophy,
The City University of New York.

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract**INTRAPSYCHIC AND SYMPTOMATIC CHANGE
IN PATIENTS WITH BORDERLINE PSYCHOPATHOLOGY****by****Hilary Levine****Advisor: Diana Diamond, Ph.D.**

This dissertation combined case-study methodology with empirically validated baseline and outcome measures to document both intrapsychic and symptomatic change in borderline patients treated with Transference Focused Psychotherapy for one year. It was designed to be a preliminary investigation of the effectiveness of this treatment in bringing about changes in character structure, specifically, object relations, characteristic defensive styles, mental representations of attachment, and the capacity for reflection about oneself and others.

Two patients with borderline personality disorder in treatment with the same therapist, but with different attachment classifications were chosen for this study. The patients' attachment statuses were re-assessed after one year using the Adult Attachment Interview. The patients' capacities for reflective function and the level of their differentiation and relatedness were assessed using the Reflective Function Scale and the Object Representation Inventory. At four-month intervals, randomly selected psychotherapy sessions were coded with the Defense Mechanism Rating Scales to assess the patients' use of defense mechanisms throughout the year. In addition, assessments of the patients' symptomatology occurred at four-month intervals using self-report

measures, including: the Beck Depression Inventory, the Brief Symptom Index, and the State-Trait Anger Expression Inventory. Throughout the treatment, the patients tracked their symptomatic behavior and rated their urges to self-harm and quit treatment. Each of the factors hypothesized by Otto Kernberg to discriminate between levels of personality organization (i.e., primitive defenses, identity diffusion, and reality testing) were assessed with the Inventory of Personality Organization. At the end of the year, the patients and therapist were interviewed with the Patient-Therapist Adult Attachment Interview and asked to reflect upon his or her experience of the other during the treatment process.

Both patients were rated as having shifted from insecure to secure states of mind with respect to attachment and experienced a significant reduction in their levels of distress and in their self-destructive behavior after one year of treatment. On other measures their trajectories of change were quite different from one another. The findings underscore the importance of using multiple measures in evaluating clinical process and outcome. In addition, the findings highlight the role of attachment in determining the course of treatment, the quality of the alliance, and the types and direction of change one would expect to see in a psychodynamic treatment.

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"Would you tell me please which way I ought to go from here?"
"That depends a good deal on where you want to get to," said the Cat.
"I don't much care where--" said Alice.
"Then it doesn't matter which way you go," said the Cat.
"-- so long as I get somewhere," Alice added as an explanation.
"Oh, you're sure to do that," said the Cat, "if you only walk long enough."
 -- Lewis Carroll's Alice's Adventures in Wonderland

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CHAPTER ONE

INTRODUCTION

Borderline personality disorder has long presented unique challenges to the mental health profession. These patients, characterized by extreme emotional lability, self-injurious, impulsive behavior, and chronic instability in interpersonal, social and occupational functioning, are disproportionately represented in mental health clinics and emergency rooms (Bongar, Petersson, Golann, & Hardiman, 1990)¹. Their slow rate of change, high rate of drop-out, and proclivity towards acting out intense feelings rather than verbalizing them, have led many clinicians to view this group of patients as intractable. Many have suggested that treatment at best serves a stabilizing function in these patients' lives but does little to bring about fundamental personality change. In more recent years, however, there has been a growing conviction that modified psychodynamic treatments can produce lasting change in both the intrapsychic disturbances (such as primitive object relations and immature defense mechanisms) and problematic behaviors and symptom constellations characteristic of borderline patients (Kernberg, 1984; Masterson, 1987).

One such treatment, Transference Focused Psychotherapy (TFP), developed by Otto Kernberg and colleagues, is designed to ameliorate the pathogenic object relations and defenses that lead to the chronic affective, behavioral, and cognitive disturbances that

¹ According to the DSM-IV (1994) the prevalence of borderline personality disorder is estimated to be about 2% of the general population, about 10% of psychiatric outpatients, and about 20% of psychiatric inpatients. Of patients diagnosed with a personality disorder, 30-60% are diagnosed with borderline personality disorder. It has been estimated that sixty-nine to seventy-five percent of borderline patients have a history of at least one self-injurious act (Cowdry, Pickar, & Davies, 1985; Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983). Bongar et al (1990) found that while borderline patients comprised one

characterize borderline psychopathology. More specifically, TFP seeks to aid patients at a borderline level of organization in developing more integrated, multidimensional images of self and other, in improving their defensive functioning, and in promoting identity cohesion. In so doing, the treatment is presumed to both modify character structure and to curtail problematic behaviors such as the impulsive, self-destructive, and suicidal actions so characteristic of these patients.

The delineation of TFP has grown out of theoretically driven clinical research on the assessment and treatment of borderline patients, conducted as part of the Personality Disorders Institute at New York Hospital- Cornell Medical Center. To date, the clinical researchers involved in this project have developed a treatment manual (Kernberg, 1989), now in a second edition (Clarkin, Yeomans, & Kernberg, 1999) and a number of companion manuals (Koenigsberg, Kernberg, Stone, Applebaum, Yeomans; & Diamond, 2000; Yeomans, Selzer, & Clarkin, 1992) which detail the fundamental theory and technique behind the treatment and offer suggestions for tailoring the treatment to the specific needs of each patient. In addition, they have developed instruments for assessing therapist adherence and competence. While there has been much clinical and anecdotal evidence in support of the effectiveness of TFP, and it has in fact been cited as the most widely used psychodynamic treatment with this particular population (Zittel & Weston, 1998), only a limited number of systematized studies of the treatment have been conducted thus far (Clarkin, Foelsch, Levy, Delaney, & Kernberg, in review; Levy, Clarkin, & Kernberg, 1999).

percent of patients seen in the psychiatric emergency room in one year, they accounted for over twelve percent of all emergency room visits.

Currently, Kernberg, Clarkin, and colleagues in the Personality Disorders Institute are engaged in a longitudinal NIMH funded research project examining the effectiveness of TFP for patients with BPD (grant number: MH53705-02; Principal Investigator: John Clarkin, Ph.D.). The preliminary findings are quite promising. In a study comparing the psychological functioning of twenty-three women diagnosed with Borderline Personality Disorder before and during a one-year course of TFP, the patients exhibited a marked decrease in the number of emergency room visits, psychiatric hospitalizations, and length of inpatient stay. In addition, they reported a significant diminution of symptomatology and an increase in their reasons for living. Furthermore, TFP appeared to be effective in reducing the high drop-out rate characteristic of these patients (Clarkin et al., in review).

The above findings are promising and suggest that TFP is effective in reducing many of the severe symptoms and behaviors associated with BPD. The investigation, however, of the types of intrapsychic and characterological change specifically targeted in TFP lags behind studies documenting changes in symptoms and behavior. This discrepancy is largely due to the difficulties inherent in developing instruments and coding systems sensitive enough to detect the complexity of intrapsychic structural phenomena and yet explicated enough so that trained raters can reliably score the data. In recent years a number of theoretically grounded, psychodynamically informed instruments have been shown to be valid and reliable means for assessing psychodynamic process and outcome. The advent of methodologically sound instruments for investigating complex psychodynamically based constructs affords us an unprecedented opportunity to examine the efficacy of treatments such as TFP in bringing about intrapsychic change (Blatt, Chevron, Quinlan, Schaffer, & Wein, 1992; Fonagy, Steele,

Steele, Leigh, Kennedy, Mattoon, & Target, 1995; George, Kaplan, & Main, 1996; Perry, 1990).

As part of the longitudinal research project described above, this dissertation combines case study methodology with empirically validated baseline and outcome measures in an attempt to document both intrapsychic and symptomatic change in two patients with borderline psychopathology who were treated with TFP for one year. It is designed to be a preliminary investigation of the effectiveness of this treatment in bringing about changes in character structure, specifically, object relations, characteristic defensive styles, mental representations of attachment, and the capacity for reflection about oneself and others. These constructs are all hypothesized to be highly significant and reciprocally influential in the diagnosis and treatment of borderline psychopathology and have in recent years each been operationalized with empirically sound measures.

These particular aspects of character structure were chosen for a number of reasons. Given that the central goal of Transference Focused Psychotherapy is the amelioration of patients' pathogenic object relations, this study seeks to explore the extent to which the treatment is successful in changing patients' dominant object representations. One particularly fruitful way of looking at object representations is derived from attachment theory and research. According to attachment theory, first articulated by John Bowlby (1969; 1973; 1977; 1980), beginning in infancy people develop increasingly complex internal working models of self and others on the basis of repeated interactions with primary caretakers. These models inform a person's expectations about how others are likely to respond to him or her. While shown to be largely stable over time, internal working models are amenable to change as a result of

new influences (Elicker, Englund, & Sroufe, 1992; Grossmann & Grossmann, 1991; Koenigsberg, Kernberg, Stone, Applebaum, Yeomans, & Diamond, 2000; Main, Kaplan, & Cassidy, 1985; Waters, Merrick, Albersheim, & Treboux, 1995).

Working from the hypothesis that mental representations of the self vis-à-vis attachment figures could be captured through an in depth linguistic analysis of how people speak about their experiences with attachment figures, Mary Main and colleagues (1985) devised the Adult Attachment Interview and an accompanying coding system for assessing the quality of a person's mental representations of attachment. The Adult Attachment Interview has been established as a valid and reliable instrument for coding "states of mind" which reflect the operation of internal working models of attachment.

The two patients in this study were selected in part because they were found to be representative of two distinct attachment types. The two patients were given the Adult Attachment Interview again at the end of one year of TFP to assess how, if at all, their states of mind with respect to attachment were altered after one year of treatment. The interviews were also scored for the level of reflective function, the ability to take into account one's own and others' mental states in understanding behavior. In addition, the patients were given a more psychoanalytically based measure of object representations at the beginning and end of treatment. Given that another of TFP's primary aims is to help the patients develop healthier defenses, this study will track patients' use of defense mechanisms during psychotherapy sessions over the course of one year to assess whether the treatment is effective in increasing their use of more adaptive, higher level defenses.

Kernberg and colleagues maintain that shifts toward greater integration of object representations coupled with the development of higher level defenses typically coincide

with a reduction in the severe symptom presentations and self-destructive behavior characteristic of these patients. Although, as noted above, it is simpler to measure behavioral change and symptom reduction, these facets of change in and of themselves are not necessarily indicative of enduring intrapsychic change. As many analytic theorists have professed, changes in symptom distress and maladaptive behaviors are necessary but not sufficient evidence of structural change (Clarkin, Yeomans, & Kernberg, 1999; Kernberg, 1984; Rangell, 1993). Furthermore, a patient's symptom presentation can be misleading. For instance, a patient may minimize distress and not present as overtly symptomatic but may in fact be perceived by others as highly symptomatic and/or highly distressed in ways that the patient is not aware. Another patient may be severely symptomatic and quite open about her degree of psychic turmoil, but be better able to verbalize these feelings to her therapist rather than act them out. The goals of TFP are multifaceted and involve both symptomatic and behavioral change, as well as enduring intrapsychic change. Therefore, this study will also track the patients' symptoms, substance use (and desire to use), self-injurious urges and behavior, and urges to quit treatment over the course of their first year of TFP.

It has been argued that the majority of measures used to assess psychodynamically informed process and outcome oversimplify complex constructs, thereby sacrificing validity in the service of establishing reliability (Horowitz, 1987; Luborsky & Crits-Christoph, 1998; Meehl, 1978). For this reason, it is particularly valuable to conduct case-focused studies of psychotherapeutic process and change. Using a single case study design (Jones & Windholz, 1990) and drawing on multiple sources of data collected over time, this study aims to provide a complex account of the

dynamic and evolving nature of internal character structure as it is influenced by a psychodynamic treatment. Until now, the measures used in this study have not been applied in conjunction with one another in the assessment of intrapsychic and symptomatic change in the therapeutic process. The findings of this smaller study will hopefully generate hypotheses that can be investigated in future studies with larger samples.

The following chapter will present a brief history of the theory and treatment of borderline psychopathology, including the evolution of Otto Kernberg's theory and treatment of patients with borderline personality organization. Particular emphasis will be given to these individuals' object relations, characteristic defense styles, and symptom constellations. Relevant research on object representations and defense processes in borderline patients, as well as studies of therapeutic change, will be presented. This will be followed by a brief description of Transference Focused Psychotherapy, the treatment utilized in this study. The next section will include an overview of attachment theory and research, its relevance to understanding borderline personality disorder, and research in which the Adult Attachment Interview has been used to assess therapeutic outcomes. Finally, the chapter will conclude with a discussion of the relationship between internal working models of attachment, object representations and defensive processes, and how concurrent use of these constructs can enhance the investigation of intrapsychic change.

CHAPTER TWO

LITERATURE REVIEW

BORDERLINE PSYCHOPATHOLOGY

Over the last century psychoanalysts have struggled to understand and to develop effective treatments for a somewhat mysterious group of patients characterized by extreme shifts in functioning, emotional lability, intense, volatile relationships and thrill seeking, impulsive, and/or suicidal behavior. Between the late 1930s and the early 1950s, the general consensus was that patients with these characteristics were suffering from a pre-schizophrenic or latent schizophrenic condition and that they were somewhere on the border between psychotic and neurotic. There was little consensus, however, on what to call the condition. Diagnoses ran the gamut from ambulatory schizophrenia (Zilboorg, 1941), "as if" personalities (Deutsch, 1942), pseudoneurotic schizophrenia (Hoch & Polatin, 1949), psychotic characters (Frosch, 1964) to schizophrenia without psychosis (Beck, 1959).

Numerous attempts have been made to provide greater specificity in the diagnostic assessment of these patients (Grinker, Werble, Drye, 1968; Gunderson & Singer, 1975). In the mid 1970s, John Gunderson and colleagues launched a series of descriptive studies in which they attempted to more precisely identify the clinical phenomenology and symptoms characteristic of the borderline patient. Gunderson and Singer (1975) reviewed the literature and identified the following six characteristic features of borderline patients: intense affect, usually depressed or hostile, a history of impulsivity, a kind of social adaptiveness, brief psychotic experiences, loose thinking in unstructured situations, and relationships which vacillated between superficiality and

extreme dependency. Gunderson (1987) later revised these characteristics to include: low achievement despite the apparent ability to function at higher levels; impulsivity, specifically in substance abuse and sexual behavior; manipulative suicide attempts, presumably designed to enlist the help of others; heightened affectivity in the absence of feelings of satisfaction; mild psychotic experiences; compulsive social involvement in response to a sensitivity to being alone; and disturbed close relationships. Years of empirical research has showed that, in fact, there exists an identifiable borderline "syndrome," which is distinguishable from other syndromes (Gunderson, 1994; Gunderson & Phillips, 1991; Gunderson and Singer, 1975). Gunderson's work was instrumental in bringing recognition of a borderline personality disorder to mainstream psychiatry.

It was not until 1980, that the borderline diagnosis was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The DSM model, derived from phenomenologic psychiatry, defines personality disorders as a constellation of specific symptoms and behavioral characteristics and does not take into account underlying causes. The DSM-IV, (American Psychiatric Association, 1994) states that patients must meet five of the following criteria in order to be diagnosed as having borderline personality disorder: 1) frantic efforts to avoid real or imagined abandonment; 2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; 3) identity disturbance: markedly and persistently unstable self-image or sense of self; 4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, shop-lifting, reckless driving, binge eating; 5) recurrent suicidal behavior, gestures, or threats, or self-mutilating

behavior; 6) affective instability due to a marked reactivity of mood; 7) chronic feelings of emptiness; 8) inappropriate, intense anger or difficulty controlling anger; and 9) transient, stress-related paranoid ideation or severe dissociative symptoms.

While the DSM approach has the advantage of delineating clear-cut, identifiable criteria for making the diagnosis, it has been sharply criticized for its lack of a cohesive theory or developmental grounding (Cicchetti, 1987). It fails to distinguish common features of severe personality disorders from those that are less severe (Kernberg et al., 1989). Some argue that reliance on overt symptomatology can result in an inaccurate diagnosis because symptoms in and of themselves can be misleading (Frosch, 1964; Kernberg et al., 1989). The same behavior exhibited by two patients may stem from different emotional motivational sources (Clarkin et al., 1999).

Kernberg's Model of Borderline Psychopathology

In response to these shortcomings, Otto Kernberg (1975) developed a theory of borderline psychopathology that integrated psychoanalytic drive theory, ego psychology, and object relations theory. Kernberg observed that a patient's presenting symptoms could not be relied on as an adequate means for making the diagnosis because the same symptoms or behaviors can have different underlying bases. Thus, borderline conditions can manifest in a variety of ways. Kernberg's conception of borderline personality organization is broader than the DSM diagnosis of borderline personality disorder in that it encompasses many of the personality disorders included in the diagnostic manual.

According to Kernberg's theory, borderline pathology reflects a type of intrapsychic organization, distinguishable from psychotic and neurotic personality structure on the basis of the patient's degree of identity integration, the types of defensive

operations the person most characteristically employs, and his or her capacity for reality testing. People with borderline personality organization (BPO) have a vague, diffuse sense of themselves, use primarily primitive defenses, and yet maintain the capacity for reality testing. In contrast, individuals with neurotic personality organization (NPO) have an integrated and stable sense of themselves and use higher level defenses such as repression. Those organized at a psychotic level of functioning are distinguished by their severe impairment in reality testing. Unlike patients functioning at a psychotic level of organization, patients with BPO generally perceive things the way most people do. If for example, a patient with BPO presents an unusual interpretation of another's behavior and s/he is confronted about it, s/he can usually acknowledge that his or her perspective is different from how most others would view the same situation. Under stress, however, these individuals' capacity for reality testing may be temporarily compromised, causing them to perceive things in a more idiosyncratic manner consistent with their internal experience.

Kernberg (1975) hypothesizes that borderline character pathology results from problems in the development of early object relations. Prior to the attainment of either self or object constancy, infants register different experiences with others anew each time, such that different experiences with the same person are not integrated into a single representation. An infant may experience a caregiver who is in one moment immediately responsive to his or her needs and who in another is unavailable as two distinct objects. According to Kernberg, in the course of normal development, infants develop distinct good and bad introjects, initially on account of the ego's inability to integrate libidinal drive derivatives and aggressive drive derivatives. The infant's emerging ego defensively

maintains this split in order to protect the positive introjects from being overwhelmed or contaminated by the negative ones. In optimal circumstances, the mechanism of splitting, which is characteristic of infants in the first year of life on account of the ego's lack of integrative capacity, is replaced by higher level defenses, and the individual develops more complex, nuanced representations of both self and other.

In the case of individuals with BPO, Kernberg hypothesizes that as infants they experience an excess of aggression, stemming from a combination of constitutional and environmental factors (Kernberg, 1975). This over-abundance of aggression makes it difficult for them to achieve an integration of self and object representations because images of good-self and good-other are constantly in danger of being destroyed by unmodulated aggression. The resulting anxiety is so intense that the pre-disposed child does whatever it takes to keep good and bad representations separate. The child is thus spared from recognizing, for example, that the internalized "good mother" is the same person as the frustrating, hateful "bad mother." Consequently, individuals with borderline personality organization are conscious of both libidinal and aggressive representations, but these representations are kept separate from one another, resulting in rigid, caricatured portraits of self and others.

A variety of studies on the object relations of patients with borderline pathology have garnered support for Kernberg's theory (Bell, Billington, Cicchetti, & Gibbons, 1988; Greene, 1996; Lerner & St. Peter, 1984; Spear & Sugarman, 1984; Stuart, Westen, Lohr, Silk, Benjamin, Becker, & Vorus, 1990). In a review of these studies, Westen (1990) summarized the findings as follows. The object relations of patients with borderline pathology as measured with an array of projective instruments are consistently

characterized by pathological representations of self and others, in which boundaries are often blurred and representations of more than one affective valence are kept separate and unintegrated. Their protocols reflect an experience of the object world as malevolent and an emphasis on others as need-gratifying. Others' behavior, thoughts, and feelings are interpreted in idiosyncratic ways which are at times primitive (i.e., developmentally immature) and at times simply unusual, "distorted by motivational and defensive processes and by defective cognitive structures and procedures" (Westen, 1990, p.682). They show tendencies toward over-elaborated, confabulatory depictions that are highly distorted. Furthermore, their protocols reflect a sensitivity to loss, separation, and abandonment.

According to Kernberg (1975; 1985), patients with borderline pathology are characterized in part by the use of primitive defensive operations. The primitive defense mechanisms are distinguished from higher order defense mechanisms in that they result in more pronounced interpersonal distortions. Splitting, the mechanism by which positive and negative self and other representations are kept isolated from one another in order to protect the ego from anxiety, is at the core of the other defense mechanisms characteristic of these patients: primitive idealization, projection, projective identification, denial, omnipotence and devaluation. The most commonly recognized form of splitting is exemplified when a patient characterizes self or others as either "all good" or "all bad," rather than integrating negative and positive qualities into cohesive images. Often the patient's characterizations of self and other will vacillate between idealization and devaluation. The patient may describe someone in one way and then within the same session describe the person in an opposite fashion without noting the contradiction.

Furthermore, even when the patient is made aware of the contradiction or spontaneously recalls having had a polar perspective, it is with an incapacity to hold these two emotional states simultaneously. Kernberg (1985) describes this defensive process as a form of denial. Splitting may also manifest in a patient's assuming contradictory sides of a conflict within a single session and without conscious recognition of the contradiction in behavior and/or cognition.

A related defense, primitive idealization, involves the characterization of external objects as all good and powerful in an effort to protect the self from bad objects, his or her own aggression, or from the aggression projected onto others. Kernberg (1985) notes, "...It is the direct manifestation of a primitive, protective fantasy structure in which there is no real regard for the ideal object, but a simple need for it as a protection against a surrounding world of dangerous objects" (p.30). Through the process of identification, primitive idealization may also serve as a source of gratification. By association, the patient is aggrandized and made to feel powerful, important, and worthy.

Another common defense of a person with BPO, projective identification, involves the attribution of an affect or impulse that one finds unacceptable to another, such that the person remains fully aware of the feeling or impulse but experiences it as justifiable in response to the other. The person often arouses in the recipient of the projection, the precise feelings he or she initially believed to be there, creating a cyclical dynamic. For instance, a patient might project aggressive feelings onto the therapist and then become aggressive in response. The therapist might then respond aggressively, strengthening the patient's conviction. Kernberg (1985) adds that in response to the threat of attack, the patient feels a heightened need to control the other in self-defense.

Kernberg (1985) describes omnipotence and devaluation, also prototypical defenses in persons with BPO, as two sides of the same coin. In brief, omnipotence refers to a person's attempt to assume a superior position to another whereas devaluation refers to the attribution of extreme negative qualities onto another. For example, a patient may engage in demanding behavior that reflects a sense of herself as lacking in resources while idealizing the therapist as having all that she needs. Then, within the same session, profess to be above learning anything from the therapist, thereby assuming an omnipotent stance and devaluing the therapist. Kernberg adds that presentations of the self as insecure, self-critical, and inferior, usually coexist with self representations colored by grandiosity and omnipotence. Like the other defenses, devaluation and omnipotence serve multiple functions. In addition to boosting a person's self-image by comparison, devaluation may also serve to protect the self from unfulfilled wishes or longings in which the self is beholden to the other. Similarly, an omnipotent stance may preemptively protect the self from a threat to self-esteem caused by disappointment or powerlessness.

Numerous studies of psychological test data have garnered support for Kernberg's clinical observation that patients functioning at a borderline level of organization are more likely to employ splitting and related primitive defense mechanisms than patients functioning at either neurotic or psychotic levels of organization (Cooper, Perry, and Arnow, 1988; Greene, 1996; Lerner, Albert, & Walsh, 1987; Lerner & Lerner, 1980; Lerner, 1990; Montello, 2000; Perry & Cooper, 1986). In studies conducted by Lerner and colleagues in which they used the Lerner Defense Scale, the Rorschachs of patients functioning at a borderline level of organization were more likely to include evidence of splitting and projective identification than those of patients' at either neurotic or

psychotic levels of functioning (Lerner & Lerner, 1980; Lerner, Sugarman, & Gaughran, 1981). Notably, splitting and projective identification were present in the records of the borderline patients but not in those of the neurotic patients (Lerner & Lerner, 1980).

Using Perry's Defense Mechanism Rating Scale, the system that will be employed in this study, Montello (2000) studied the defensive functioning of six patients diagnosed with both borderline personality disorder and borderline personality organization and found that lower order defenses were rated more frequently than higher order defenses. Splitting, idealization, devaluation, projection, projective identification, omnipotence, and denial accounted for 46% of all rated defenses, but were not rated at a significant level more frequently than all other defenses. Consistent with Montello's findings, patients with borderline personality disorder have been found to use splitting and projective identification significantly more than either antisocial personality disordered patients or those diagnosed with bipolar II (Perry & Cooper, 1986).

While the use of primitive defenses serves an adaptive function in reducing a person's experience of intrapsychic conflict, the psychic energy involved in maintaining such active mechanisms comes at a cost. The individual is left with a weakened ego, the makings of an unstable identity, and vulnerable reality testing (Kernberg, 1975; 1985). The consequent lack of integration of self and other representations interferes with the development of an integrated ego identity and results, instead, in profound identity diffusion. Thus, patients with BPO often exhibit a marked sense of confusion regarding values and aspirations. They frequently lack adaptive sublimatory channels that would allow them to sustain a sense of pleasure in work or recreational activities. They may

express or manifest confusion regarding their sexual orientation. They report a subjective sense of emptiness, boredom, and inner deadness.

Transference Focused Psychotherapy

Beginning in the 1970s, largely as a result of Kernberg's seminal theories on the early developmental conflicts underlying borderline conditions, the analytic community experienced a renewed interest in applying more expressive, interpretative approaches with these patients (Aronson, 1989; Horowitz, Gabbard, Allen, Frieswyk, Colson, Newsom, & Coyne, 1996; Waldinger & Gunderson, 1987). Treatment goals became more ambitious with the aim shifting from crisis management, containment, and the strengthening of ego functions to the resolution of pathogenic object relations and intrapsychic conflict.

Working from the assumption that substantial changes to the pathological character structure of patients functioning at a borderline level of organization could only be achieved through intensive treatment geared toward the identification and working through of early object relations, Kernberg and colleagues designed a treatment, now called Transference Focused Psychotherapy (TFP; Kernberg, 1975; Kernberg, Selzer, Koenigsberg, Carr, & Applebaum, 1989). The treatment is based on the premise that patients' pathology is an expression of an unconscious repetition of their pathogenic internalized object representations. The primary goal of TFP is to improve the patient's capacity for experiencing self and others in more complex, integrated, and reality-based ways while at the same time reducing the need for primitive defensive operations that weaken ego structure. Through this process, the patient develops a greater capacity for impulse control, affect tolerance, and sublimation of instinctual needs and experiences a

reduction in clinically significant symptoms. In the long run, these gains result in greater stability and satisfaction in both work and love.

The focus of TFP is on continuously identifying, and later interpreting, the pathological object relational paradigms that become activated in the here and now of the transference. In borderline patients the transference can shift rapidly depending on which internalized relationship is being experienced in the moment and which role within the relationship is being unconsciously assigned to each participant of the dyad. Since the internalized object relations of borderline patients are primitive in nature, i.e., rigid, highly distorted images of self and others, each object relations paradigm is comprised of a part self representation, a part object representation, and an accompanying affect. Through interpretation, these split-off part-self representations gradually become integrated into a more coherent whole self-representation. Similarly, split-off part-object representations become integrated in ways that allow the hated and loved aspects of another to co-exist. Thus, it is the analysis of the rapidly shifting, highly distorted, and fragmented primitive transference paradigms which is purported to be the primary vehicle of change in this treatment.

TFP is typically carried out two times a week. The duration of the treatment is open-ended and usually lasts for several years. The course of treatment can be broken down into five phases: 1) history taking and contract setting (pre-treatment); 2) the identification of dominant object-relational patterns in the transference (i.e., the early treatment phase); 3) the integration of these polarized, part-object representations (i.e., the midphase); 4) the linking of current relational patterns with early experiences (i.e., the advanced phase); 5) and a termination phase.

The treatment begins with a consultation phase that includes a thorough assessment of the patient's history and character structure. Central to the treatment is the collaborative negotiation of a treatment contract that details the respective responsibilities of patient and therapist and clarifies the parameters within which the treatment can be effective. On the basis of the patient's history, the patient and therapist delineate behaviors (such as missed appointments, substance abuse, deception, and withholding relevant information) that are likely to arise and interfere with the treatment. For example, a patient who reacts to painful feelings by making suicidal gestures and then enlists the therapist in repeated rescue attempts will make it impossible for the therapist to maintain an exploratory stance or what Kernberg and others refer to as "therapeutic neutrality" (Kernberg et al., 1989). This concept of therapeutic neutrality, derived from the work of Anna Freud (1936), refers to the therapist's position of equal distance from the forces involved in the patient's intrapsychic conflict. Thus, one way of viewing the treatment contract with borderline patients is that it serves to protect therapeutic neutrality, which is a prerequisite for an analysis of the transference (Yeomans, Selzer, & Clarkin, 1992). Research suggests that a well designed treatment contract can significantly reduce the high rate of drop out, commonly observed in borderline populations (Yeomans, Getfreund, Selzer, Clarkin, Hull, & Smith, 1994). Another benefit of this phase of treatment is that it serves to highlight the dominant transference patterns likely to arise in treatment.

Much of the early work nevertheless involves establishing an alliance, addressing the patient's urges to discontinue therapy, and confronting acting out both within and outside the therapy. For obvious reasons, self-destructive and treatment interfering

behaviors are high on the list of thematic priorities² to be addressed in sessions. Usually, within the first six months of therapy, these behaviors, however, become less prevalent, and attention can shift to a fuller exploration of the unfolding transference. The therapist can then more actively focus on identifying the patient's primitive and polarized self and object representations.

The second phase of treatment involves the identification and clarification of dominant object-relational patterns in the transference. An early phase of this process involves clarifying the patient's perceptions and expectations of the therapist and of him or herself from moment to moment. Clarification, the first stage in the interpretive process, refers to the act of calling the patient's attention to one aspect of his or her verbal communication or non-verbal behavior and inviting the patient to explore its significance. Intense affective states in the patient and/or therapist (or a striking lack of affect when it might be expected) often serve as sign-posts for the presence of dominant object relations. The therapist then labels the various part self and part object representations which are active in the present interaction, a process referred to as "naming the actors" (Kernberg et al., 1989). "Roles" can be played out in alternating patterns. In this case, the same self-object dyad may be active, but the roles become reversed. For example, within the same

² Kernberg and colleagues (Kernberg, et al., 1989; Clarkin, Yeomans, & Kernberg, 1999) have articulated a hierarchy of thematic priorities beginning with those involving treatment emergencies (suicidal ideation or behavior) or threats to the continuity of treatment and moving downward to themes with significant transference implications. The following is a summary of the Hierarchy of Thematic Priorities:

1. Suicide or homicide threats
2. Overt threats to treatment continuity
3. Dishonesty or deliberate withholding in sessions
4. Contract breaches
5. In-session acting out
6. Between session acting out
7. Nonaffective or trivial themes
8. Transference manifestations
9. Nontransference affect-laden material

session, a patient may feel controlled by a dominating parent figure (i.e., the therapist) and then soon after assume the role of the dominant other, leaving the therapist feeling controlled. Once the therapist has identified the patient's repertoire of primitive self and object representations, the focus shifts to one of integration.

The third phase of treatment focuses on the integration of these disparate, partial, and polarized representations and is largely accomplished through interpretation of the patient's primitive defenses, such as splitting. As Clarkin and colleagues note (1999), "This extreme separation of incompatible states leads to patients experiencing as *external to them* parts of their inner world that cannot be tolerated at the same time as the part they are consciously experiencing" (p. 82). To bring these split representations to the patient's awareness, the therapist calls attention to and interprets the patient's use of defenses.

The treatment moves into the advanced phase as the patient becomes more aware of the multifaceted aspects of his or her identity which have at different times been repudiated or projected into others. What was previously perceived as externally based is now understood to be internally generated. The next stage involves helping the patient tolerate ambivalent feelings toward the same object and contradictory aspects of the self. The model predicts that with the growing capacity for ambivalence, patients will become better able to verbalize their feelings rather than act them out. Similarly, patients with somaticizing tendencies become better able to experience and discuss their emotional difficulties rather than relegating them to parts of the body (like-wise for patients with eating disorders). In general at this stage, patients become more self-reflective.

As patients become more reflective, the relationship with the therapist deepens. The integration of internalized object relations is accompanied by greater complexity and continuity of the experience of self and others. One consequence of this development is that the patient can now make use of genetic interpretations in which the present transference is linked with unconscious correlates from early pathogenic relationships. Another consequence is that the quality of the transference shifts from being more paranoid, primitive, and distorted to more integrated, flexible, and realistic. At this point, patients may express remorse over prior psychological attacks made toward the therapist or significant others. They may also experience sadness regarding their own lives. Thus begins a process of mourning, and in this respect, preparation for termination.

Ideally, termination is agreed upon mutually. From the therapist's perspective, "Treatment should be terminated when there has been (1) adequate symptom resolution and (2) significant personality change so that identity diffusion has been resolved, ego strength has been increased, and initial treatment goals have been reached" (Kernberg et al., 1989, p. 147). If the treatment has been successful, the termination process is similar to that which occurs with patients at a neurotic level of personality organization. Inevitably, termination stirs up powerful separation anxiety. With borderline patients in particular, the prospect of termination is often accompanied by a temporary period of regressive behavior, sometimes of a self-destructive or outwardly aggressive nature. At this late stage of the therapy, however, such behavior can usually be effectively interpreted and contained. The development of more integrated self and other representations is usually accompanied by a greater capacity to recover from transient lapses in impulse control and affective regulation.

Relevant research on therapeutic change

To date, while there has been much clinical and anecdotal evidence in support of the effectiveness of TFP, only a limited number of systematized studies of the treatment have been conducted (Clarkin, Foelsch, Levy, Delaney, & Kernberg, in review; Levy, Clarkin, & Kernberg, 1999). Kernberg and colleagues are currently engaged in a longitudinal NIMH funded research project examining the effectiveness of TFP for patients with BPD (grant number: MH53705-02). The preliminary findings are promising.

In a study comparing the psychological functioning of twenty-three women diagnosed with Borderline Personality Disorder before and during a one-year course of TFP, the patients exhibited a marked decrease in the number of emergency room visits (55% reduction), psychiatric hospitalizations (67% reduction), and length of inpatient stay (89% reduction; 39.2 versus 4.5 days). In addition, they reported a significant diminution of symptomatology and an increase in their reasons for living. Furthermore, TFP appeared to be effective in reducing the high drop-out rate characteristic of these patients (Clarkin et al., in review). Kernberg and colleagues are currently undertaking a randomized clinical trial comparing TFP to Dialectical Behavior Therapy and a structured, manualized supportive psychotherapy.

So far, the findings suggest that TFP is effective in reducing many of the severe symptoms and behaviors associated with BPD. Analytically based treatments, such as TFP, however, endeavors to produce not only change in manifest symptoms and behavior, but also enduring change in the so-called “structure” of the personality (Dewald, 1972; Kernberg, 1993; Zilberg, Wallerstein, Dewitt, Hartley, & Rosenberg, 1991).

According to Kernberg's model, structural change involves "integration of self-concept and concept of significant others; integration of split-off affect states such that affective experience and expression become enriched and modulated; and the development of discriminating relationships in depth with others" (Clarkin, Yeomans, & Kernberg, 1999, p. 105). Within this framework, changes in object representations are an essential component of structural change.

Numerous studies have found that the quality and level of a person's object relations and object representations can be systematically assessed and that a person's object relations can be altered in the course of psychotherapy (Diamond, Kaslow, Coonerty, & Blatt, 1990; Eklund & Nilsson, 1999; Kavanagh, 1985). The Object Representation Inventory (ORI; Reference) and its accompanying scoring systems have been found to be particularly effective ways of assessing object relations over the course of psychodynamic treatment. Using the ORI and the Rorschach, Diamond and colleagues (1990) investigated whether separation-individuation disturbances could be effectively addressed and reworked in the course of a long-term inpatient treatment. They found that over the course of treatment, the patients' showed higher levels of separation-individuation and intersubjectivity and a narrowing in the range and variability in self-other differentiation.

In a related study, Blatt and colleagues (Blatt, Wiseman, Prince-Gibson, & Gatt, 1991) found that patients' improvement in therapy as measured by the Global Assessment Scale was paralleled by changes in the conceptual level and the degree of differentiation and articulation of their descriptions of their parents as measured by the Object Representations Inventory (ORI). As expected, the patients' object

representations became increasingly differentiated and complex over the course of treatment. Interestingly, patients did not exhibit significant change in the conceptual level of their representation of their therapists. In sum, these studies support the hypothesis that a psychodynamically oriented treatment, such as TFP, may be effective in altering patients' object representations.

In keeping with Kernberg's theory, a number of studies have found that as a result of intensive psychotherapy in which patients experienced a reduction in psychiatric symptoms, patients also experienced a shift in their predominant use of defenses (Ablon, Carlson, & Goodwin, 1974; Akkerman, Carr, & Lewin, 1992; Cramer & Blatt, 1993; Semrad, Grinspoon, & Feinberg, 1973). Cramer and Blatt (1993), for example, found that after fifteen months of intensive inpatient treatment, patients showed a reduction in independently rated symptoms and exhibited a decrease in their use of immature defenses.

Other studies have not found evidence for change in defense after only one year of treatment. In a study of six borderline patients being treated with Transference Focused Psychotherapy, the data did not indicate a significant change in maturity of defensive functioning after ten months of treatment (Montello, 2000). It has been argued by some that changes in the level of defense maturity may take decades (Winston, Winston, Samstag, & Muran, 1994). In the above study, however, while as a group, the patients' overall level of defensive functioning did not appear to have improved, a closer examination of the individual's trajectories over the course of treatment revealed that half of the patients exhibited a small positive shift in defensive functioning while the other half showed an equally small negative shift.

What might account for the fact that after ten months of treatment, half the patients in this study were found to be using higher level defenses while half actually appeared to be using lower level defenses than the ones they were employing at admission? There are many ways to understand these findings. It is possible the quality of the treatments differed or the particular matches between patient and therapist differed in fit. Alternatively, the patients whose defensive functioning improved may have been different in other regards from the patients whose defensive functioning decreased¹. Another likely possibility, however, is that, as has been well documented and as is consistent with clinical lore, patients will often become more symptomatic in the process of becoming healthier (Blatt & Ford, 1994). The system needs to be unbalanced before it can be restructured. The existing defensive constellation needs to be challenged before healthier defenses can be put into place. Thus, it may be that the patients in Montello's study who after ten months of treatment appeared to be using lower level defenses than they were using prior to treatment, were actually en route to healthier defensive functioning. These findings point to the need for more in depth, case-focused analyses of treatment process over longer periods of time.

II. ATTACHMENT THEORY

Although not part of Kernberg's original conceptualization of the etiology of borderline personality organization, attachment theory is in many ways consistent with and supportive of his integrative object relations approach. Specifically, Kernberg's emphasis on mental representations as the building blocks of character is consistent with

¹ In a separate study, Hull, Clarkin, and Tatsuyuki (1993) found that borderline patients' level of identity consolidation and degree of interpersonal difficulties were predictive of the patients' course in treatment.

attachment theorists' emphasis on the role that internal working models play in personality development. Given the prevalence of disturbed interpersonal functioning, fears of separation and abandonment, and the lack of stable identity in patients with borderline personality disorder, borderline psychopathology has been conceptualized as reflecting significant attachment disturbance (Gunderson, 1996; West, Keller, Links, & Patrick, 1993).

Attachment theory, stemming from the theoretical contributions of John Bowlby (1958; 1969; 1973; 1977; 1980), stipulates that an infant is predisposed from birth to forming a selective attachment to primary caregivers and that this affective bond serves an serves a vital evolutionary function of increasing the infant's chance of survival. The infant inevitably develops strategies to regulate proximity to the caregiver, strategies that are shaped in part by the nature of the caregiver's response to the infant's distress at separation and to his or her attempts to re-establish proximity. Bowlby (1969) argued that, "The child's hunger for his mother's presence is at least as great as his hunger for food" (p.xiii).

Drawing on his cross-discipline studies of ethology, evolutionary biology, and information-processing theory, Bowlby observed that from birth infants engage in behaviors such as crying, clinging, looking, and reaching in order to gain and maintain closeness to an attachment figure. During the second half of the first year, these "attachment behaviors" become integrated into a goal-corrected control system, with the goal being to maintain optimal proximity to a primary caretaker and to foster a feeling of security. In times of danger, stress, or even novelty, the infant's attachment system will

Patients rated as having low levels of identity diffusion and interpersonal difficulties upon admission to an

be activated. The infant will engage in attachment behaviors until comforted and reassured of his or her safety by the attachment figure. When the child has reached the critical level of felt security, he or she will venture out and explore the environment (to the extent that he or she is developmentally capable), using the primary caretaker as a secure base (Ainsworth, Blehar, Waters, and Wall, 1978).

Assessments of the relative safety or danger of a given situation and of the availability and responsiveness of the care-taker are not made afresh each time, but rather, are based largely on the cumulative experiences of the infant (Bowlby, 1973; Bretherton, 1985). Bowlby hypothesized that an infant's interactive experiences become generalized into increasingly complex "internal working models" of the self and others. These internal working models form the basis of the infant's expectations of the availability and accessibility of his caretakers and later inform expectations of other figures in the individual's life. As Bretherton (1985) notes, the notion of a "working" model highlights the dynamic nature of these mental representations, and the word "model" emphasizes their constructive nature. Over time internal working models of self and others become increasingly complex and differentiated.

Given that internal working models are constructed on the basis of infants' experiences in relationships, models of self and other "develop so as to be complementary and mutually confirming" (Bowlby, 1973, p. 204). A child's model of self will be based in part on how acceptable he or she feels in the eyes of the caregiver. For example, a child whose primary early experience is one of neglect and rejection is apt to form a self-image

inpatient unit reported a greater decrease in symptoms at discharge.

of being unlovable. In contrast, a child whose caretakers are responsive and attuned will develop a working model of himself as worthy of others' love and attention.

An infant will do whatever is necessary emotionally, cognitively, and behaviorally to maintain an ongoing relationship with primary attachment figures. Bowlby maintained that "... to the degree that [an infant's or child's] needs for comfort and nurture are intolerable to the caregiver, he will distort or disguise his feelings and needs, he will distort his thinking and empty his memory" (Slade, 1996, p. 7). In other words, infants and children will curtail behaviors that appear to threaten their relationships with caregivers and will put out of consciousness thoughts or feelings that would interfere with their doing so. As noted by Costello (2000), "These self-regulatory processes require that the individual fit his experience and behavior to the conditions under which the attachment figure is most likely to provide caregiving. They denote how the self must be experienced in order to obtain a relationship with the other; they denote which states in the other must be elicited and which avoided (p.114-115).

In an attempt to provide empirical support to Bowlby's theory of attachment and to assess individual differences in attachment behavior, Mary Ainsworth and colleagues developed the Strange Situation, a twenty-minute procedure involving a series of separation and reunion episodes between one year olds and their mothers (Ainsworth, Blehar, Waters, & Wall, 1978). Ainsworth noticed three organized patterns of responses to the separations from and reunions with the mother. The majority of the infants in her non clinical sample expressed some distress when the mother left the room, actively greeted her upon her return, and then redirected their attention to the toys in the room and explored the environment using their mother as a "secure base." Ainsworth labeled this

pattern of behavior secure. Another group of infants, classified as “insecure-avoidant,” behaved coolly toward their mothers throughout the procedure, focusing instead on the toys. Notably, upon their mother’s return, they averted their gazes, turned away, or appeared oblivious to her presence. A third group of infants whom she categorized as “insecure-ambivalent,” monitored their mothers’ whereabouts closely, became extremely distressed upon separation, and then responded to the reunion with a combination of clinging and anger or marked passivity.

A fourth group of infants, later described by Main and Solomon (1990) as “disorganized/ disoriented.” These infants did not display an organized pattern of attachment behavior. They seemed to lack a readily observable strategy for coping with the separations and reunions with the mother. Instead, they exhibited a combination of sequential and simultaneous displays of contradictory behavior patterns, undirected and incomplete actions, stereotypes, asymmetrical and mistimed movements, and anomalous postures (Main, 1995a).

The Strange Situation has been widely used in the United States as well as in Germany, Israel, and Japan (Grossmann, Grossmann, Spangler, Suess, & Unzner, 1985; Miyake, Chen, & Campos, 1985; Sagi, Lamb, Lewkowicz, Shoham, Dvir & Estes, 1985). In Ainsworth’s original Baltimore sample and in most non-clinical samples in the United States, approximately 65-70% of infants assessed using the Strange Situation procedure are classified as secure; 20-25% fall into the anxious-avoidant category; and less than 10% are rated as anxious-resistant (van IJzendoorn & Kroonenberg, 1988; Slade & Aber, 1992). Approximately 13% of infants in low-risk samples were initially regarded as

unclassifiable. Ninety percent of these infants would now be classified as disorganized/disoriented (Main, 1995a).

In the last 20 years, developmental researchers have extended studies of mother-infant interactions to include studies of internal working models of attachment. In recent years attachment theorists have begun to study the relevance of attachment theory to the etiology and treatment of more severe psychopathology. As a result, there has been a resurgence of interest in the integration of attachment theory and psychoanalysis and research into the ways in which attachment theory can inform the psychoanalysis process.

Although Bowlby (1979) proclaimed that attachment phenomena is active throughout the life span, "from the cradle to the grave" (p. 129), it was not until the mid-1980s that research was conducted on adult attachment. Main, Kaplan, and Cassidy (1985) reconceptualized individual differences in attachment organization to include differences in the mental representations of the self in relation to attachment figures as expressed through language. This "move to the level of representation" introduced the possibility of measuring the attachment organization of older children and adults.

In an effort to interview the parents of children who were observed in the Strange Situation paradigm, Main and colleagues developed the Adult Attachment Interview (AAI), an interview designed to assess adults' states of mind with respect to attachment experiences (George, Kaplan, & Main, 1985). The AAI is an hour long, semi-structured, clinical interview which asks for both descriptions and evaluations of significant attachment-related experiences and summaries of how these experiences have affected their development. Thus, the task for the interviewee is to access, describe, and reflect on

memories in the sequence determined by the interviewer while maintaining coherent discourse (Hesse, 1996). This is a challenging task due to the emotionally charged nature of the material and the way in which the questions unbalance the interviewee. Along these lines, the interview has been described as "surprising the unconscious" (George, Kaplan, & Main, 1985), thereby making unconscious processes more accessible.

The AAI and corresponding system of analysis purport to assess "states of mind" which reflect the operation of internal working models of attachment. In this regard, internal working models are considered "a set of conscious and/ or unconscious rules for the organization of information relevant to attachment and for obtaining or limiting access to that information" (Main, Kaplan, & Cassidy, p.66). The interview, which is transcribed verbatim, is ultimately assigned one of the following primary attachment classifications: Secure/Autonomous, Dismissive, Preoccupied, and Unresolved. The adult ratings parallel the infant classifications of Secure, Anxious-Avoidant, Anxious-Resistant, and Disorganized/ Disoriented. Recently a fifth category, Cannot Classify, has been added to reflect those interviews which do not fall into one of the pre-existing classifications.

It is important to note here that ratings are derived more from the manner in which subjects talk about their histories than an evaluation of the content. In fact, the coding scheme is not dependent on the accuracy of what is reported. The essential component of the scoring system is the way in which the interviewee violates or conforms to coherent discourse, based on the work of the linguistic philosopher Grice (1975). Grice proposed that rational discourse subscribes to an overriding "cooperative principle" which necessitates adherence to the following four maxims: quality-to be truthful and

have evidence for what you say; quantity- to be succinct yet complete; relation- to be relevant or on topic; and manner- to be clear and orderly. Discourse is viewed as coherent “when a subject is able to access and evaluate memories while remaining plausible (consistent/ truthful) and collaborative” (Hesse, 1996, p.6). Interestingly, the construct of coherence used for assessing attachment organization in the AAI coding system is conceptually similar to the psychoanalytic theory of structural aspects of representation (Levy & Blatt, 1999)

What follows is a brief description of each of the attachment classifications³. Individuals whose interviews are rated as secure typically describe both positive and negative aspects of their relationships with their parents in a coherent, internally consistent manner. They support their descriptions of these relationships with specific memories. Their interviews suggest that they are thinking things through in a fresh and undefensive manner and that they have integrated their childhood experiences in a way which allows them to be autonomous in their relationships with their parents as adults. While these individuals did not necessarily have nurturing nor supportive parenting experiences, they can discuss and evaluate the impact of these experiences on their development in a clear and succinct manner.

Individuals who are classified as dismissive tend to minimize the significance of attachment figures in their lives and to deny the impact of these relationships on their development. In contrast to individuals rated as secure, those rated as dismissive have evidently not fully integrated their negative memories from childhood into their overall mental models of these relationships. Their interviews are notable for inconsistencies,

³ For more extensive descriptions of the adult attachment classifications, see Main 1995a.

contradictions, and an overall constriction of affect. Occasionally, these individuals will describe their parents in glowing, idealized terms, but they will be unable to back up their descriptions with convincing examples. Sometimes, they simply contend that they have no memories of their childhoods and can not give any specific examples of what they mean.

Adults who are classified as preoccupied discuss their attachment related experiences in a more incoherent, entangled manner, which gives the impression of their being emotionally flooded (or overwhelmed) by their past experiences. The interviews reveal a confused, angry, or passive, preoccupation with parental relationships and attachment experiences. These individuals appear to get lost in the experiences about which they are speaking, which sometimes involves their reverting to childlike speech, confusing the past with the present, or addressing their parents directly as though they were present. It seems difficult for those who are rated as preoccupied to step outside these relationships and evaluate them more objectively.

Adults who are judged to be unresolved with respect to attachment show lapses in monitoring of reasoning or discourse, specifically during the discussion of traumatic events, such as the death of a significant person in their life or experiences of physical or sexual abuse. Examples of such breaks in monitoring of reasoning include: subtle indications that a deceased person is believed to be living; confusion around the circumstances of a person's death; extreme detail in talking about experiences of loss or abuse; sudden eulogistic speech uncharacteristic of the rest of the interview. At times during the discussion of the traumatic episode, these individuals appear to get lost in thought during prolonged silences and then forget what they were talking about. Aside

from these isolated breaks in discourse, these adults typically exhibit a predominant attachment strategy and are thus also given one of the three main classifications described above.

Interviews in which no single attentional strategy is dominant and thus, do not fall into one of the above three categories, are given a “cannot classify” rating. These interviews are characterized by a global breakdown in discourse and inconsistent uses of attachment strategies. Sometimes the breakdown in discourse described above as characteristic of the unresolved attachment status is in cannot classify interviews not isolated to the discussion of trauma but is pervasive throughout the transcript. Alternatively, these interviews contain strong indicators of contrasting states of mind with respect to attachment. While the majority of individuals from normative samples seem to fall into one of the primary attachment classifications, it is possible that the attachment styles of adults with more serious psychopathology and impaired object relations are not captured by the existing system. For this reason the “cannot classify” category may be of particular importance.

In a meta-analysis of several samples, 55% of adults were rated as secure, 16% dismissing, 9% preoccupied, and 19% unresolved (van IJzendoorn and Bakermans-Kranenburg, 1995). Adult attachment classifications have been found to predict parent-infant attachment behaviors in the Strange Situation procedure: parents who are rated on the AAI as secure-autonomous tend to have infants who exhibit secure attachment behavior; parents rated as dismissing tend to have infants who manifest avoidant behavior; parents rated as preoccupied tend to have infants who demonstrate ambivalent behavior; and parents rated as unresolved tend to have infants who engage in disorganized

behavior. Van IJendoorn & Bakermans-Kranenburg, (1995) found that the secure-insecure correspondence between parents' AAI classification and infants' Strange Situation response was approximately 75% in studies in which the AAI was given after the child's birth and in progressive studies in which the parent was interviewed before the birth of the child.

Many researchers have become interested in the question of what accounts for this apparent transmission of attachment status from parent to child (Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Fonagy, Steele, Steele, Leigh, Kennedy, Mattoon, & Target, 1995; Slade, 1999). Fonagy and his colleagues have proposed that a parent's capacity for "reflective functioning" determines the extent to which he or she can regulate and symbolize affectively charged experiences, and thus be able to help his or her child contain and integrate affect. Essentially, reflective function (RF) is an awareness of mental process in the self and in the other-- that is, the ability to take into account one's own and others' mental states in understanding behavior. RF is thought to result from the child's internalization, not of the image of the other, but of the other's capacity to coherently and accurately represent the child's mental processes.

As Bowlby predicted, early attachment experiences and mental models have now been shown to be relatively stable, to persist across the life-span, and to be among the major determinants of personality across generations (Elicker, Englund, & Sroufe, 1992; Grossmann & Grossmann, 1991; Main et al, 1985; Waters, Merrick, Albersheim, & Treboux, 1995). There have been several attempts to predict adult attachment classification on the basis of these individuals' attachment behavior as infants as observed in the Strange Situation procedure. In at least two different studies (Hamilton, in press;

Waters, Merrick, Treboux, Crowell, & Albersheim, in press), adult attachment classifications of young adults were found to be predictable from their Strange Situation behavior with mother 16 to 20 years previously. As noted by Clarkin and colleagues (1999), recent studies have found that 64 to 80 percent of individuals assessed for attachment at one year using the Ainsworth Strange Situation procedure and again in young adulthood on the AAI showed continuity of secure versus insecure attachment classification from infancy to young adulthood (Hamilton, in press; Hesse, 1999; Waters, Merrick, Treboux, Crowell, & Albersheim, in press). (See Main, 1995b for reviews of research on continuity.)

Although attachment classifications have been found to be largely stable over time, the relative importance of various contributions to stability and change-- such as new long term relationships, evolving relationships with the same family members, and traumatic life events-- needs further exploration. The occurrence of negative life events experienced before age eighteen, such as physical or sexual abuse, parental illness, death, divorce, or psychiatric disorder has been found to be associated with shifts in attachment status from security to insecurity (Koenigsberg et al., 2000; Waters et al., in press). One would expect that the treatment relationship with its reparative potential could facilitate change in the other direction.

ATTACHMENT & THERAPEUTIC PROCESS

In 1988, Bowlby wrote, "A therapist applying attachment theory sees his role as being one of providing the conditions in which his patient can explore his representational models of himself and his attachment figures with a view to reappraising and restructuring them in light of the new understanding he acquires and the new experiences he has in the

therapeutic relationship” (p. 138). Bowlby emphasized the importance of the therapist serving as a secure base, a reliable and trustworthy person with whom the patient can explore his and her thoughts and feelings much like an infant uses an attachment figure. The therapist has since been described as a prototypical attachment figure (Farber, Lippert, and Nevas, 1995). Like that between a child and a parent, the therapeutic relationship involves care-taking from someone perceived as “stronger and wiser” (Bowlby, 1977).

Given that patients typically seek help from a therapist when they are in emotional distress, i.e. at a time when the attachment system is most likely to be activated, the therapeutic relationship is uniquely suited to evoke and illuminate patients’ working models of attachment (Farber, Lippert & Nevas, 1995; Kobak & Shaver, 1987). Patients inevitably bring to therapy expectations of the therapist that are consistent with their attachment histories and ripe for exploration, a phenomena consistent with psychoanalytic theories of transference. Thus, a patient with a dismissing attachment style is likely to experience the therapist as cold and rejecting or to selectively pick up on these qualities and ignore contradictory evidence. In contrast, a patient with a preoccupied attachment style may experience the therapist as alternatively seductive and rejecting, or be particularly sensitive to such subtle vacillations in the therapist’s manner. The therapist’s task is to identify such patterns and to help the patient attend to experiences that contradict their history and their expectations.

Research has shown that people tend to elicit responses from others that are consistent with their expectations (Snyder, Tanke, & Berscheid, 1977). Therapists, too, are naturally inclined to respond in ways that are consistent with their patients’

expectations and complementary to their interactive manner. A dismissing patient is likely to evoke feelings of rejection in the therapist and may cause the therapist to become distant, thereby confirming the patients' expectation of others and strengthening his or her existing model of attachment. A patient with a preoccupied style of attachment who feels helpless and fearful that the therapist will be unable to help him/her may generate similar feelings of helplessness in the therapist and incline the therapist toward assuming a care-taking role. If therapy is to be effective in altering internal working models of attachment, such pulls must be monitored and used to inform the treatment.

Clinicians have become increasingly interested in the application of attachment theory to clinical phenomena including treatment alliance (Mackie, 1981), transference-countertransference dynamics (Ammaniti, 1999; Fonagy, 1998; Slade, 1997; Szajnberg & Crittendon, 1997), patients' characteristic response to endings and separations (Gunderson, 1996; Holmes, 1996, 1997, 1998; Stein, 1991), therapeutic response and outcome (Dozier, 1990; Dozier & Tyrell, 1998; Fonagy et al, 1995; Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, Target, & Gerger, 1996). In a study which investigated patterns of treatment use and response in 40 young adults with severe psychopathology, Dozier (1990) found that people tend to approach treatment in ways that are consistent with their attachment organization. Individuals who were classified as secure were better able to rely on the therapist as a trustworthy and reliable attachment figure and to follow through with their prescribed treatment. Those who were rated as avoidant were less likely to seek out treatment and to make use of treatment if offered, than those who were classified as preoccupied. Avoidant tendencies were associated with greater rejection of treatment providers, less self-disclosure, and poorer use of treatment. Those who were

rated as preoccupied tended to present as needy and dependent but were not significantly more compliant with treatment than those who were rated as avoidant.

BORDERLINE PSYCHOPATHOLOGY AND ATTACHMENT

Bowlby (1973) noted the prevalence of attachment issues in adult psychopathology. He associated anxious- ambivalent attachment with: "A tendency to make excessive demands on others and to be anxious and clingy when they are not met, such as is present in dependent and hysterical personalities" (Bowlby, 1973, p.14). He linked avoidant attachment to, "a blockage in the capacity to make deep relationships, such as is present in affectionless and psychopathic personalities" (Bowlby, 1973, p.14). Bowlby believed that attachment difficulties increase vulnerability to psychopathology (Bowlby, 1977), and determine the specific types of difficulties that arise. Although as early as 1977, Bowlby proclaimed that childhood attachment forms the basis for an individual's "later capacity to make affectional bonds as well as a whole range of adult dysfunctions" including "marital problems and trouble with children as well as... neurotic symptoms and personality disorders," (Bowlby, 1977, P. 206), it has only been in the last decade that attachment theory has been used to further our understanding of the etiology and treatment of clinical disorders.

Personality disorders, and borderline personality disorder in particular, have in recent years been hypothesized to involve disturbances in working models of self and others (Fonagy et al., 1996; Levy, Blatt, & Shaver, 1995). The hallmark traits of borderline personality disorder-- a pattern of unstable, chaotic, and intense interpersonal relationships, intense fluctuations in mood, often triggered by interpersonal injuries, feelings of emptiness, discomfort with being alone, as well as frantic efforts to avoid real

or imagined abandonment -- have been re-conceptualized as stemming from underlying attachment disturbances (Diamond, Clarkin, Levine, Levy, Foelsch, & Yeomans, 1999; Fonagy et al., 1995; Gunderson, 1996; West, Keller, Links, & Patrick, 1993). A growing number of studies using both interview and various self-report measures have linked borderline pathology to a range of insecure attachment patterns (Diamond & Doane, 1994; Fonagy et al., 1995; 1996; Hobson, 1993; Levy & Shaver, 1995; Patrick, Hobson, Castle, Howard, Maughn, 1994; Sack, Sperling, Fagen, & Foelsch, 1996; Sperling, Sharp, and Fishler, 1991; West, Keller, Links, and Patrick, 1993)⁵.

There has been a growing interest in whether or not patients with borderline personality disorder have an identifiable characteristic attachment style. Given that individuals with borderline pathology tend to be hyper-vigilant in their relationships and frequently engage in behaviors which activate others to assume the role of caregiver, it seems likely that they might show a tendency to manifest a preoccupied state of mind on

⁵ An important consideration is whether the existing attachment classification systems, such as Main and colleagues which was normed on non-clinical samples, are adequate to capture the attachment organization of more disturbed patients. Researchers have rightly questioned whether individuals with clinical disorders are even classifiable under the existing coding system. To date there have been several groups of researchers who have administered the Adult Attachment Interview to subjects with borderline personality disorder and other severe psychopathology (Allen, Hauser, and Borman-Spurrell, 1996; Fonagy, Steele, Steele, Leigh; Kennedy, Mattoon, & Tager, 1995; Hobson, 1993; Patrick et al., 1994). Unfortunately, the majority of the research groups cited above did not implement the "cannot classify" rating but instead, gave each interview a forced rating, using one of the four main classifications.

One exception to this problem can be found in a follow-up study of 142 upper middle class adolescents half of whom had psychiatric histories. Allen, Hauser, and Borman-Spurrell (1996) compared the adult attachment classifications of these individuals in young adulthood with their psychiatric status eleven years earlier. Half of the sample consisted of individuals who were psychiatrically hospitalized at age 14 and diagnosed with various non-organic and non-psychotic disorders such as conduct disorder, oppositional defiant disorder, depression etc. The other half comprised the control group and was taken from a public high school. Any and all direct references to the subjects' psychiatric status were disguised so as to keep the raters blind to this factor. Twenty-six percent of the young adults who had been psychiatrically hospitalized during their adolescence were placed in the "cannot classify" category in comparison to seven percent of the control group.

It appears as though some subjects with psychopathology are classifiable under the existing system and some are better placed in the "cannot classify" category. Further research is needed to better understand this group of individuals for which the existing system is insufficient. Furthermore, it is imperative that future studies utilize this new "cannot classify category."

the AAI. There is some research that supports this hypothesis. In a study conducted by Fonagy and colleagues (1996), seventy-five percent of the patients diagnosed with BPD were rated as preoccupied on the AAI. Approximately half of those rated as preoccupied were found to be in a rarely used subgroup (E3), fearfully preoccupied with respect to attachment related traumas.

Other studies have yielded similar findings (Hobson, 1993; Patrick, Hobson, Castle, Howard, & Maughan, 1994). Hobson (1993) compared the attachment representations of 12 subjects who met DSM-III-R criteria for borderline personality disorder to those of 12 female subjects who met DSM-III-R criteria for dysthymia. The groups were comparable in intellectual achievements, age, socioeconomic status, and current depressive symptomatology. All 12 of the borderline subjects were rated as preoccupied in comparison with 4 out of 12 of the dysthymic subjects. Furthermore, 10 of the 12 borderline subjects were classified as belonging to the preoccupied subcategory characterized by "confused, fearful, and overwhelmed" states in relation to their attachment figures and experiences. None of the dysthymic patients fell into this subcategory.

Similar numbers from each group of subjects reported histories of significant trauma or loss as measured through the AAI rating schedule. However, 9 out of the 9 borderline subjects in comparison to 2 out of the 10 dysthymic subjects meeting criteria for trauma or loss were judged to be unresolved with respect to the abuse or losses they discussed. Looking more closely at experiences of early trauma, Hobson found that all 6 of the 6 borderline subjects reporting experiences ranging from "frightening beatings from

parental figures to childhood sexual abuse," were rated as unresolved while none of the 5 dysthymic patients with comparable histories fell into this category.

Although there does not appear to be a one-to-one correspondence between particular personality disorders and attachment classifications based on the AAI, existing research confirms clinical wisdom that patients with borderline personality disorder manifest insecure attachment patterns of one sort or another. It has been speculated that variations in attachment classifications may discriminate among subtypes of borderline pathology (Levy & Shaver, 1995). Some studies indicate that subjects 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 & Shaver, 1995; Rosenstein & Horowitz, 1996). It may be that borderline patients with co-morbid substance abuse problems, conduct disorders, and/ or narcissistic and antisocial traits are more likely to be on the dismissing end of the spectrum whereas borderline patients with more histrionic traits and greater affective instability fall on the preoccupied end of the spectrum (Rosenstein & Horowitz, 1996). Other studies (Adam, 1994; Adam, Keller, & West, 1995) have found that borderline patients prone to self-injurious/ para-suicidal behavior are more likely to be classified as unresolved with respect to traumatic experiences on the AAI.

Adam, Keller, and West's (1995) research on the attachment patterns of suicidal adolescents may have implications for our understanding of the relationship between attachment and suicidal behavior in borderline patients. Having previously found that parental loss in the context of an unstable home environment was prevalent in the histories of suicidal adolescents, Adam and colleagues studied the hypothesis that

dysfunction in the attachment system is a major risk factor in the vulnerability to suicidal behavior in teenagers. They compared the attachment organization of suicidal adolescents to a matched non-suicidal clinical population and concluded that subjects with unresolved and preoccupied classifications were more likely to be at risk for suicidal behavior. Those who were not unresolved for trauma and those in the dismissing groups were at a decreased risk of suicidality relative to those classified as secure. Females who were judged to be unresolved were most likely to be in the suicidal behaviors group, regardless of their secondary attachment classification. Almost all subjects in the preoccupied group who had histories of loss, separation, or trauma were found to be unresolved. Adam and colleagues extrapolated that an underlying preoccupied organization may be a significant risk factor predisposing these individuals to problems in coping with trauma.

Considerable research has been done on the relationship between attachment and psychopathology. Individuals classified as preoccupied report higher levels of symptoms than those classified as either dismissing or secure (Dozier, 1990). Adults who are rated as dismissing tend to under-report symptomatology most likely on account of a defensive exclusion of distress in anticipation of their needs not being attended to. It has been hypothesized that preoccupied individuals, who use hyper-activating strategies, are more likely to experience disorders such as depression and anxiety in which distress is felt more acutely rather than being defended against. Dismissing individuals with a tendency toward de-activating strategies are more likely to be diagnosed with disorders in which symptoms are experienced as external to the self, such as substance abuse and eating disorders (Dozier & Tyrrell, 1998). For the most part, research has supported this

hypothesis (Allen, Hauser, and Borman-Spurell, 1996; Cole-Detke & Kobak, 1996; Patrick et al., 1994; Rosenstein & Horowitz, 1996).

Relevant research on change in attachment and reflective functioning

Despite the links between attachment classification and borderline conditions, there have been few systematic attempts to explore the ways in which attachment organization may affect the course of treatment or aspects of the therapeutic relationship with these patients. One exception is Fonagy and colleagues (Fonagy et al., 1995; Fonagy et al., 1996) who found that of 35 non psychotic patients all of whom were judged to be insecure at admission, 14 (or 40 percent) showed a shift to secure attachment status after one year of psychodynamically- oriented inpatient psychotherapy. At discharge these patients tended to depict their parents in less bland and idealized ways and showed a diminution in pervasive blocks in memory on the AAI subscales.

In a study conducted by Fonagy and colleagues (1995) in which the AAI was administered to a sample of non-psychotic inpatients, about 40% of which met DSMIII-R criteria for borderline personality disorder, the AAI classifications did not distinguish patients with borderline personality disorder from those with other personality disorders. Instead, the borderline patients' attachment interviews were notable for a higher prevalence of reported sexual abuse, higher ratings for a lack of resolution of abuse (but not loss) scale, and significantly lower ratings on their measure of reflective functioning. Fonagy and colleagues (1995) have hypothesized that individuals who experience severe maltreatment in childhood tend to respond by disavowing the mental contents of the minds of their care-takers in order to avoid having to think about others' wish to harm them. As a result, these individuals lag in their development of the reflective self-

function, and are thus more likely to remain unresolved with respect to their abuse histories (Fonagy, 1991).

Implications of Attachment, Object Relations, and Defense for the Proposed Study

In this study intrapsychic change is being examined from multiple vantage points using measures derived from attachment theory, object relations theory, and ego psychology. Attachment theory and object relations theory share an emphasis on the central role of early parent-infant interactions in shaping personality development. Both theories have contributed significantly to an understanding of how recurrent interactions with caregivers are organized into mental representations that serve as heuristic guides for subsequent relationships. While these two theories share common roots, they have, however, evolved in epistemologically distinct ways (Fonagy, 1999). Internal working models of attachment and psychoanalytic concepts of mental representations, while analogous, are different in important respects (Levy & Blatt, 1999).

A primary distinction between the two theories is that attachment theorists have tended to focus exclusively on the role of an infant's actual experiences with primary caretakers in the formation of internal working models of attachment whereas object relational theorists incorporate the role of fantasy and libidinal drives in shaping an individual's burgeoning representations of self and other. Although trained as a psychoanalyst, Bowlby took issue with the extent to which a child's drives, fantasy life, and intrapsychic conflict were being emphasized over the child's actual experiences with caregivers. He conceived of internal working models of attachment as accumulated, generalized interactions with significant others that serve to regulate, interpret, and

predict both the attachment figure's and the self's attachment related behavior, thoughts, and feelings (Bretherton and Munholland , 1999).

Bowlby's exclusion of the role of fantasy and drives had implications for the origins of defense within an attachment model. In contrast to the psychoanalytic notion of defense as arising from intrapsychic conflict, from an attachment perspective, defensive processes develop in response to early social experiences. Infants learn to shape their behavior, tailor their beliefs, and to distort their internal experience in such a way as to maximize a caregiver's physical and emotional availability. Individuals develop both conscious and unconscious assumptions about themselves and others, which outside of the original conditions, are distorted in the context of new relationships.

The construct of internal working models of attachment is by definition narrower than the psychoanalytic construct of self and other representations in that the former are based exclusively on attachment related experiences. Furthermore, from an attachment perspective, models of self and other develop in tandem. They are, according to Bretherton and Munholland, "ipso facto complementary" (p. 91). A working model of the self as lovable, valuable, and competent, for example, develops side by side with a model of attachment figures as emotionally responsive and encouraging of exploration. Likewise, a working model of the self as unlovable and ineffective is linked to a working model of others as rejecting and either discouraging and/or interfering with exploration. This is in contrast to the object relational construct of representations in which models of self and other, while related, develop independent of each other.

Another major difference between the attachment construct of internal working models and psychoanalytic theories of representation is that the former lacks a

developmental basis. From an attachment perspective, the presence of a secure attachment to primary caregivers predisposes a child toward more differentiated, coherent, and flexible self and other representations. In contrast, object representations, construed through the lens of object relations theory, are believed to proceed through a developmental sequence (Blatt, 1974; Diamond & Blatt, 1994; Levy & Blatt, 1999). According to this model, modes of representation become increasingly complex, abstract, symbolic, and verbally mediated over time. The representations themselves begin as global, diffuse, fragmentary, and inflexible and become increasingly differentiated, complex, flexible, and hierarchically organized (Blatt, 1974; Diamond & Blatt, 1994; Levy & Blatt, 1999).

Mental representations of self and other while derived largely from early interactions with significant others, are influenced by the individual's psychosocial stage and accompanying intrapsychic conflicts, fantasies, and wishes. The resulting "representational world is multilayered, with conscious aspects that are relatively accurate depictions of consensual reality, and unconscious aspects that reflect fundamental needs or fantasies and primitive idiosyncratic constructions of self and others, the latter being predominant in severe psychopathology" (Diamond & Blatt, 1994, p. 73). As noted by Levy and Blatt (1999), attachment theorists and researchers have tended to emphasize content (positive vs. negative) over structure (i.e., degree of differentiation and integration), thereby disregarding what many analysts regard as a critical component of personality. Individuals classified as having the same attachment organization may vary in the degree of differentiation, integration, and internalization of their self and other object representations, though this would not be distinguished in the

present AAI coding scheme (Diamond & Blatt, 1994; Levy, Blatt, & Shaver, 1998; Levy & Blatt, 1999).

Although psychoanalysis and attachment theory and research evolved largely independent of one another, in more recent years, a number of trends have contributed to a rapprochement between the two schools of thought. Within psychoanalysis, there has been a shift from an almost exclusive focus on drive and unconscious fantasy to a greater appreciation of the role of early experience in later object relations (Lichtenberg, 1999; Slade, 1999). In addition, as the efficacy of psychoanalysis has come under scrutiny by the health care industry and by competing orientations, greater efforts were made to document the effectiveness of psychoanalysis and to elucidate how such change occurs.

Contemporaneously, developmental researchers began extending their studies of mother-infant interactions to include studies of individuals' internal working models of attachment across the life span. Attachment theorists began studying the relevance of attachment theory to the etiology and treatment of more severe psychopathology. Main's discovery of patterns of mental representations that parallel infants' patterns of behavior in the strange situation peaked the interest of many psychoanalysts. As a result of all of these factors, there has been a resurgence of interest in the integration of attachment theory and psychoanalysis and research into the ways in which attachment theory can inform the psychoanalysis process.

Recognition of the similarities between internal working models of attachment and object relational constructs of self and object representations, have resulted in numerous investigations of their relationship (Diamond & Blatt, 1994). Studies have found that security of attachment is strongly related to the quality and developmental level of object

relations (Levine, Tuber, Slade, & Ward, 1991; Levy, Blatt, & Shaver, 1998; Rothstein, 1997; Sack, Sperling, Fagen, & Foelsch, 1996). In a study of young adults' attachment styles and the structure and quality of their representations of their parents, Levy, Blatt & Shaver (1998) found that the adults who rated themselves as secure on a self-report attachment questionnaire described their parents in ways that were more differentiated and organized at a higher conceptual level than the descriptions of subjects who rated themselves as insecurely attached. The parental descriptions of the adults who rated themselves as insecurely attached were also distinguished on the basis of their being more malevolent and punitive.

Individual attachment patterns have been increasingly noted to involve defensive processes in that they reflect efforts to minimize anxiety associated with threats of losing significant others (Bowlby, 1980, Fonagy, 1999). The presence of defensive processes in attachment behavior has been documented in empirical studies. Infants classified as avoidant in the Strange Situation procedure exhibit little emotion and have been described as affect "minimizers" (Cassidy, 1994). Although physiological studies of these infants have demonstrated that following separations from their mothers during the Strange Situation procedure, their heart rates are as elevated as those in the secure group, they appear unflustered and show little if any signs of distress (Sroufe & Waters, 1977). According to Main (1995b), they engage in an organized shift of attention away from the source of distress, (i.e., in this case, the mother and her absence) and toward the inanimate environment (in this case, the toys). Upon the mother's return, rather than seeking her out for comfort, they will often ignore her. Main surmises that these infants are not only

inhibiting attachment behaviors, but also repressing or deactivating anger toward their mothers.

Conversely, infants classified as ambivalent in the Strange Situation have been characterized as affect “maximizers” (Cassidy, 1994). They appear quite distressed during the separation phase and then rather than settling down upon mother’s return, their affect is heightened. In contrast to the avoidant group, the ambivalent infants seem to have a diminished capacity for defending against or regulating emotion. It has been hypothesized that these infants maximize their display of emotion and attachment related behaviors as a way of seizing the attention of unpredictable, inconsistent caregivers (Main, 1995a).

Consistent with the above infant research, there is some evidence to suggest that adults with different attachment statuses show propensities for different defense mechanisms. In a study of primiparous women conducted by Slade (1993), women rated as dismissing on the AAI had Rorschach protocols characterized by higher indications of repression, less anxiety, and more ideational defenses. In addition, they had a higher frequency of thought disordered responses than the other groups. Slade concluded that these lapses in cognitive organization, indicative of breaks in reality testing, were likely on account of the interference of unintegrated, dissociated negative affects. In contrast, the women rated as preoccupied manifested higher levels of anxiety than either of the other groups and a lower frequency of ideational defenses. On the Rorschach they gave evidence of being overwhelmed by affect. Consistent with attachment theory, the women rated as secure expressed minimal anxiety and were better able to express and integrate affect. Although studies such as this one suggest that different states of mind with

respect to attachment may be associated with different defense mechanisms, future studies are needed to clarify the precise nature of the relationship between attachment classifications and defensive processes.

As should be clear from the above review, an integration of concepts from object relations and attachment theories offers a more complex perspective on the inter-relationships among interpersonal, affective and cognitive dimensions in personality development than either one independently (Blatt, 1995; Blatt, Auerbach, & Levy, 1997; Diamond & Blatt, 1994). Despite the interconnectedness of attachment, object representations, and defense, these constructs have not yet been looked at together in relationship to one another. The proposed study aims to examine the relationships between these constructs as they contribute to change in the psychotherapy process.

CHAPTER THREE

METHODOLOGY

Procedure

The present study is designed to be a preliminary investigation of the effectiveness of Transference Focused Psychotherapy in bringing about changes in borderline patients' internal character structure, specifically their mental representations of attachment, their object relations, their characteristic defensive styles, and their capacity for reflection about themselves and others. In addition, this study examines the extent to which patients also experience a reduction in reported affective and behavioral symptomatology.

This study was conducted as part of an NIMH-funded study (Treatment Development for Borderline Personality Disorder Project; Principal Investigator: John F. Clarkin; grant no: MH-53705-02) being conducted at the Personality Disorders Institute at New York Presbyterian Hospital-Weill Medical College of Cornell University, Westchester Division in White Plains. The primary aim of the larger study was to demonstrate that a group of experienced clinicians could be trained to both reliably and competently conduct a manualized psychodynamic psychotherapy entitled Transference Focused Psychotherapy (TFP) with a heterogeneous group of borderline patients. A secondary aim of the larger project was to gain preliminary data on the effectiveness of TFP in reducing the parasuicidal and impulsive behaviors of this group as well as contributing to intrapsychic structural change.

To facilitate an in depth, case-focused examination of clinical process and outcome, two subjects, representative of the larger sample of 20 women, were chosen for this study. Both met stringent criteria for Borderline Personality Disorder and Borderline Personality Organization but were assessed as having different states of mind with respect to attachment at the beginning of treatment. One was rated as ‘unresolved’ with respect to trauma and given a secondary classification of ‘preoccupied’ and the other was rated as ‘dismissing.’ The fact that these patients were found to have qualitatively different states of mind with respect to attachment at the beginning of treatment presents an opportunity to examine how patients with different statuses of attachment relate to the therapist, navigate the treatment process, and change over time.

The patients in the study were treated twice a week for fifty-minute sessions by the same clinician for one year and assessed throughout the treatment. At the end of the year, the patients’ states of mind with respect to attachment were re-assessed using the Adult Attachment Interview (AAI). The patients’ capacities for reflective function as reflected in their Adult Attachment Interviews were assessed at four months and at one year using the Reflective Function Scale. Also at four months and at one year, patients were given the Object Representation Inventory (ORI), in order to measure change in their level of object representations after treatment. At four-month intervals, transcriptions of randomly selected psychotherapy sessions were coded with the Defense Mechanism Rating Scales to assess the patients’ use of defense mechanisms throughout the treatment year.

In addition, assessments of the patients’ symptomatology occurred at four-month intervals using self-report measures. These included: the Beck Depression Inventory

(BDI), the Brief Symptom Index (BSI), and the State-Trait Anger Expression Inventory (STAXI). In addition, the patients filled out diary cards in which they tracked symptomatic behavior (including daily alcohol consumption, medications taken, illicit drugs used, instances of parasuicide, and misery), and rated their suicidal ideation and urges to self-harm and quit treatment. Finally, each of the factors hypothesized by Otto Kernberg to discriminate between levels of personality organization (i.e., the use primitive psychological defenses, identity diffusion, and reality testing) was assessed with the Inventory of Personality Organization (IPO) at the beginning and end of the treatment year.

Finally, at the end of the year, the patients and therapist were interviewed with the Patient-Therapist Adult Attachment Interview (PT-AAI), an interview adapted from the Adult Attachment Interview that asks each participant to reflect upon his or her experience of the other during the treatment process. The interviews assess patient and therapist states of mind with regard to attachment within the context of the therapeutic rather than the parent-child relationship. For a summary of the measures used in this study, please refer to Table 1.

Table 1**SUMMARY OF MEASURES:**

<u>Intrapsychic Change:</u>	<u>Initial</u>	<u>4 mos</u>	<u>8 mos</u>	<u>12 mos</u>
Adult Attachment Interview (AAI)		X		X
Object Representation Inventory (ORI)		X		X
Reflective Function Scale (RFS)		X		X
Defense Mechanism Rating Scale (DMRS)	X	X	X	X
Patient-Therapist Adult Attachment Interview (PTAAI)				X
<u>Behavioral and Symptom Change:</u>	<u>Initial</u>	<u>4 mos</u>	<u>8 mos</u>	<u>12 mos</u>
Daily Diary Cards	-----DAILY-----			
Beck Depression Inventory (BDI)	X	X	X	X
Brief Symptom Inventory (BSI)	X	X	X	X
State-Trait Anger Inventory (STAXI)	X			X
Inventory of Personality Organization (IPO)	X			X

Subjects

In order to be admitted into the study, subjects had to have met five out of nine criteria for Borderline Personality Disorder as assessed with the SCID-II and did not meet DSM-IV criteria for schizophrenia, bipolar disorder, substance dependence, or mental retardation¹. In addition, subjects had to have engaged in at least two incidents of parasuicidal behavior during the past five years, with at least one of these occurring within the eight weeks prior to admission to the study. Subjects were not excluded on the basis of being on anti-depressants or other psychotropic medications. A psychiatrist affiliated with the study monitored these patients during the tenure of their participation. These psychopharmacological sessions were of twenty minutes duration and usually took place once every eight weeks.

The two patients selected for this study, heretofore referred to as Alex and Jen, were chosen on the basis of several factors. First, they were representative of the larger sample and were both in treatment with the same clinician. Second, they both completed all of the assessments and were compliant in filling out the weekly diary cards. Third, at four months into treatment the two patients were found to have categorically different states of mind with respect to attachment as measured with the Adult Attachment Interview and its accompanying scoring system.

Both are Caucasian women, diagnosed with Borderline Personality Disorder and Borderline Organization. Alex is a married woman in her thirties, who was unemployed at the beginning of the study. During the treatment year, she obtained a position in the

¹ All subjects were pre-screened with a clinical interview and two semi-structured interviews (i.e., the Schizophrenia and Substance Abuse subsections of the NIMH Diagnostic Interview Schedule and the Parasuicide History Interview).

publishing industry, consistent with her goal of working towards a career as a screenplay writer. In conjunction with her borderline pathology, Alex was assessed as having prominent narcissistic and antisocial features. She had had several trials on various medications prior to her involvement in the study, but was not on any psychotropic medications during the treatment year. She was initially classified on the Adult Attachment Interview as being “unresolved for trauma and loss,” a classification indicative of disorientation and/or disorganization in reasoning, discourse, or behavior around discussions of loss and trauma. She was given a secondary classification of “preoccupied,” which is indicative of an angry, conflictual, and enmeshed attitude vis-a-vis attachment figures and experiences.

The second subject Jen, also in her thirties, married during the course of the study and was employed in a public relations business. She had been previously diagnosed with Major Depression and had a history of alcohol abuse and an eating disorder, neither of which was active at the time of admission. She was referred to the research project after a brief hospitalization, precipitated by a non-lethal overdose. This suicide attempt appeared to others, including her therapist, to come out of the blue because she had not formerly expressed any suicidal ideation. She was maintained on Venlafaxine (100mg po tid) and Trazodone (50mg po qPM) throughout the treatment. Jen was initially classified on the AAI as “dismissing,” on the basis of her manifesting active derogation and a devaluing attitude toward attachment relationships and their impact on her.

The clinician in this study is a Caucasian male psychiatrist with over ten years of experience as a therapist and researcher in the Cornell Borderline Psychotherapy Research Project. He participated in a weekly supervision group conducted by Dr. Otto Kernberg.

The therapist was judged in independent supervisory ratings to be both competent in conducting the treatment and adherent to the TFP manual.

Measures:

The Adult Attachment Interview (AAI):

The Adult Attachment Interview (George, Kaplan, & Main, 1985) is a semi-structured, clinical interview designed to evoke thoughts, feelings, and memories about early attachment experiences in order to elucidate individuals internal working models of attachment. The interview, consisting of 17 questions asked in set order with standardized probes, elicits general descriptions of subjects' early relationships with primary caretakers, specific memories of attachment related experiences, and reflections on how the past has influenced their present.

After being asked to orient the interviewer to the composition of their family of origin, subjects are asked to describe their childhood relationship with their parents (or primary caretakers). They are then asked to choose five words that reflect their early relationships with each parent and to support these descriptions with specific memories. The next set of questions focus on the subjects' memories of being in physical and emotional distress and how they remember their parents responding to them (e.g., during times when they were upset, injured, and sick as children). Later in the interview, they are 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 subjects reflect on their parents' styles of parenting and that they consider how their childhood experiences with their parents have

influenced who they have become. The structure and content of this interview has been described as "surprising the unconscious" (George et al, 1985), and allowing numerous opportunities for the interviewee to elaborate upon, contradict, or fail to support previous statements.

The AAI is transcribed verbatim according to strict transcription rules. Trained coders assess the nature of the subjects' early experiences with attachment figures and their current state of mind with respect to attachment (Main & Goldwyn, 1998). Raters use three sets of sub-scales. The first set of scales are based on the raters' inferences about the individual's experiences of his or her parents in childhood (e.g., the extent to which each parent appears to have been loving, rejecting, neglecting, involving, and role reversing). The second set of scales consist of ratings of the individual's style of discourse (e.g., coherence of transcript, idealization, insistence on lack of recall, active anger, lack of resolution of abuse and/ or trauma, and overall coherence of thought). The third set of ratings includes assessments of the individual's overall state of mind with respect to attachment. Interviews are ultimately assigned one of four 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. Recently a fifth category, cannot classify, has been added for those interviews which do not fall into one of the pre-existing classifications.

What follows is a brief description of each of the attachment categories. [For more extensive descriptions, see Main (1996).] Individuals rated as secure/ free-autonomous (F) typically describe both positive and negative aspects of their relationships with their

parents in a coherent, internally consistent manner. They support their descriptions of these relationships with specific memories. Their interviews suggest that they are thinking things through in a fresh and undefensive manner and that they have integrated their childhood experiences in a way that allows them to be autonomous in their relationships with their parents as adults. While these individuals did not necessarily have nurturing nor supportive parenting experiences, they can discuss and evaluate the impact of these experiences on their development in a clear and succinct manner.

Individuals who are classified as dismissive (D) tend to minimize the significance of attachment figures in their lives and to deny the impact of these relationships on their development. In contrast to individuals rated as secure, those rated as dismissive have evidently not fully integrated their negative memories of their childhoods into their overall mental models of these relationships. Their interviews are notable for inconsistencies, contradictions, and an overall constriction of affect. Occasionally, these individuals will describe their parents in glowing, idealized terms, but they will be unable to back up their descriptions with convincing examples. Sometimes, they simply contend that they have no memories of their childhoods and can not give any specific examples of what they mean.

Adults who are classified as preoccupied (E) discuss their attachment related experiences in a more incoherent, entangled manner, which gives the impression of their being emotionally flooded (or overwhelmed) by their past experiences. The interviews reveal a confused, angry, or passive, preoccupation with parental relationships and attachment experiences. These individuals appear to get lost in the experiences about which they are speaking, which sometimes involves their reverting to childlike speech,

confusing the past with the present, or addressing their parents directly as though they were present. It seems difficult for those who are rated as preoccupied to step outside these relationships and evaluate them more objectively.

Adults who are judged to be unresolved (U) with respect to attachment show lapses in monitoring of reasoning or discourse, specifically during the discussion of traumatic events, such as the death of a significant person in their life or experiences of physical or sexual abuse. Examples of such breaks in monitoring of reasoning include: subtle indications that a deceased person is believed to be living; confusion around the circumstances of a person's death; extreme detail in talking about experiences of loss or abuse; sudden eulogistic speech uncharacteristic of the rest of the interview. At times during the discussion of the traumatic episode, these individuals appear to get lost in thought during prolonged silences and then forget what they were talking about. Aside from these isolated breaks in discourse, these adults typically exhibit a predominant attachment strategy and are thus also given one of the three main classifications described above.

Interviews which do not fall into one of the above three categories are given a cannot classify rating (CC). These interviews are characterized by a global breakdown in discourse and inconsistent uses of attachment strategies. Sometimes the breakdown in discourse described above as characteristic of the unresolved attachment status is in cannot classify interviews not isolated to the discussion of trauma but is pervasive throughout the transcript. Alternatively, these interviews contain strong indicators of contrasting states of mind with respect to attachment. While the majority of individuals from normative samples seem to fall into one of the primary attachment classifications, it

has been hypothesized that the attachment styles of adults with more serious psychopathology and impaired object relations might not be captured by the existing system.

Interviews are also assigned sub-classifications within each of the primary attachment classifications. For example, within the preoccupied classification (E), there are three subtypes. Interviews are assigned a classification of E1 when the subject exhibits a passive stance in describing childhood experiences. Interviews are assigned a classification of E2 when they are noted to have current anger regarding their early experiences with caregivers. A classification of E3 is given to those interviews in which the subject manifests a preoccupation with traumatic events from childhood.

The AAI has been found to have both predictive and discriminant validity (van IJzendoorn, 1995). The AAI classifications of parents predict their infants' classifications as measured through the Strange Situation Procedure. Psychometric studies have repeatedly demonstrated that the AAI ratings are unrelated to intelligence, social desirability, general personality measures, memory, and verbal fluency, and are stable across interviewers (Bakermans & van IJzendoorn, 1993; Main, 1996; Sagi et al., 1994; van IJzendoorn, 1995). Studies done in several different countries have found that the three primary classifications are stable over a period ranging from one to fifteen months (van IJzendoorn, 1995).

In the present study interviews were scored independently by two raters trained by Main and Hesse and judged to be reliable. These raters were trained in the most recent five category attachment system which includes the Cannot Classify category. One rater was given the four-month interviews and the other scored the twelve-month interviews.

Both were blind to all identifying characteristics of the subjects, including their psychiatric status and diagnosis and to the nature of the study.

Reflective Function (RF):

The Reflective Function Scale is a system developed by Peter Fonagy and colleagues as part of the London Parent-Child Project (Fonagy, Moran, Steele, Steele, & Higgett, 1991) to assess individuals' capacities to recognize and understand the mental processes of both self and others. Based in part on one of Main's sub-scales of attachment, metacognitive monitoring, it was initially designed to be applied to the Adult Attachment Interview. More recently, it has been applied to other narratives as well, including psychotherapy sessions (Bernbach, 2001) and the Patient-Therapist Adult Attachment Interview (Diamond, Clarkin, Levine, Levy, Foelsch, & Yeomans, 1999).

The term reflective function (RF), as defined by the authors of the manual, refers to the psychological processes underlying the capacity to mentalize (Fonagy, Target, Steele, & Steele (1998). Reflective functioning or mentalization is the expression of this psychological capacity (Fonagy & Target, 1996; Target & Fonagy, 1996). The manual includes operationalized definitions of individual differences in adults' metacognitive capacities.

The first step in the coding process involves identifying passages for scoring. Two types of passages are rated: those offered in response to demand questions, in which speakers are prompted to demonstrate their capacity for reflective functioning, and those offered in response to permit questions, in which speakers spontaneously demonstrate reflective functioning without being directly queried. The former type of passage is always rated while the latter is not. These individual passages are then considered in the

context of the whole interview in order to assign the interview an overall RF rating. The Reflective Function Scale ranges from negative RF (-1), characterized by overly concrete discourse, a lack of mentalization or gross distortions of the mental states of others, to exceptional RF (9), characterized by complex, elaborate, and/or original reasoning about mental states. An overview of the scale points is presented in Appendix A.

Preliminary studies support the reliability and predictive and discriminant validity of the Reflective-Functioning scoring system (Bernbach, 2001; Fonagy et al., 1996; Fonagy et al., 1998; Levinson & Fonagy, 1998). In a study of one hundred pregnant women and their spouses, Fonagy and colleagues (Fonagy, Steele, & Steele, 1991) reported that inter-rater reliability for the mothers' RF scores was .67 and for the fathers' RF scores was .83. RF was found to be unrelated to a variety of demographic characteristics of the sample, including level of education, IQ, social class, socio-economic group, age, and marital status. In addition, RF ratings were found to be unrelated to other measures of personality and the quality of the parent-child relationship. In subsequent studies, the RF scale has been found to discriminate clinical from non-clinical populations (Fonagy et al., 1996; Levinson & Fonagy, 1998). Patients with borderline pathology have repeatedly been found to have low levels of reflective function (Fonagy et al., 1996).

In this study, the Reflective Function Scale was applied to the Adult Attachment Interviews by raters, trained in the application of the Reflective Function Manual, version 4.1 (Fonagy et al., 1997), by the authors. Separate raters scored transcribed versions of the four month and one year Adult Attachment Interviews for the level of Reflective Function (RF) present in the subjects' discourse. The raters were blind to the patients' diagnoses and to the nature of the study.

The Object Representation Inventory (ORI):

The ORI (Blatt, Chevron, Quinlan, Schaffer, & Wein, 1992) is an open-ended projective technique which elicits narrative descriptions of self and significant others. In this study, subjects were asked to describe their mother, father, self, and therapist. Their descriptions were followed by a brief inquiry. The ORIs were audiotaped, transcribed verbatim, and scored using the **Differentiation-Relatedness Scale of Self and Object Representations** (Diamond, Blatt, Stayner, and Kaslow, 1994). This ten point scale, found in Appendix B, measures the degree of self-other differentiation and relatedness. Scale points 1 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, including an increased tolerance of ambiguity; scale points 8 and 9 indicate a sense of self and others as empathically interrelated in reciprocal mutually enriching interactions; and scale point 10 is indicative of a reflective sense that descriptions represent continually unfolding constructions of self and other (Diamond, Kaslow, Coonerty, & Blatt, 1990).

Previous research with both clinical and non-clinical samples supports the construct and predictive validity of this instrument (Blatt, Stayner, Auerbach & Behrends, 1996; Levy, Blatt, & Shaver, 1998; Stayner, 1994) as well as its independence from age, intelligence, length of hospitalization, and age of onset of psychiatric disorder (Stayner, 1994). In this study, independent raters achieved an intraclass correlation

coefficient (ICC) = .96. Once reliability had been established, discrepancies between the two coders were resolved by consensus.

Defense Mechanism Rating Scales (DMRS)

The Defense Mechanism Rating Scale (DMRS; Perry, 1990) is a system for assessing the use of defense mechanisms based on clinical interviews or psychotherapy session material. The DMRS was chosen for this study because it has been found to be most appropriate tool for post hoc assessment of defenses using audio- and video-taped and transcribed material (Baerson, 1998). It consists of 27 defense mechanisms that have been classified into seven major levels of defense, organized from least to most mature (See Appendix C). The manual provides a definition of each defense, an explanation of the functions of each defense, information on how to discriminate it from other defenses, and examples of its application on a three-point scale. Each scale point is anchored with specific examples of the probable use of the defense and the definite use of the defense. A rater identifies each use of a defense as it occurs in the session by bracketing the section of text in which it is judged to be operating. Instances of each defense are tallied and then divided by the total instances of all defenses to yield a percentage. The resulting profile yields percentages of defensive functioning due to each defense. In addition, each defense is assigned a weight according to its place in the overall 7-point hierarchy of defenses. An overall defensive functioning score is derived by dividing the total number of defenses by the sum of the defenses multiplied by the weight factor. Thus, higher overall defensive functioning scores signify the use of more mature defenses and lower scores reflect the use of lower level defenses (Perry, Kardos, & Pagano, 1991).

In this study, every four months, one psychotherapy session was transcribed and subjected to the above analyses. A trained coder, blind to the order of the sessions and any identifying characteristics of the patients, rated each session using only the transcripts.

Daily Diary Cards

Daily Diary Cards are a tool developed by Linehan and colleagues (Linehan, 1983) for helping patients track instances of parasuicide, alcohol consumption, illicit drugs used, prescription and non-prescription drugs used, other risk or problem behaviors, and daily misery as well as urges to engage in the above behaviors and to drop out of treatment. In this study, patients were asked to fill out the diary cards on a daily basis throughout the one-year treatment and to return them to their therapist once each week. The patients' responses over the course of the treatment year will be represented graphically in order to view the trajectories of their self-destructive urges and behavior over the treatment year.

Beck Depression Inventory (BDI)

The BDI (Beck, Ward, Mendelsohn, Mock, & Einbaugh, 1960; Beck, Steer, & Garbin, 1988) is a widely used, well validated questionnaire for measuring the severity of depressive symptoms in both psychiatric and normal populations. Subjects are asked to rate the extent to which they experience symptoms of depression. BDI scores ranging from 0-13 represent "Minimal Depression." Total scores between 14 to 19 reflect "Mild Depression." Total scores between 20 to 28 reflect "Moderate Depression." Total scores between 29 to 63 reflect "Severe Depression." Beck and colleagues (Beck, Steer & Brown, 1996) have demonstrated that the measure possesses adequate reliability and validity for clinical purposes.

Brief Symptom Inventory (BSI)

The BSI (Derogatis, 1993), the short form of the Symptom Checklist-90-R (SCL-90-R), is a 53 item questionnaire which assessed symptom distress. Subjects rate how distressing each symptom is on a scale from 0 (not at all) to 4 (extremely). The items are clustered into nine dimensions: Depression, Obsessive-Compulsive, Anxiety, Interpersonal Sensitivity, Psychoticism, Phobic Anxiety, Paranoid Ideation, Hostility, and Somatization. The score for each dimension is the average of items in that domain. The BSI yields three global indices of distress: The Global Severity Index, derived from the overall average of reported symptomatology; the Positive Symptom Total, which is the number of symptoms rated one or higher; and the Positive Symptom Distress Index, which is the total divided by the Positive Symptom Total.

State-Trait Anger Inventory (STAXI)

The STAXI (Spielberger, Jacobs, Russell, & Crane, 1983) is a 44-item self-report questionnaire designed to assess the experience and expression of anger. The experience of anger is divided into two types: state anger and trait anger. State anger is a subjective experience that varies in intensity from mild annoyance to intense rage and is accompanied by muscular tension and arousal of the autonomic nervous system. According to Spielberger, Jacobs, Russell, & Crane (1983) “over time, the intensity of state anger varies as a function of perceived injustice, attack or unfair treatment by others, and frustration resulting from barriers to goal-directed behavior” (p.1). In contrast, trait anger is conceptualized as an underlying disposition to perceive situations as irritating or frustrating and an accompanying tendency to react in such situations with heightened state anger. Individuals who rate highly on trait anger experience state anger more

frequently and with greater intensity than those who rate low on trait anger. In this system, the expression of anger is conceptualized as having three major components: anger-out (the expression of anger towards others or objects); anger-in (anger that is suppressed or directed inward), and anger-control (attempts to control the expression of anger).

The STAXI yields six scales, including: State Anger (S-Anger); Trait Anger (T-Anger); Anger-in (AX/In); Anger-out (AX/Out); Anger Control (AX/Con); and Anger Expression (AX/EX). Within the Trait Anger scale, there are two subscales: Angry Temperament (T-Anger/T) and Angry Reaction (T-Anger/R). Subjects rate themselves on four-point scales that assess either the intensity or the frequency of their anger or the frequency that their anger is experienced, expressed, suppressed or controlled. Raw scores are converted to percentile ranks and T scores. The Trait Anger scales have been found to have strong convergent validity with other measures of hostility. The STAXI has been used extensively in clinical and health psychology research.

Inventory of Personality Organization (IPO)

The IPO (Kernberg & Clarkin, 1995; Lenzenweger, Clarkin, Kernberg, & Foelsch, in press) is a 155-item self-report questionnaire that operationalizes the principle dimensions of personality organization described by Kernberg: identity diffusion, primitive psychological defenses, and reality testing. The primary clinical scales include 57 items². The scale utilizes a five-point Likert-type format. The internal consistency and test-retest reliability have been demonstrated in both non-clinical and clinical samples. Early studies of criterion validity, derived from comparisons with a personality

disordered clinical sample, have provided support for the measure (Foelsch, Clarkin, Kernberg, Somavia, Normandin, & Lenzenweger, 2000). Construct validity of each of the primary scales as well as the instrument as a whole has been demonstrated in studies with non-clinical samples (Lenzenweger et al., in press).

The Patient Therapist Adult Attachment Interview (PT-AAI)

The PT-AAI (Diamond, Clarkin, Levy, Levine & Kotov, 1999) consists of 28 questions, adapted from the adult attachment interview, to assess states of mind with respect to attachment in the context of the therapeutic dyad. In separate interviews, the patient and therapist are asked to reflect on the history of his or her relationship with the other in general and then to choose five words to describe the relationship, supporting these descriptions with specific examples or incidents from the treatment. Speakers are also asked about memories of being upset with the other and how the other responded, experiences of separation in the context of the treatment, feelings of being rejected by the other, and about whether the individual has ever felt that the continuity of the treatment was threatened. In addition, both patient and therapist are asked why they think the other acted the way he or she did during the course of treatment, and are asked to describe and evaluate the effects of the psychotherapy.

Although a scoring system has recently been developed for the purpose of assessing states of mind with regard to attachment within the context of the therapeutic relationship, for the purpose of this research, data from these interviews will be used qualitatively to add to our understanding of how the course of treatment was influenced

² The IPO includes several supplementary scales of interpersonal phenomena that are not included in this study.

by the patients' attachment and how the therapeutic process contributed to the types of changes which were observed to occur in the patients.

Research Design & Data Analysis

The research design of this dissertation involves research-informed case study methodology (Barlow & Hersen, 1984; Hilliard, 1993; Soldz, 1990). The case study has long played a central role in both the development of theoretical models and in refining clinical theory (Blaustein, 1995; Jones, 1993). In recent years this methodology has been further developed through the use of time-series analyses, i.e., repeated measurement of patients' thoughts, feelings, behavior, symptoms etc. over the course of psychotherapy (Blaustein, 1995; Hilliard, 1993; Jones 1993; Jones, Ghannan, Nigg, & Dyer, 1993; Moras, Telfer & Barlow, 1993). Case focused methodology has been noted to be of greater clinical relevance than many larger scale studies because it allows for an in-depth, nuanced analysis of clinical material.

On the basis of their comprehensive review of research on psychoanalytic process and outcome, Galatzer-Levy, Bachrach, Skolnikoff, and Waldron (2000) conclude, "single-case methods are the most promising line of approach to exploring the efficacy of psychoanalysis" (p.230). Notably, in their review, they carefully distinguish case studies from case reports in that the former, like the present study, employs systematic, rigorous methodology for collecting, analyzing, and reporting data. In this study, two patients were continually assessed throughout one year of Transference Focused Psychotherapy with empirically validated measures.

Case studies are a particularly effective means for studying clinical process and outcome because the gap between research and practice is narrowed (Hayes, 1998). As Kazdin (1998) notes,

Researchers often rigorously investigate psychotherapy but may sacrifice clinical relevance in the populations, therapeutic conditions, and standardization of treatment that research may require. Hence, investigation of psychotherapy often obscures aspects of the phenomena of interest (Strupp & Hadley, 1999), and even under the best conditions, treatment may only be an “analogue” of the clinical situation (p.404).

Consequently, case focused methodology has recently been heralded as a particularly effective and suitable mode for studying psychotherapy process and outcome (Hilliard, 1993; Jones, 1993; Jones et al., 1993; Moras, Telfer & Barlow, 1993). It is for these reasons that this research design was chosen for the present study.

The results of this research will be presented in a case study format³. Changes from the beginning to the end of the treatment year in the subjects' attachment status, level of object representations, level of reflective function, characteristic defense mechanisms, symptoms of psychopathology, and behavioral manifestations of their distress, such as substance use and self injury, will be reported and presented graphically. Qualitative data from the interviews and psychotherapy sessions will be presented to deepen our understanding of the process of intrapsychic and symptomatic change over the course of treatment, and comparisons will be made between subjects. While the generality of the findings is limited on account of the small number of subjects involved, the study is designed to generate hypotheses for future research.

³ Identifying features of the patients' backgrounds have been altered to protect their confidentiality.

HYPOTHESES

- 1) By the end of one year, both patients will have moved toward having more secure/autonomous representations of attachment but are unlikely to be rated secure. The more subtle shifts will be evidenced by an increase in coherence, improved recall, and a decrease in the defensive exclusion of painful memories.

- 2) Shifts toward security in internal working models of attachment will be paralleled by shifts towards higher levels of self-other differentiation and relatedness (ORI), higher levels of reflective functioning, and an increase in their use of higher level defenses (DMRS). By the end of the treatment year, patients will show a greater proclivity towards higher level defenses, such as repression, suppression, humor, sublimation, anticipation, and intellectualization.

- 3) Shifts toward security will be accompanied by a diminution of reported symptomatology (as measured by the BDI, BSI, and Daily Diary self-reports) in the patient initially rated as unresolved/preoccupied. Shifts toward security in the patient initially rated as dismissing will be accompanied by an increase in reported symptomatology as she will be less likely to defensively exclude her experience of distress from awareness.

- 4) After one year of treatment, both patients will show improvements in the three psychostructural characteristics noted by Kernberg and colleagues (Clarkin et al., 1999) to be at the core of Borderline Personality Organization (identity diffusion,

primitive defensive functioning, and reality testing) as measured with the Inventory of Personality Organization questionnaire (IPO).

- 5) Based on Kernberg's theory that patients with borderline pathology have an excess of aggression, it is expected that at the beginning of treatment both patients will rate themselves as high in the trait of anger and that after one year of TFP, will rate themselves lower.

- 6) Initial Attachment classification will be related to the predominant type of defenses used by each of the patients. Specifically, Alex, the patient whose primary attachment status at the first assessment point is unresolved is likely to show indices of dissociation. In addition, given her secondary classification as preoccupied with respect to attachment, it is likely that she will manifest primitive defense mechanisms such as splitting, projection, projective identification, omnipotence, idealization, devaluation, and acting out in early treatment sessions (i.e., within the first four months). Jen, the patient who is assessed as dismissing with respect to attachment will be more likely during the first four months of treatment to use ideational defenses and those characterized by a disavowal of disturbing thoughts, memories, feelings and wishes (such as repression, intellectualization, rationalization and denial).

CHAPTER FOUR

RESULTS

This section will begin with a brief description of the backgrounds of each patient and an overview of their course in treatment, data derived from the patients' Adult Attachment Interviews, the Patient-Therapist Adult Attachment Interviews, and the psychotherapy sessions proper. It will be followed by a presentation of the results, organized by the specific hypotheses presented at the end of the previous chapter.

Patient Background and Course of Treatment

Alex

Alex, a married woman in her mid-thirties, was unemployed at the start of the treatment year. She was referred to the Borderline Psychotherapy Research Project by her former psychiatrist towards whom she had developed an unmanageable transference leading her to call him frequently between sessions, repeatedly threatening to harm herself or commit suicide. Prior to admission into the study, she took a potentially lethal overdose that she subsequently recovered from without marked physical impairment. Once admitted to the study, she attended her sessions regularly, although her course in treatment was quite tumultuous.

The intensity and turbulence that characterized the early phase of Alex's treatment is not surprising given the nature of her early childhood experiences with her parents. Alex was the second child born to parents who repeatedly separated and reunited throughout her childhood. She described them as hippies from the sixties generation and reported that they often experimented with drugs and smoked marijuana in the house. Her older sister died of leukemia two years before Alex was born. Her

parents would often dress her in her sister's clothes and would comment that they believed her to be the reincarnation of her sister's soul. Alex's mother had a chronic degenerative physical illness with an accompanying mood disorder. She often relied on Alex for both physical and emotional care-taking. At the beginning of treatment, Alex described her mother as her best-friend and greatest confidante. She said that growing up she had few friends and spent the majority of her free time with her mother. Her mother appears to have been alternately over-involved and neglectful. She would frequently seek out contact with Alex when she was lonely and climb into bed with her when she was unable to sleep. She would occasionally masturbate in front of her daughter. Furthermore, her mother expected her to clean up after her in the bathroom when she was unwell. Alex characterized her father a passive, irresponsible hippy, who was also an alcoholic. Boundaries were confusing with him as well. She described him as more like a peer than a parent in that he seemed to be dominated by his wife and would occasionally treat Alex more like a substitute spouse than a daughter. Alex felt that he was passive and never stood up to her mother. He would commiserate with Alex about how crazy her mother was acting but did not intervene to protect her in any way. He coped by periodically leaving home for extended periods of time without informing anyone of his whereabouts. Both her parents engaged in behavior that was frightening and hard for her to comprehend. Her mother's illness and medication regimen resulted in her sometimes walking around the house in a dazed stupor, mumbling to herself. After having had several family pets disappear unexpectedly, in her teens Alex witnessed her father breaking the neck of one of their cats.

At the initial assessment, Alex received a primary classification of Unresolved with respect to trauma. Individuals who are rated as Unresolved for trauma manifest cognitive/affective disorganization reflected in a breakdown in coherence of discourse or lapses in the monitoring of reasoning while discussing frightening or abusive experiences involving attachment figures. In Alex's case, her discourse became more disorganized when she spoke of attachment-related traumas such as witnessing her father kill their cat and experiencing sexually inappropriate behavior at the hands of her parents. She appeared unable to complete sentences, showed indices of traumatic memory loss, and fluctuated in her confidence of the veracity of her memories and experiences. For example, asked about memories of sexual abuse, she states,

Well just things like um like I have a memory of, you know, of holding on to my dad's penis (Laughs) like when I was- I don't know how old I was, I just remember, that...Because then when I got um and my mom like you know was like always had the vibrator in her hands (Laughs). I swear to God.

A little further into the interview, the interviewer asks again about her memory of touching her father's penis, and she says,

I don't know where that came from, I just have it (Laughs). I really don't know. I mean I think I must have been pretty young. I mean I don't think he would've. And I don't even remember it as- from what I remember, it wasn't like even at his suggestion, it was at my mother's (Laughs). So I mean it's not his fault...

As is evident in this example, Alex's efforts to describe the event are compromised: her memories of inappropriate sexual conduct blur together; she has trouble completing her thoughts, and she attempts to deny her father's responsibility for the abuse.

In addition to being rated as unresolved for trauma, Alex received a secondary classification of Preoccupied, with specific subtypes of fearfully preoccupied with traumatic events (E3) and angry, conflicted (E2). The E3 classification signifies that

during the AAI Alex evidenced a preoccupation with past traumas such that these experiences appeared to be interfering with her current thought processes and her ability to reflect coherently on her attachment history. References to various traumatic experiences repeatedly intruded into her train of thought. At the time of her initial assessment, at least in the context of the attachment interview, Alex appeared to be overwhelmed and confused by the inappropriate sexualized conduct of her parents as well as by the frightening behavior she witnessed, such as the killing of her cat.

In addition, Alex was given an E2 classification because she spoke of her attachment relationships in a confused, conflicted, and angry manner, suggestive of a present entanglement. Her interview, which was fraught with hostile sarcasm, revealed intense conflict about her role as her mother's care-taker. At times she described it as reflective of their intimacy and at other times recognized it as problematic. She vacillated between blaming herself and blaming her parents for the person she has become. In discussing both past and present experiences, she gave the impression of being encumbered by a preoccupying anger, as indicated in the following passage in which she reflects on her present relationship with her mother:

Like it makes me really angry when she talks about going to support groups for parents of the mentally ill. It just pisses me off. I'm like "You're the last person that should have any sort of support." And even if it's true, I don't like being categorized that way, not by her. Somebody else could, I suppose, but not her... She's so obviously invested in thinking about any problem I have as biological. So she's always calling me up from Boise, Idaho to tell me about some new drug. And I'm just like, "I know you're in Idaho and that just the hotbed for all these kinds of discoveries, but believe me, it's being taken care of."

The coherence of the interview is compromised by oscillating, polarized positive and negative evaluations of her parents, emotions which take her off task, and a loss of distance about her experiences.

Reflecting on his first impression of Alex during the Patient-Therapist Attachment Interview, the therapist recalled that she was “intimidating,” “a hot potato,” someone with whom he had to remain on guard, more so than with most. He noted that with her in particular, the establishment of a solid treatment contract would be essential to the viability of the therapy. Alex was hospitalized briefly three times during the initial phase of treatment for self-destructive behavior and suicidal ideation. During one of these hospitalizations she began an affair with another patient who proposed that they make a murder-suicide pact. When her therapist insisted that she end this dangerous relationship as her continuing it was at odds with her therapeutic goals, the patient informed him that the man with whom she had become involved was now threatening the therapist’s safety.

A large part of the early phase of Alex’s treatment centered around the interpretation of her aggression and sadistic impulses toward the therapist and others. For instance, on one occasion, Alex admitted herself to the emergency room because she was feeling suicidal. While being evaluated, she changed her mind and decided that she did not need to be hospitalized. She called her therapist and threatened to really kill herself if her did not get her released. After being informed by the evaluating resident that she would indeed be hospitalized, Alex, who had cleverly managed to conceal a razor blade, cut both of her wrists while under the observation of a security guard. She later reported this incident to her therapist with glee, thus allowing him to interpret her pleasure in the aggression of her actions. This incident and its resulting analysis appear to have served as a turning point in the treatment in part because it brought Alex’s aggression into the foreground of the treatment.

Soon after, her urges to self-harm and her self-destructive behavior diminished. She began more creatively expressing aspects of her aggression rather than acting them out. For instance, in a session during the second half of the year, she informed her therapist about a screenplay she was writing about a well-intentioned therapist whose very interventions that were meant to help the patient led to her suicide. As is clear from this example, Alex's self-destructive impulses became something that could be put into words and discussed in the therapy rather than enacted outside the therapy. The meaning of her self-destructive impulses was explored in connection with the transference.

Her life outside of treatment became more stable as well. She ceased engaging in sexual relations outside of her marriage. She obtained a job in a publishing firm, an accomplishment consistent with her goal of becoming a screenplay writer. She stopped engaging in self-injurious behavior and was not hospitalized again during the treatment year.

Although the early stages of treatment were quite challenging and at times frightening for the therapist, when interviewed at one year, he described his relationship with the patient as committed, stable, seductive, interesting, and enjoyable. For her part, reflecting on her year in treatment, Alex remarked that at the beginning she was skeptical about the treatment and the therapist's intentions, and that she consequently assumed a self-protective, somewhat withholding stance. She said,

I thought that he didn't really have that much interest in like me or helping me, and that it just had to do with the study. I had the sense that he would almost probably like forget about me in between session. And then of course because I was paranoid about those types of things, I was sort of the worst way that I could be, which is--I mean I wasn't so much dishonest, but I was not as forthcoming. I just tried to be tricky in real lame, sad, borderline ways, because I thought it was somehow defending myself against something, and at the same time, was wasting time of course...And now I feel like there's a mutual respect... and I don't feel

like it's necessary to outsmart him...So I think things have like settled and all the bullshit parts of me seem to have, you know, gone home to rest.

Alex's growing commitment to the therapy manifested in a variety of ways. She consistently came to her appointments on time, altered her work schedule around her sessions, and when it came time to make a decision about whether to continue in treatment past the research year, which necessitated her paying a fee, she was relatively clear about her wish to continue. Asked how she thinks her experiences with her therapist have effected her, she said,

I guess, I feel a little more secure, in general. Just because he's been so kind of reliable- like just sort of as a steadying influence almost. I kind of feel like I survive the unreliable things in day to day life better just because there's something that's sort of steady. And just having one thing even, or another thing because my husband is pretty reliable too, that's kind of safe helps with all the things that aren't safe. I guess the way a home would ideally when you're a kid.

Jen

Jen, a single woman, also in her mid-thirties, had been in therapy for many years primarily with rotating psychiatric residents at a local hospital. She was employed in a public relations firm but expressed great dissatisfaction with her job and was unclear about future career goals. She had a history of substance dependence and an eating disorder, neither of which were active at the time of admission to the study. She was referred to the Borderline Psychotherapy Research Project after she made a suicide attempt that came as a complete surprise to the therapist who had been treating her for about a year. Her therapist at the time, who had understood her as primarily depressed and had not picked up on the extent of her character pathology, felt wary about continuing to treat her and recommended that she begin with a new therapist as part of the research project. Thus, her relationship with the therapist in the project was colored

from the onset by her having felt rejected and abandoned by her former therapist, an experience consistent with her expectations based on her childhood history.

In her initial attachment interview, Jen described the atmosphere in her house growing up as cold and stark:

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...

Jen's description of her mother was consistent with her depiction of the house. She was emotionally cool and distant. Aside from a distant memory of having been rocked to sleep as a baby, Jen did not recall either of her parents being physically affectionate with her or touching her at all, for that matter. Though her mother was at home with her during her childhood, she had few memories of their spending time together. She recalled that she once told her mother that she felt depressed and her mother's response was that children do not get depressed. She described her father, however, as severely depressed. On several occasions, her father insinuated that he planned to kill himself. Jen described feeling responsible in some way for her father's depression, as though if she had been less of a burden, maybe he would not have felt such pressure. Her parents had a highly conflictual marriage. Her father was often enraged and volatile, and while he was never physically assaultive towards anyone in the family, he would occasionally punch his hand through walls and break mirrors. She does not recall his having been physically abusive to either her or her mother, but the threat of violence permeated the household. Jen also recalled numerous experiences of feeling rejected and unimportant, including one in which no one acknowledged her eighth birthday. Even after she brought it to their attention, she recalls that nothing was made of it. She said that when she upset,

she coped by hiding out by herself and that no one seemed to care or notice if she wasn't around.

At the initial assessment, Jen was rated as Dismissing with a specific subtype of devaluing of attachment (D2). Her stance towards her parents vacillated between being directly critical and devaluing and aloof and detached, in both cases with a substantial lack of nuanced memory for affectively charged experiences. She enumerated experiences of having been rejected with little emotional flavor. Similarly, Jen minimized the impact of such experiences on her personality. For example, asked about the impact on her of her father's repeated threats that he would commit suicide, Jen responded,

I'm sure it must [have affected me] but I don't know how really. I mean, I'm sure if, you know, 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.

Her initial interview reveals her effort to keep her memories and associated feelings of difficult experiences at a distance, whether through active derogation or detachment. As is typical for individuals rated as dismissing of attachment, Jen appeared to minimize the importance and value of attachment relationships.

Jen's dismissing attachment style was clearly evident in the way in which she engaged in treatment. She was compliant, came punctually to each of her appointments, but appeared to be going through the motions with little emotional investment. Her therapist described her as sitting rigidly, often gritting her teeth in sessions, such that her body language communicated a defensiveness, "kind of a wall that she didn't want me to get behind." She tended to speak on more superficial levels about the details of her day and resisted her therapist's attempts to get at deeper issues.

Jen's presentation was distinctly colored by her co-morbid depressive disorder, for which she was treated with an anti-depressant as well. Her affect was somewhat muted. She mumbled and spoke softly. As is characteristic of individuals with a dismissing attachment style, Jen worked hard to avoid getting emotionally upset, and when her sadness leaked out, she would become apologetic and try to shift her attention away to something unrelated. She often seemed to be psychically hiding in the therapy much like she did when she was upset as a child and would hide in a closet. In the PT-AAI, her therapist described her as well-behaved, unforthcoming, distant, and guarded, in a way that often resulted in his feeling bored and disengaged. He stated,

I always felt that she was afraid that if I - if she revealed too much that I would either see her as crazy or somehow in the process, she might become crazy. There was just this sense that she was there against her will because she had to be in therapy. She gave the sense that she was being interrogated but giving as little as she could to get through the experience.

Separations from her therapist did not seem to phase her on any manifest level. Asked about separations from her therapist in her PT-AAI, Jen remarked, "I didn't really feel any thing, you know, no problem. You mean when he went away or something like that? Nothing. I didn't mind." Jen's aloof and guarded manner had the effect of making her therapist feel rejected and unimportant much like she had felt as a child. Her therapist recalled his surprise when one day, Jen began her session remarking, "I'm getting married this afternoon." While her therapist had been aware that she was considering marriage, she had not told him that she had either made a decision nor that she had been planning a wedding. It was as though she insured that her therapist would disregard the significance of this occasion much like her parents had dismissed the significance of her eighth birthday.

Although her therapist was intellectually aware of the extent to which Jen was identified with her representation of her parents as cold and rejecting, and as result had a counter-transferential reaction in which he felt dismissed and unimportant as she had as a child, he appears to have had some difficulty stepping outside of this dynamic. In his PT-AAI, he remarks that he became increasingly persistent in his confrontations with her because it became clear to him that she was not as fragile as he had initially thought and that she was in fact quite entrenched in a defensive stance. This intensification of confrontation appears to have both increased Jen's emotional responsiveness and her self-protective defensiveness.

The last two months of the therapy focused to a large extent on whether Jen would continue in treatment past the one year research phase. She had clearly made some significant gains. She had become better able to verbalize her feelings rather than act out in self-injurious ways. She had untangled herself from several co-existing relationships and had gotten married. She also left a job that she had been dissatisfied with, though she was not feeling motivated to search for something better and had chosen for the time being to stay at home and be supported by her husband. Jen adamantly insisted that while she knew it would be a good thing for her to continue in treatment, she did not want to do what it would take to continue, namely to begin working again or to have her husband pay for the treatment. When pressed by her therapist to discuss other factors that might be underlying her decision, Jen was constricted in her exploration, saying things such as "I just don't want to. I could, but I don't want to."

Results

Attachment Status

Hypothesis 1: By the end of one year, both patients will have moved toward having more secure/ autonomous representations of attachment but are unlikely to be rated secure. The more subtle shifts will be evidenced by an increase in coherence, improved recall, and a decrease in the defensive exclusion of painful memories.

As shown in Table 2, by the end of the treatment year, both patients were rated as having shifted from insecure to secure states of mind with respect to attachment. After one year of treatment, Alex was given a primary classification of Secure, F5 subtype and a secondary classification of Unresolved (U). Her F5 classification reflects the fact that she continued to show elements of entanglement with pockets of moderate involved anger, but was generally coherent and collaborative. Her attachment interview at one year demonstrated a growing capacity to evaluate her relationships with her parents with perspective, humor, and candor. At one year, Alex still showed signs of being unresolved for trauma, but the lapses in her discourse were less pronounced and less frequent than at the initial assessment. As displayed in Table 3, Alex's subscale ratings at the end of the year reflect an increase in the coherence of her transcript, a greater capacity for metacognitive monitoring, and a decrease in the disorganization of her speech when speaking of traumatic events, primary factors behind her change to a secure classification.

At the end of one year of treatment, Jen was rated as Secure, F1a subtype, a sub-classification characterized by some setting aside of attachment related memories in the context of a re-evaluation of difficult early experiences. As is the case for individuals rated as fitting the F1a subtype, Jen appears to be making a deliberate effort to shift attention away from painful memories associated with difficult attachment experiences and away from the attachment figures themselves and toward alternative experiences. At

one year, although Jen continues to speak about her attachment relationships and experiences in a somewhat constricted manner, she appears to have greater access to affect. This is evidenced in the different manner in which she speaks about the deaths of her grandparents from the first assessment to the second. In the first assessment, she focuses on what little she recalls of the facts and speaks in a intellectualized way about how others felt. In the second assessment, she speaks more of her own sadness and volunteers more about her relationships with her grandparents and her reaction to their deaths. Throughout the interview, her speech has a fresher quality to it, indicative of a growing capacity to more openly explore her thoughts and feelings. As can be seen in Table 4, Jen's subscale ratings indicate that at one year, she was significantly less derogating of both her parents, more coherent in her discourse, and better able to use metacognitive processes to reflect on her experience.

Table 2
Adult Attachment Interview Classifications

	Time 1	Time 2
Alex	Unresolved (U)/ Preoccupied (E3b/E2)	Secure (F5)/ Unresolved (U)
Jen	Dismissing (Ds2)	Secure (F1A)

Table 3
Alex's AAI Subscale Ratings

	Time 1		Time 2	
	Mother	Father	Mother	Father
Scales for Experience of Parents				
Loving	1	2.5	1.5	2.5
Rejecting	8	5	5	3
Involving/Reversing	8	6	8.5	7
Pressure to achieve	4	1	1	1
Neglecting	1	1	1	(5)
Scales for State of Mind with respect to parents	Mother	Father	Mother	Father
Idealizing	1	1	1	1
Involving anger	6	2	4	1
Derogation	1	1	4	1
Scales for overall state of mind				
Overall derogation of attachment	1		4	
Lack of recall	4		1.5	
Meta-cognition	1		4	
Passivity	4		3.5	
Fear of loss	N/A		N/A	
Unresolved loss	4.5		3	
Unresolved trauma	6		5	
Coherence of transcript	4		7	
Coherence of mind	4		4.5	

Table 4
Jen's AAI Subscale Ratings

	Time 1		Time 2	
	Mother	Father	Mother	Father
Scales for Experience of Parents				
Loving	3	3	2	1
Rejecting	6.5	6	7	5
Involving/Reversing	1	5	(5)(1)	(7)(1)
Pressure to achieve	1	1	1	1
Neglecting	1	1	1	8
Scales for State of Mind with respect to parents	Mother	Father	Mother	Father
Idealizing	1	1	3.5	1
Involving anger	1	1	2	2
Derogation	6	6	1	3
Scales for overall state of mind				
Overall derogation of attachment	6		3	
Lack of recall	5.5		5	
Meta-cognition	1		3	
Passivity	3		3	
Fear of loss	N/A		N/A	
Unresolved loss	2		1	
Unresolved trauma	N/A		N/A	
Coherence of transcript	3.5		5	
Coherence of mind	3.5		5	

Self & Object Representations, Reflective Function, and Defensive Functioning

Hypothesis 2: Shifts toward security will be paralleled by shifts towards higher levels of self-other differentiation and relatedness, by shifts towards higher levels of reflective functioning, and by an increase in the patients' use of higher level defenses

a) Self-Other Differentiation

Shifts toward security of attachment were paralleled by shifts toward higher levels of self-other differentiation for Alex more so than for Jen. Both Alex and Jen's initial descriptions of self, mother, father, and therapist were characterized by either extreme unilateral idealization or denigration (scale point 4) or by unintegrated oscillations between polarized evaluations, such as overwhelming closeness versus extreme distance, invasive control versus total abandonment, intense rage versus idealizing love (scale point 5). For example, asked to describe herself, Alex gives the following response:

Well I didn't bring my DSM book along with me...but I should have it memorized by now...I think I must be really angry... I'm definitely scared... and I feel very, uh, 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 abilities 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.

Alex's initial self-description is notable for its pervasive negative valence and self-denigration, characteristic of a scale point 4 response. Jen's initial self description is as follows:

I don't know. I don't even know what I'm like really. Kind of timid. Kind of shy. I don't really have a lot of interests. I'm kind of a loner. I like to be alone a lot. I think I'm very compassionate. I always feel if someone has a problem, I want to help them. Maybe too compassionate cause everyone else's problems are more important than mine. I really don't know. That's about all I can think of.

As is characteristic of scale point 5 responses, Jen's description of herself reflects a tenuous identity, marked by opposing, polarities, lacking in context or specificity. She appears to be aware of disparate aspects of herself but these qualities remain

unintegrated. Her initial description of her therapist, also rated at a scale point 5, reflects a defensive over reliance on concrete properties in an effort to capture a tenuous representation. She says:

I think he's pretty smart. I don't know. I don't know anything about him really. I think he's very... he keeps a distance better than maybe other therapists I've had. Maybe more impartial, more matter of fact, kind of. My other therapists maybe got more involved with me personally. I mean, I think he cares about me. I think he just doesn't show it really...He's nice. I don't know, that's about it.

Her description of her therapist also reflects a preoccupation with boundaries and issues of closeness and distance, characteristic of rapprochement functioning.

Although after one year of treatment both patients were rated as having shifted to secure states of mind with regard to attachment, only one of them, Alex, the patient whose attachment classification shifted from Unresolved/ Preoccupied to Secure/Unresolved showed on average an increase in self-other differentiation and relatedness scores. The average of her ORI ratings shifted from 4.6 (Self-other idealization or denigration) to 6.4 (Emergent constancy of self and other). Jen, the patient with an initial rating of Dismissing who was rated as Secure at one year, had ORI ratings which remained at 4.6 (Self-other idealization or denigration) from the beginning to the end of treatment. Please refer to Table 5 for a breakdown of the ORI ratings with regard to self, mother, father, and therapist at four months and at one year.

Table 5
Self-Other Differentiation and Relatedness Ratings

	Time 1	Time 2
Alex		
Self	4	6
Mother	4.5	5
Father	5	7
Therapist	5	7.5
Mean	4.6	6.4
Jen		
Self	5	3
Mother	4.5	5.5
Father	4	5
Therapist	5	5
Mean	4.6	4.6

At one year Alex's self and object descriptions ranged from scale point 5 (description of mother) to scale point 7.5 (description of therapist), indicating movement towards higher stages of self-other differentiation and relatedness with rapprochement-like polarization and oscillation replaced by more integrated, modulated, and nuanced self and other descriptions. In contrast to her initial self description, her description of herself at one year reflects a shift towards a more individuated and cohesive sense of self and is given a scale point 6. She states,

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.

Her description of her therapist, rated at scale point 7.5, showed not only increased modulation and integration, but also an increased regard for his individuality and the specific context that contributes to how she views him. She also gave some evidence of a growing appreciation that one's sense of self and other is a continually unfolding process (an element characteristic of scale point 8). Asked to describe her therapist, she states,

How can I describe him? It's just going to be everything is something I'm attributing to him. But he seems to be a very decent person and. . . .I think he's you know sincere and is helping me very much I mean I've been . . . very helped by this therapy. I think he 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 him, is all . . .

In sum, for Alex her shift in her mental representations of attachment 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.

Although Jen's self and object descriptions reflect some improvement, there is little evidence of substantial change along the dimensions of differentiation and relatedness in her representations. Her descriptions of her parents were less unilaterally polarized in a negative direction and showed more oscillations between positive and negative descriptions. Interestingly, her self-description from the initial assessment (scale point 5) to one year (scale point 3) reflects a decrease in developmental level of self-other differentiation. After one year of treatment, her sense of self appears more tenuous and suggests greater reliance on others to maintain stability and consolidation. At one year Jen described herself in the following manner:

...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.

Her description of her therapist remains at a scale point 5. It is strikingly similar to her initial description of him, notable for its concrete, superficial nature, as indicated below:

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

At one year, despite a shift to security as measured with the AAI, Jen's self and object representations continue to reflect a defensive emphasis on concrete properties and ambivalent, unintegrated oscillations characteristic of rapprochement functioning.

b) Reflective Function

As evident in Table 6, shifts to security of attachment were paralleled by improvements in reflective functioning for Alex but not for Jen. On the basis of their initial Adult Attachment Interviews, both patients were rated as manifesting low or questionable reflective function (scale point 3), indicating the presence of a somewhat banal and superficial awareness of the mental states of others. At one year Alex's capacity for reflective function was rated as having improved from a scale point 3 (questionable or low RF) to a scale point 5, signifying the presence of ordinary reflective functioning. In contrast, at one year, Jen's capacity for reflective functioning continued to be rated at a scale point 3 (questionable or low RF).

Table 6
Reflective Function Ratings

	Time 1	Time 2
Alex	3	5
Jen	3	3

c) Defense

As indicated in Tables 7a and 7b, on the basis of a psychotherapy session during the first month of treatment, Alex and Jen's overall levels of defensive functioning (ODF) were rated at 4.3 and 4.2, respectively, on a scale ranging from 1 (low) to 7 (high). Alex's overall level of defensive functioning was rated at 4.7 at four months, 4.5 at eight months, and 4.6 at one year. Jen's overall level of defensive functioning was rated at 5.0 at four months, 5.1 at eight months, and 4.3 at one year. Thus, Alex's ODF did not vary much over the course of treatment year while Jen's ODF increased at four and eight months and then returned to where it was at the beginning of treatment at the one year point. Interestingly however, as reflected in Table 8, when the defenses are broken down into two groups consisting of higher level (levels 5-8) and lower level defenses (levels 1-4) and the proportion of use is tracked over the year, both patients manifest a trend towards use of higher level defenses over the course of the treatment.

Table 7a**Alex's Defenses in Order of Frequency of Use**

	Time 1	Time 2	Time 3	Time 4
Higher level defenses (5-7)	Undoing (8) Reaction formation (3) Repression (3) Intellectualization (2) Affiliation (1)	Intellectualization (8) Repression (4) Undoing (2) Displacement (1)	Intellectualization (4) Reaction formation (4) Self observation (1) Isolation (1) Undoing (1)	Reaction Formation (9) Intellectualization (4) Repression (4) Displacement (2) Undoing (1)
Lower level defenses (1-4)	Devaluation (4) Denial (3) Acting out (2) Passive aggression (2) Splitting (1) Idealization (1) Rationalization (1)	Devaluation (6) Projection (4) Passive aggression (1)	Acting out (3) Devaluation (1) Splitting (1)	Denial (2) Projection (2) Devaluation (1) Rationalization (1) Acting out (1)
Level of defensive maturity	4.3	4.7	4.5	4.6

Table 7b**Jen's Defenses in Order of Frequency of Use**

	Time 1	Time 2	Time 3	Time 4
Higher level defenses (5-7)	Isolation (5) Repression (3) Undoing (1) Reaction formation (1) Displacement (1)	Repression (15) Intellectualization (7) Undoing (1)	Intellectualization (13) Undoing (6) Repression (5) Reaction formation (4) Self-assertion (2)	Repression (12) Intellectualization (4) Undoing (3) Displacement (2)
Lower level defenses (1-4)	Rationalization (5) Denial (2) Acting out (1) Passive aggression (1)	Devaluation (1) Projection (1) Rationalization (1) Projective identification (1)	Acting out (3) Rationalization (2) Hypochondriasis (1)	Denial (8) Rationalization (4) Projection (1) Acting out (1)
Level of defensive maturity	4.2	5.0	5.1	4.3

Table 8**Proportions of the Patients' Use of Higher Versus Lower Level Defenses****Alex**

	Time 1	Time 2	Time 3	Time 4
% Higher level defenses (5-7)	52	58	69	74
% Lower level defenses (1-4)	48	42	31	26

Jen

	Time 1	Time 2	Time 3	Time 4
% Higher level defenses (5-7)	55	72	83	60
% Lower level defenses (1-4)	45	28	17	40

Tables 9 and 10 present the frequencies of individual defenses used during each session for each patient. As can be seen in Table 9, Alex appears to be using a progressively higher percentage of higher level defenses at each assessment point. Jen, too, appears to be using an increasingly higher percentage of higher level defenses at four months and at eight months, with a decrease in her use of higher level defenses at the one year assessment. Thus, although neither of the patients' overall level of defensive functioning (ODF) appears to have improved much over the course of one year of treatment, both patients showed an increase in percentage of use of higher level defenses.

Table 9
Alex: Frequency of Individual Defenses

	Time 1	Time 2	Time 3	Time 4
Level 7-Mature				
Affiliation	1			
Altruism				
Anticipation				
humor				
Self-Assertion				
Self-Observation			1	
Sublimation				
Suppression				
Level 6-Obsessional				
Isolation			1	
Intellectualization	2	8	4	4
Undoing	8	2	1	1
Level 5-Other Neurotic				
Repression	1	4		4
Dissociation				
Reaction Formation	3		4	9
Displacement		1		2
Level 4- Narcissistic				
Omnipotence				
Idealization	1			
Devaluation	4	6	1	1
Level 3- Disavowal				
Denial	3			2
Projection		4		2
Rationalization	1			1
Fantasy				
Level 2- Borderline				
Splitting (Object images)	1		1	
Splitting (Self images)				
Projective Identification				
Level 1- Action				
Acting Out	2		3	1
Passive Aggression	2	1		
Hypochondriasis				
Totals	29	26	16	27
Level of Defensive Maturity	4.3	4.7	4.5	4.6

Table 10
Jen: Frequency of Individual Defenses

	Time 1	Time 2	Time 3	Time 4
Level 7-Mature				
Affiliation				
Altruism				
Anticipation				
humor				
Self-Assertion			2	
Self-Observation				
Sublimation				
Suppression				
Level 6-Obsessional				
Isolation	5			
Intellectualization		7	13	4
Undoing	1	1	6	3
Level 5-Other Neurotic				
Repression	3	15	5	12
Dissociation				
Reaction Formation	1		4	
Displacement	1			2
Level 4- Narcissistic				
Omnipotence				
Idealization				
Devaluation		1		
Level 3- Disavowal				
Denial	2			8
Projection		1		1
Rationalization	5	1	2	4
Fantasy				
Level 2- Borderline				
Splitting (Object images)				
Splitting (Self images)				
Projective Identification		1		
Level 1- Action				
Acting Out	1		3	1
Passive Aggression	1			
Hypochondriasis			1	
Totals	20	27	36	35
Level of Defensive Maturity	4.2	5	5.1	4.3

Symptomatology

Hypothesis 3: Shifts toward security will be accompanied by a diminution of reported symptomatology in the patient initially rated as unresolved preoccupied. Shifts toward security in the patient initially rated as dismissing will be accompanied by an increase in reported symptomatology.

a) Brief Symptom Inventory

As indicated in Figure 1 and Table 11, both patients experienced a decrease in their self-reported levels of symptomatology from the initial assessment to one year. Interestingly, both patients experienced a slight surge in symptoms around the one year assessment, coinciding with the end of the research year and the possibility of termination. Alex, the patient initially rated as Unresolved/ Preoccupied began treatment reporting lower levels of symptom distress than did Jen, the patient initially rated as Dismissing. While Jen's overall level of symptomatology was lower at one year than at the initial assessment, it remained higher than Alex's at the one year point.

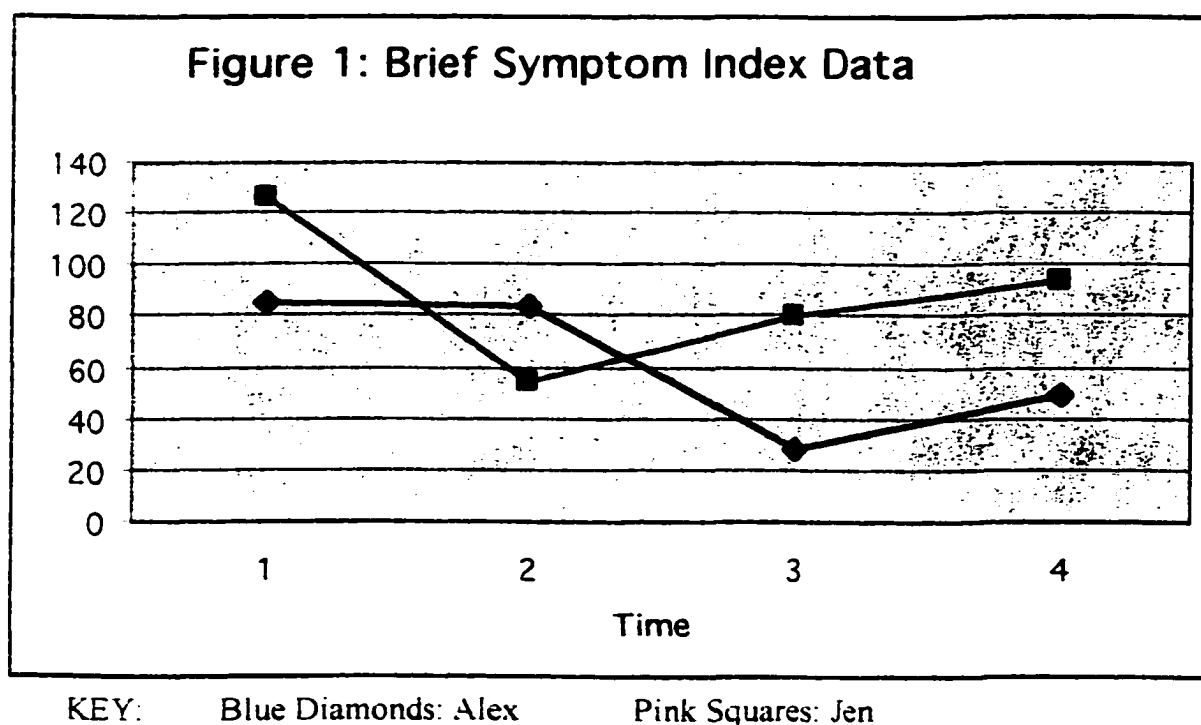


Table 11
Brief Symptom Index (BSI) Data

	Time 1	Time 2	Time 3	Time 4
Alex	86	84	28	49
Jen	126	55	81	94

The patients' scores on the dimensional scales of the BSI are reflected in Table 12. Alex experienced the greatest reduction in symptom distress from the initial assessment to one year in the following dimensions: Interpersonal sensitivity, depression, phobic anxiety, and paranoid ideation. Jen's greatest reduction in symptom distress occurred on the scales of anxiety, phobic anxiety, and psychoticism. Notably, her score on paranoid ideation increased from 1.4 to 2.6.

Table 12
Brief Symptom Index (BSI) Dimensional Scales

Alex	Time 1	Time 2	Time 3	Time 4
Somatization	.29	.71	.14	.43
Obsessive-Comp	.83	1.5	.50	.83
Interpersonal sen.	2.8	2.3	.25	.50
Depression	2.5	3.0	.67	1.5
Anxiety	1.8	1.5	.67	2.0
Hostility	1.0	1.4	.40	.40
Phobic anxiety	1.0	.80	.20	0
Paranoid ideation	2.6	1.2	1.0	1.4
Psychoticism	1.8	1.4	.40	.80
Jen				
Somatization	2.3	.86	1.1	2.9
Obsessive-Comp	2.0	.67	1.8	1.5
Interpersonal sen.	2.5	2.3	3.3	3.0
Depression	3.5	2.5	2.0	3.5
Anxiety	3.0	.50	1.0	.33
Hostility	.40	.20	.40	.20
Phobic anxiety	3.0	.60	1.4	.20
Paranoid ideation	1.4	1.0	1.8	2.6
Psychoticism	2.0	.60	1.0	1.0

b) Beck Depression Inventory

As indicated in Figure 2 and Table 13, Alex initially received a score of 53 on the BDI. It rose to 57 at four months, dropped to 33 at eight months, and then rose to 42 at the one year assessment. Jen's BDI score at the initial assessment was 74. It dropped to 48 at four months, rose to 55 at eight months, and then rose again to 65 at the one year assessment. The data from the Beck Depression Inventory parallel the data from the Brief Symptom Index in that Jen's self report ratings are higher than Alex's at the initial assessment, both patients' ratings of distress decrease from the initial assessment to one year, and Jen's ratings of her distress remain higher than Alex's at the one year assessment.

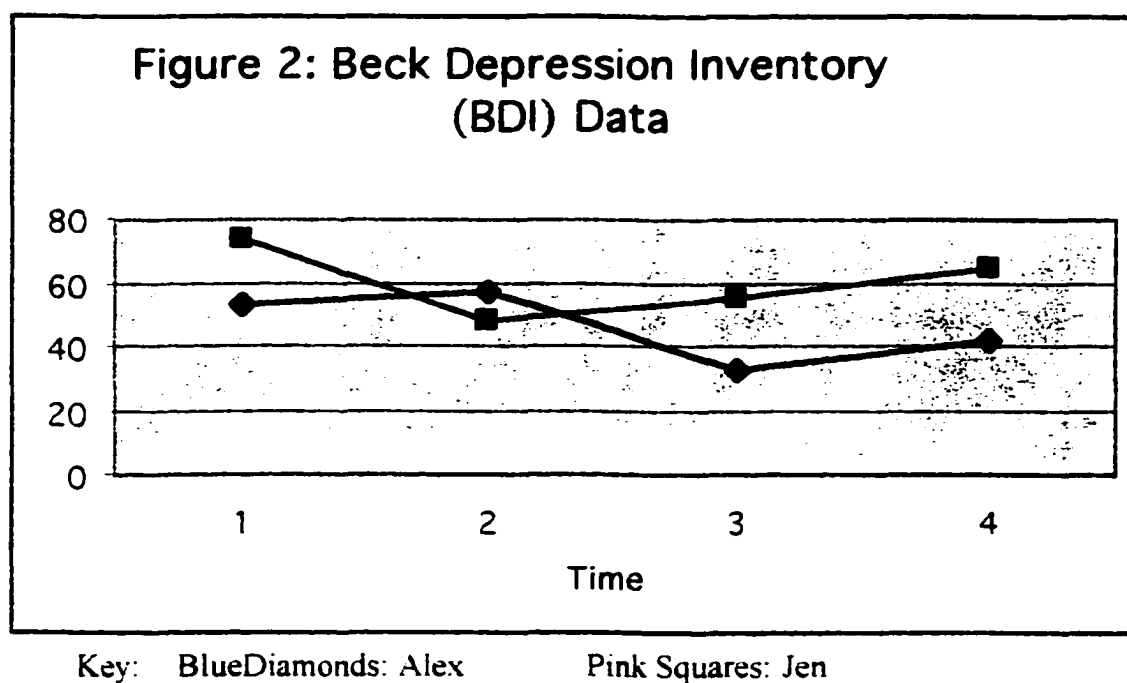


Table 13
Beck Depression Inventory (BDI) Data

	Time 1	Time 2	Time 3	Time 4
Alex	53	57	33	42
Jen	74	48	55	65

c) Diary Card Data

Both patients appear to have experienced a decrease in the number and intensity of self- destructive urges and actions during the course of the first year of therapy. Urges to use and actual use of alcohol and illicit drugs were minimal for both patients. Neither patient reported symptomatic behavior around eating disturbances over the treatment year. Alex, the patient initially classified as Unresolved/ Preoccupied on the AAI, experienced more frequent and intense urges to self-harm and actual behavior throughout the treatment, and showed a more dramatic decrease in her urges and behavior by the end of treatment. Figure 3 summarizes Alex's diary card ratings from the initial phase of treatment (weeks 1 and 6). The graph presents a summary of the data for each week, as seen on the horizontal axis, with the vertical axis representing the intensity and frequency of the self-injurious actions and urges. Figure 4 depicts Alex's urges and actions during weeks 15 and 17. As can be seen in Figure 5 illustrating Alex's diary card data from weeks 21 and 37, the amplitude of these urges appears to decrease over the treatment year. Jen, the patient initially classified as Dismissing on the AAI reported generally lower levels of urges to harm herself throughout the treatment year, with occasional spikes, as is evident in Figures 6, 7 and 8.

Figure 3: Alex: Early Treatment Phase

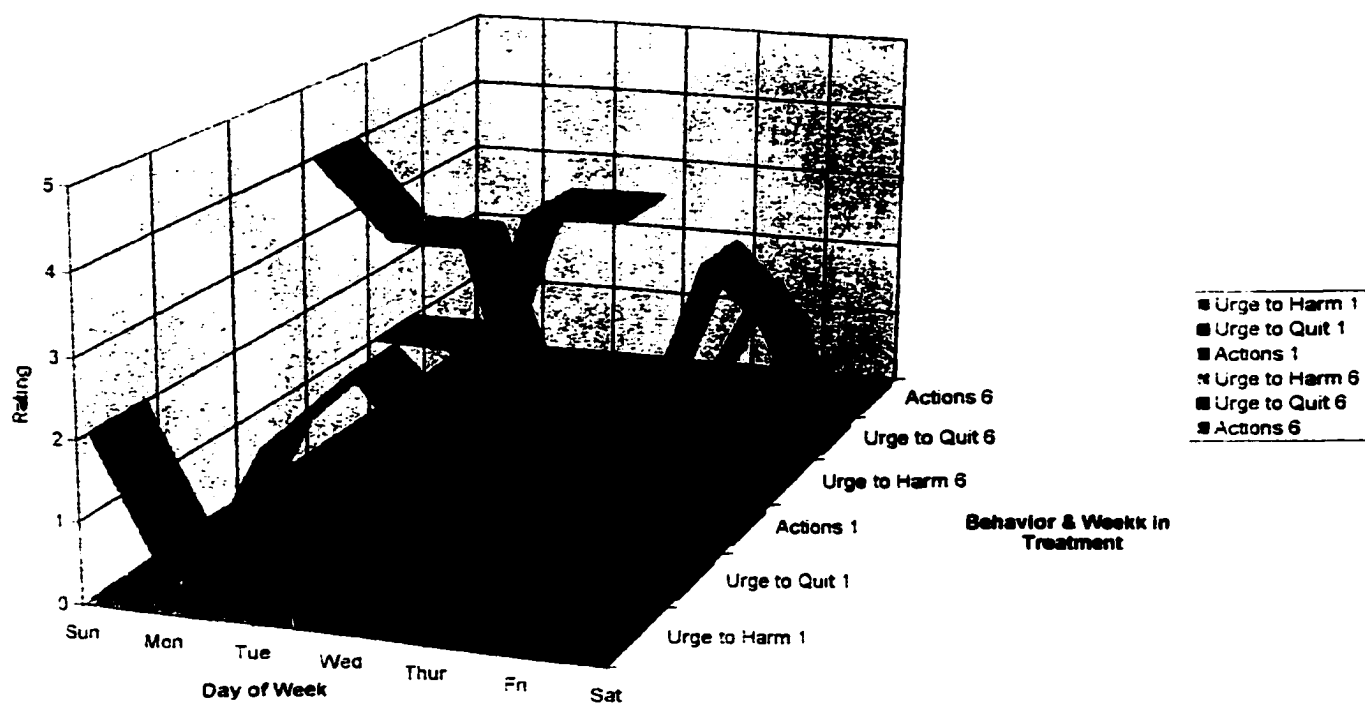


Figure 4: Alex: Middle Treatment Phase

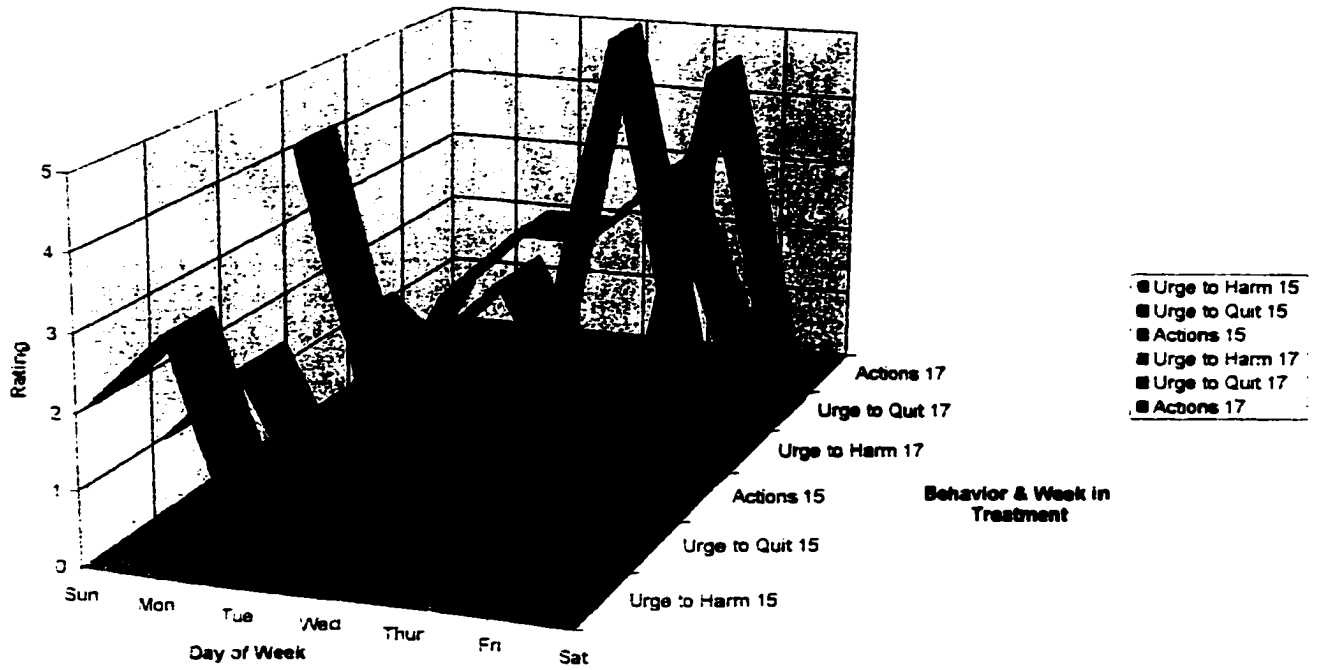


Figure 5: Alex: Late Treatment Phase

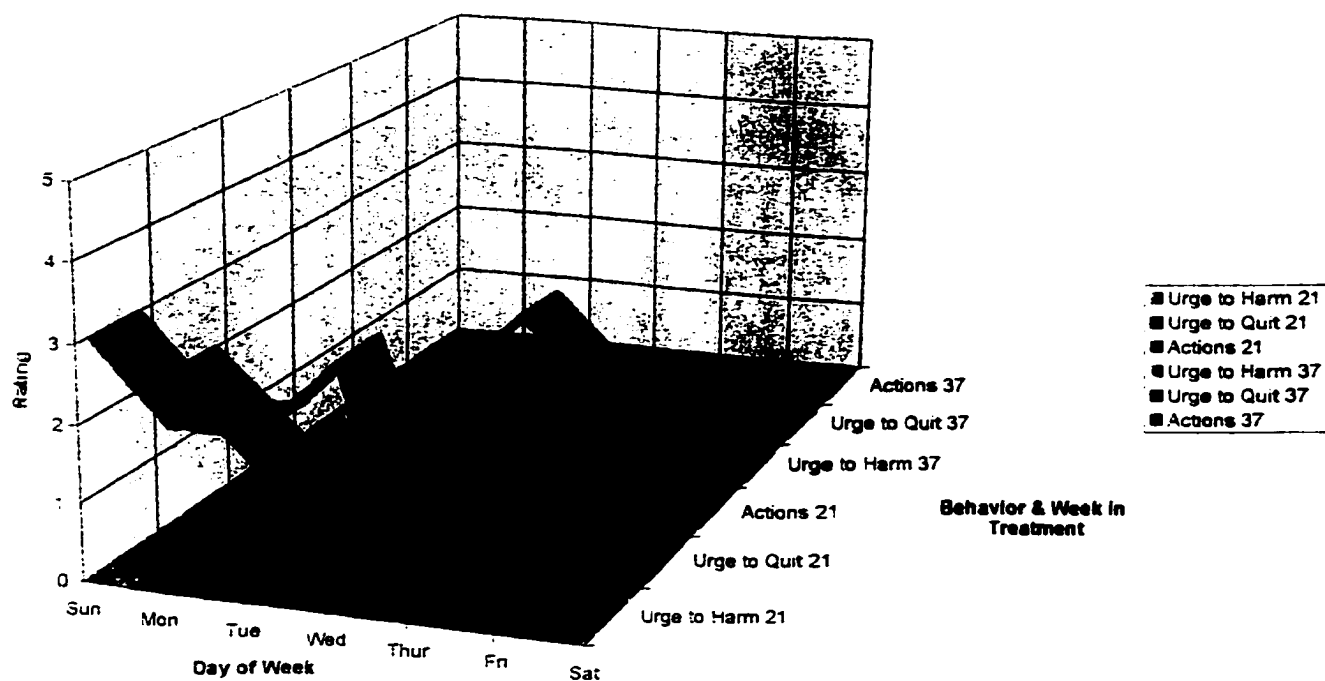


Figure 6: Jen: Early Treatment Phase

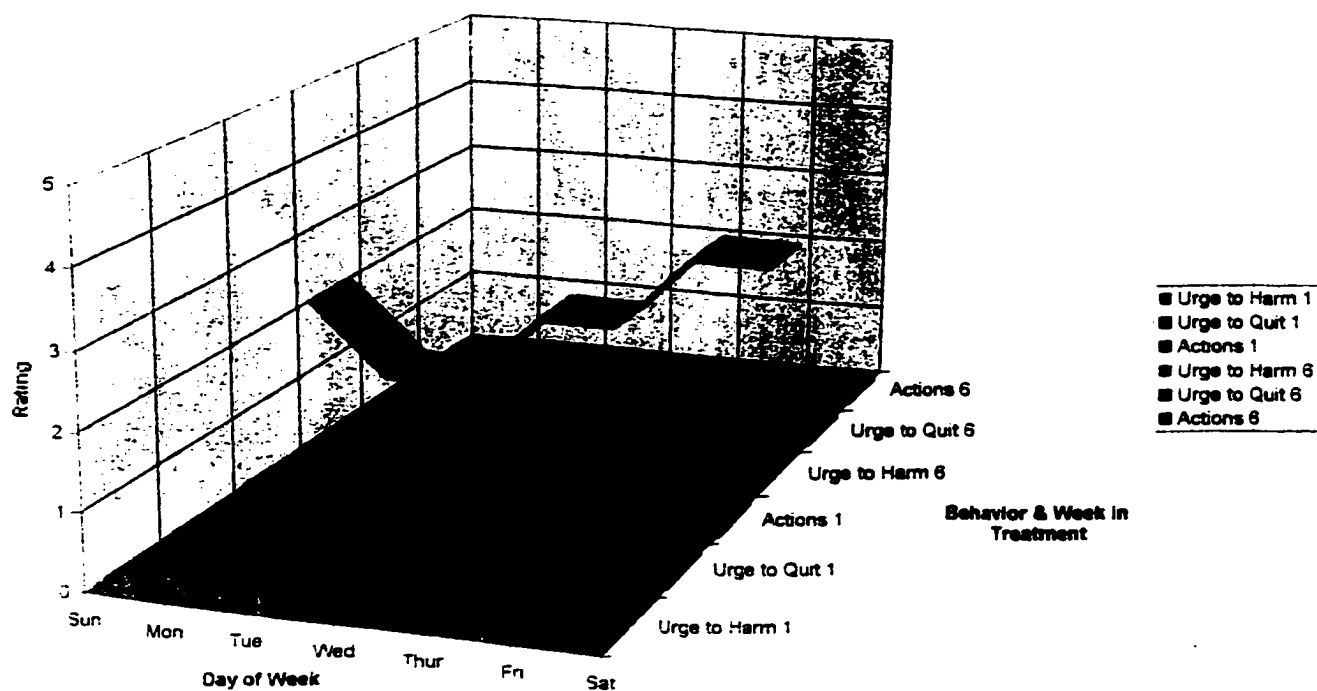


Figure 7: Jen: Middle Treatment Phase

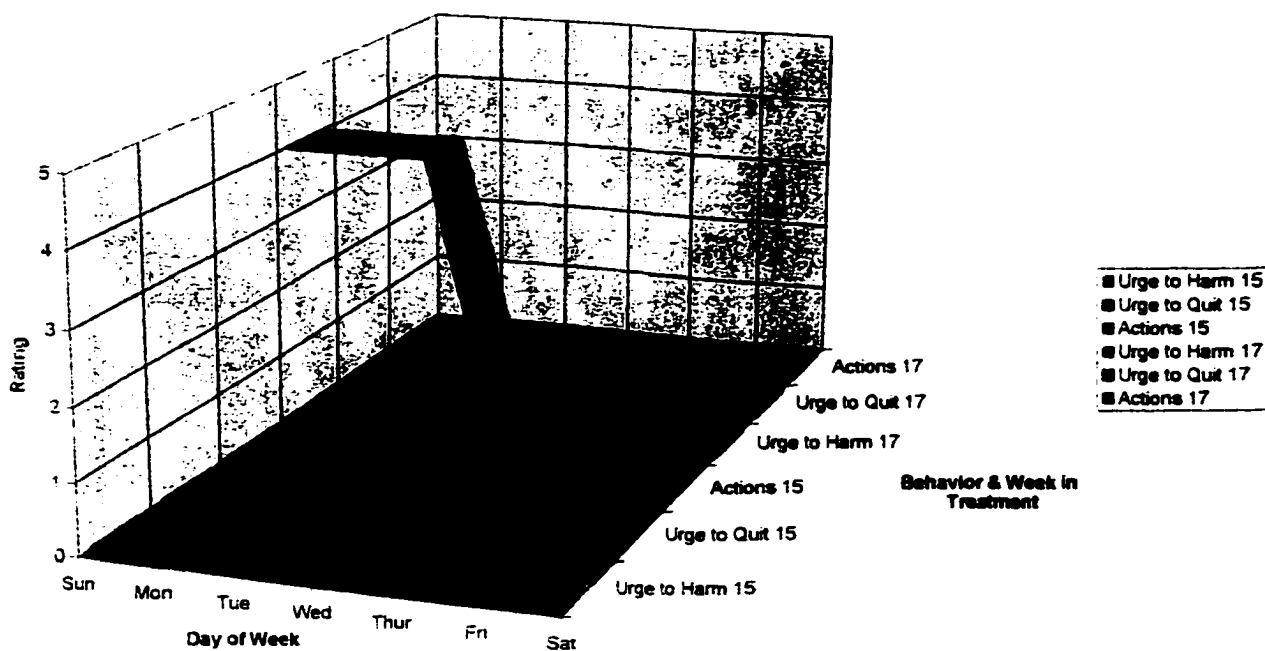
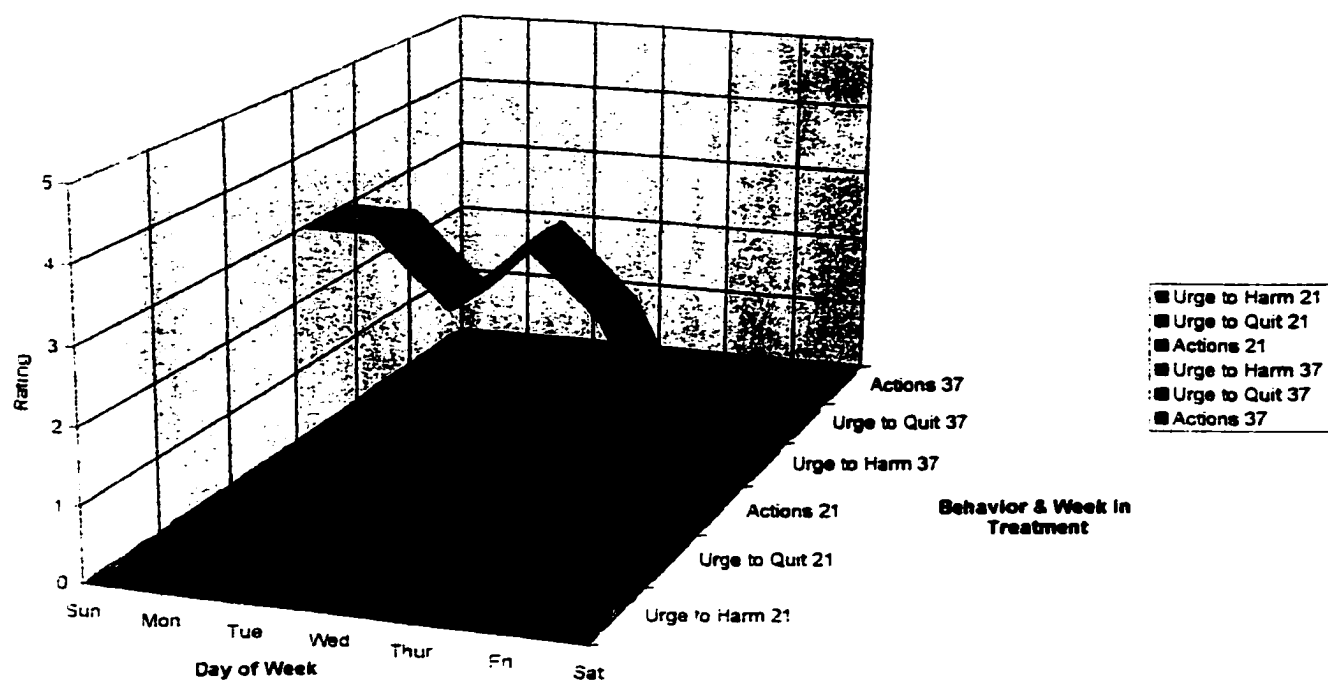


Figure 8: Jen: Late Treatment Phase



Personality Organization

Hypothesis 4: After one year of treatment, both patients will show improvements in the three psychostructural characteristics noted by Kernberg and colleagues to be at the core of Borderline Personality Organization (identity diffusion, primitive defensive functioning, and reality testing)

As reflected in Table 14, Alex's scores on the Inventory of Personality

Organization in each of the three psychostructural characteristics show improvement.

Her score on the presence of primitive defenses decreased from 69 at Time 1 to 43 at

Time 4. Her score on identity diffusion decreased from 72 to 45. Her score on impaired

reality testing shifted from 61 to 31. Jen's score on primitive defenses went from 56 at

Time 1 to 48 at Time 4. Her score on identity diffusion essentially remained stable,

shifting only from 63 to 62. Her score on impairment of reality testing shifted from 51 to

46. The data from the ratings of defenses used during psychotherapy sessions, reported

above, are consistent with these findings in that both patients show a trend towards use

of higher level defenses over the year, though Jen's use of higher order defenses appears

to drop at the one year point, during the termination process.

Table 14
Inventory of Personality Organization (IPO) Subscale Scores

	Non-clinical Norms	Clinical Norms	ALEX		JEN	
			Time 1	Time 4	Time 1	Time 4
Primitive Defenses	37.9 (8.6)	51.1 (13.8)	69	43	56	48
Identity Diffusion	30.3 (6.7)	40.4 (10.7)	72	45	63	62
Reality Testing	21.5 (8.1)	27.1 (9.9)	61	31	51	46

Note: Standard deviations are in parentheses.

Aggression

Hypothesis 5: Based on Kernberg's theory that patients with borderline pathology have an excess of aggression, it is expected that at the beginning of treatment both patients will rate themselves as high in the trait of anger and that after one year of TFP, will rate themselves lower.

As reflected in Table 15, Alex's initial State anger T-score was 66, putting her in the 95th percentile. Her overall T-score on Trait Anger was 65, putting her in the 94th percentile of adults. Similarly, her angry temperament T-score, which measures a general propensity to experience and express anger without specific provocation, was 64, also putting her in the 94th percentile of adults. Her angry reaction T-score, which measures individual differences in the disposition to express anger when criticized or treated unfairly by others, was 65, putting her in the 97th percentile. She received a T-score of 56 on the Anger-In score, a measure of the frequency with which anger is held in or

suppressed, putting her in the 71st percentile. She received a T-score of 62 on the Anger-out scale, which measures the frequency with which anger is expressed out towards others or objects, placing her in the 85th percentile.

Jen's initial T-score on State Anger was 50, putting her in the 50th percentile. Her T-score on Trait Anger was 47, putting her in the 39th percentile of adults. Her angry temperament T-score was 49, putting her in the 51st percentile. Her Angry Reaction T-score was 53, placing her in the 69th percentile. Notably, Jen's highest set of scores were in the area of Anger-in. She received a T-score of 79 on this scale, putting her in the 99th percentile of adults in this area. She received a T-score of 37 on the Anger-out scale, placing her in the 11th percentile.

As seen in Table 15, at the end of the treatment year, Alex's T-score on State Anger was down from 66 to 56, putting her in the 74th percentile. Her T-score on Trait Anger went down from 65 to 51, moving her from the 94th to the 55th percentile for other adults. Her Angry Temperament T-score also went down from 64 to 49, putting her at Time 4 in the 51st percentile. Her Angry reaction T-score went down as well from 65 to 56, putting her in the 78th percentile. Her Anger-in T-score increased from 56 to 60, moving her into the 83rd percentile. Her Anger out T-score went down from 62 to 54, putting her in the 62nd percentile.

At the end of the treatment year, Jen's State Anger rose from 50 to 63, or from the 50th to the 91st percentile of other adults. Her T-score on Trait Anger remained the same (47), keeping her at the 39th percentile. Her Angry Temperament T-score dropped from 49 to 44, moving her from the 51st to the 30th percentile. Her Angry Reaction T-

score increased from 53 to 56, moving her from the 69th to the 78th percentile. Her Anger-in T-score shifted from 79 to 75, or from the 99th to the 98th percentile. Jen's Anger-out T-score decreased from 37 to 32, or from the 11th to the 5th percentile.

Table 15

State Trait Anger Expression Inventory (STAXI) Data

	Time 1			Time 4		
Alex	Raw	%	T- score	Raw	%	T- score
S-anger	22	95	66	13	74	56
T-anger	28	94	65	19	55	51
T-anger/T	10	94	64	5	51	49
T-anger/R	14	97	65	11	78	56
AX/In	17	71	56	19	83	60
AX/Out	18	85	62	15	62	54
AX/Con	15			23		
AX/EX	36			27		
Jen	Raw	%	T- score	Raw	%	T- score
S-anger	10	50	50	19	91	63
T-anger	17	39	47	17	39	47
T-anger/T	5	51	49	4	30	44
T-anger/R	10	69	53	11	78	56
AX/In	29	(99)	79	27	98	75
AX/Out	10	11	37	9	5	32
AX/Con	28			28		
AX/EX	27			24		

Attachment Status and Defensive Functioning

Hypothesis 6: Initial Attachment classification will be related to the predominant type of defenses used by each of the patients. Specifically, Alex, the patient whose primary attachment status at the first assessment point is unresolved is likely to show indices of dissociation. In addition, given her secondary classification as preoccupied with respect to attachment, it is likely that she will manifest primitive defense mechanisms such as splitting, projection, projective identification, omnipotence, idealization, devaluation, and acting out in early treatment sessions (i.e., within the first four months). Jen, the patient who is assessed as dismissing with respect to attachment will be more likely during the first four months of treatment to use ideational defenses and those characterized by a disavowal of disturbing thoughts, memories, feelings and wishes (such as repression, intellectualization, rationalization and denial).

Despite her primary attachment classification as unresolved, Alex did not evidence any signs of dissociation as measured with the DMRS. During the first four months of treatment, as can be seen in Table 7, she most frequently used undoing, devaluation, and intellectualization followed by repression, projection, denial, reaction formation, and passive aggression. She was also rated as using acting out, displacement, affiliation, idealization, rationalization and splitting. Consistent with the hypothesis. Jen was rated as using repression more frequently than any other defense, followed by intellectualization, rationalization, isolation, denial, and undoing. On one occasion, she also evidenced reaction formation, displacement, devaluation, projection, projective identification, acting out, and passive aggression.

CHAPTER FIVE

DISCUSSION

The purpose of this research was to provide preliminary data on the patterns of intrapsychic and symptomatic change experienced by borderline patients with different attachment styles over the course of one year of Transference Focused Psychotherapy (TFP). On a variety of levels, the findings attest to the fact that both patients benefited significantly from one year of treatment. Both patients were judged by independent raters as having shifted from insecure to secure states of mind with respect to attachment and experienced a significant reduction in both their levels of distress and their self-destructive behavior after one year of treatment. Interestingly, despite their overlapping pathology at the beginning of treatment, on other measures of object relations and defense, their trajectories of change were quite different from one another. The findings of this research underscore the importance of using multiple measures in evaluating clinical process and outcome. In addition, the findings highlight the role of attachment in determining the course of treatment, the quality of the alliance, and the types and direction of change one would expect to see in a psychodynamic treatment.

In this study, both patients initially presented with impairments in their object relations that were contributing to their unstable sense of themselves, their erratic interpersonal relationships, and their self-destructive behavior. Both had made a serious suicide attempt in the weeks prior to admission. Notably, on the basis of their initial psychotherapy sessions, both patients appear to have been using a wider range of

defenses than would be predicted on the basis of Kernberg's conceptualization of borderline organization. There was indeed some indication of their using primitive and immature defenses, such as splitting, devaluation, idealization, acting out, passive aggression, and denial, but they were also employing more typically neurotic level defenses such as undoing, repression, and reaction formation. Both patients were also classifiable on the AAI despite the fact that the classification system was developed on non-clinical samples (Hesse, 1999).

There are also important differences in the patients' initial presentations. Alex did not carry an Axis I diagnosis. She was assessed as having prominent narcissistic and antisocial traits in addition to her borderline pathology. During her initial assessment, Jen was diagnosed as having a comorbid Major Depression. In addition, she was noted as having a history of alcohol abuse and an eating disorder, but was not symptomatic in these ways at the time of admission. In addition, the patients were selected in part because they were rated as having different states of mind with respect to attachment.

I will briefly summarize the findings by case. Alex, the patient who was initially classified as unresolved and preoccupied, showed steady and consistent improvements across the board on each of the measures used in this study. At one year, she was reclassified as having a secure state of mind with respect to attachment and given a secondary classification of unresolved. Her subclassification (F5) indicates that she continued to show some instances of mild resentment and anger towards her parents, though as indicated by the subscale rating of involved anger, to a much lesser degree than during the earlier interview. In addition, Alex gained a greater capacity for reflective

function. Her self and object representations became increasingly complex and differentiated, with a greater integration of positive and negative aspects. Her representation of her therapist, in particular, reflected increased modulation and integration as well as an expanded appreciation of what makes him unique and the context in which she knows him.

Alex's overall profile on the Inventory of Personality Organization, a questionnaire that operationalizes the principle dimensions of personality organization described by Kernberg (i.e., identity diffusion, primitive psychological defenses, and reality testing), suggests that after one year of treatment, she is on the cusp of functioning at a more neurotic level of organization. Her identity diffusion has improved. She is using fewer primitive defenses, and her reality testing has become stronger. The results from the IPO, a self-report instrument, are consistent with ratings made by an independent observer of her use of defense mechanisms during psychotherapy sessions. As assessed using the Defense Mechanism Rating Scale, her use of more primitive defense mechanisms declined at the same time that she appeared to be using an increased number of higher level defenses. Her use of defense mechanisms in her psychotherapy sessions, in general, diminished at eight months, suggesting that she became better able to tolerate and digest her therapist's interventions. Furthermore, Alex's subjective experience of diffuse anger and hostility diminished. She experienced a marked reduction in psychiatric symptoms such as interpersonal sensitivity, depression, phobic anxiety, and psychoticism.

Jen, the patient initially classified as dismissing, changed in more inconsistent and uneven ways over the course of treatment. She, too, was found to have a secure state of mind with respect to attachment at one year. In comparison to her earlier interview, at one year Jen appeared to have greater access to memories of her childhood and feelings related to these experiences. In addition, she was better able to coherently present a believable, consistent account of her attachment history, to support her description with examples, and to reflect on her own process of thinking about her experiences. Her sub-classification (F1a) indicates that she appeared to be actively shifting her attention away from painful memories, placing her on the dismissing end of the secure continuum¹.

The shift in Jen's attachment status was not accompanied by improvements in her level of differentiation-relatedness of her self and object representations or in her capacity for reflective function. In contrast to Alex, whose self and other representations improved across the board, Jen showed a little improvement in her object representations of mother and father, no change in her representation of her therapist, and a decrease in the quality of her self representation after one year of treatment. Her representations remained at the rapprochement level, reflected an ongoing preoccupation with issues of control and autonomy, and continued to be characterized by disparate oscillations between positive and negative descriptors. Jen's self description at one year was less differentiated and more diffuse than it was at the first assessment, reflecting a breakdown in her understanding of who she is. Consistent with the deterioration of her self-

¹ In contrast to the defensive exclusion of attachment-related experiences characteristic of individuals rated as dismissing, this setting aside of attachment-related memories appears to be a more conscious choice, more a result of suppression rather than repression.

representation, on the Inventory of Personality Organization, Jen's level of identity diffusion did not improve over the course of treatment. She did, however, show a reduction in her use of primitive defenses and an improvement in her capacity for reality testing.

Although, like Alex, Jen showed a trend towards using increasingly higher level defenses over the course of treatment (albeit with a slight drop at one year around termination), she was nevertheless rated as using defenses more frequently in the latter half of the year. It appears as though Jen felt a greater need to employ defenses in the face of increasingly threatening content during the sessions and that she was retreating from the challenges posed by treatment, perhaps portending her decision to discontinue therapy at one year. Jen endorsed a higher level of symptomatology at the start of treatment than Alex and while most of her symptoms diminished over the course of the treatment year, they remained at a higher level than Alex's at the one year point. Her experience of paranoid ideation actually increased toward the end of the year. It appears as though Jen developed an increased capacity for acknowledging her distress and for tolerating a greater range of affect.

The results of this research should be considered within the context of the specific aims of TFP. The primary goal of TFP involves changing those aspects of borderline patients' mental representations of self and other that are believed to be at the heart of their cognitive, affective, interpersonal and behavioral disturbances. In their introduction to the latest treatment manual, Clarkin, Yeomans, and Kernberg (1999) assert that

“essential change in the underlying makeup involves the resolution of fixed primitive internalized object relations and the integration of split-off conceptions of self and significant others into integrated, more mature, and flexible conceptions” (p.2). The capacity to appreciate self and others in more complex, differentiated ways rather than as oversimplified caricatures of victims and perpetrators, prisoners and guards, angels and devils makes relationships both more tolerable and ultimately more satisfying (Clarkin et al., 1999).

The AAI and its corresponding coding system offer one way of assessing change in patients’ representations of self and other. The finding that the two patients in this study were found to have changed from insecure to secure attachment classifications after one year of treatment suggests that they have developed more flexible, autonomous working models of attachment. This shift indicates a change in the patients’ capacities to explore their thoughts and feelings about themselves and their relationships to their parents more freely, openly, and coherently. Among other things, this means that they are able to reflect on themselves and significant others with greater balance and perspective, with less obvious distortions and affective dysregulation.

It is important, however, to consider what a rating of security on the AAI does and does not mean. To be classified as secure, subjects must be able to speak about a range of often emotionally laden attachment experiences without violating Grice’s maxims of coherent, collaborative discourse: 1) to speak truthfully and have evidence for what you say; 2) to be succinct, yet complete; 3) to remain on topic; and 4) to be clear and orderly. The fact that these patients are rated as secure at one year suggests they have

gained an improved capacity to tolerate affective experience, including the co-existence of conflicting emotions, such that they are able to organize their thoughts and feelings in a coherent manner. Furthermore, it seems likely given how the changes in attachment classification paralleled a reduction in self-reported symptomatology and urges to self-harm that their growing capacity to cope with and verbally express impulses and affects may have served to curb their pattern of self-destructive acting out.

While the AAI tells us information about how individuals have come to represent their attachment relationships -- and it is assumed that our representations influence our behavior-- it is not a behavioral assessment of how individuals relate to significant others. Given the severity of the object relational disturbances of the patients in this study, it would seem unlikely that after only one year of treatment, even a successful treatment, that they would relate to others in a way indicative of secure attachment. Researchers are only beginning to look at behavioral correlates of the AAI, for example attachment behavior in couples (Creasy, Boston, Tingley, Craft, & Kurtz, 1999).

Interestingly, in an article by Diamond and colleagues (1999) on these same two patients, it is noted that on a self-report attachment questionnaire, the patients did not rate themselves as having changed at all with regard to their predominant attachment experience in their closest relationships. Therefore, while the patients became more coherent in their representations of their early attachment relationships as reflected in their AAI, they continued to view themselves as insecure in their relationships. Previous research has shown that patients with borderline pathology regard themselves as more impaired in both relational and occupational domains than they are seen by

independent observers (Edel, Joy, & Yehuda, 1990). Clinically, it is important to keep in mind that patients' self-perceptions may lag behind objective markers of change.

While it was predicted that after one year of treatment the patients would have made subtle shifts towards security of attachment that would be reflected in their subscale ratings, for a variety of reasons, it seemed unlikely that both patients would be rated as having shifted from insecure to secure states of mind after only one year of treatment. First, it should be noted that studies have shown that in clinical samples, only 8% to 14% of subjects are rated as secure on the AAI (Allen et al., 1996; Fonagy et al., 1996; Patrick et al., 1996; van IJzendoorn & Bakermans-Kranenburg, 1996). Second, internal working models of attachment have been found in numerous studies to be quite stable over time and resistant to change (Ammaniti, Speranza, & Candelori, 1996; Bakermans-Kranenburg & van IJzendoorn, 1993; Crowell, Waters, Treboux, O'Connor, Colon-Downs, Feider, Golby, & Posada, 1996). While attachment theorists argue that new experiences and relationships later in life can alter a person's internal working models, one would nevertheless expect that such a process would take longer than one year of treatment. It is commonly believed by clinicians that given the severity of the representational disturbances characteristic of patients with personality disorders, it generally takes years of analytically oriented treatment to modify the existing cognitive and affective schemas.

One could wonder if the increase in the patients' coherency is simply due to the fact that after one year of treatment they have talked so much about their childhood relationships with their parents that they are now able to speak more clearly and

objectively on the subject. This conclusion, however, is unlikely in that TFP specifically de-emphasizes the active exploration of early childhood experiences and focuses instead on the here-and-now aspects of the patients' lives, specifically targeting self-destructive and treatment-interfering behavior as well as identifying dominant object relational patterns in the transference. While it is difficult to rule out the possibility that the patients spent time in therapy directly reworking narratives of their childhood, it should be noted that the therapist in the study was rated as adherent and competent in the techniques of TFP. Rather than their change in attachment status reflecting a practice effect, it is more likely that the analysis and working through of the transference has resulted in fundamental changes in the patients' mental representations that then allowed them to speak more coherently about their childhood experiences with their parents. It is also possible that the patients' shift to security is the result of a partial internalization of a secure therapeutic relationship that for the time being remains contingent on the ongoing presence of that relationship (Diamond et al., 1999).

The findings of this research support the view that a patient's attachment status influences the course of therapy, the quality of the therapeutic alliance, and the goals of the treatment (Diamond et al., 1999; Holmes, 1996; Slade, 1998). Individuals like Alex who begin treatment with an Unresolved/ Preoccupied state of mind with respect to attachment often show signs of being overwhelmed by affect and memories of traumatic experiences, such that the intensity of their feelings interferes with their ability to coherently express their internal experience and often leads to impulsive, self-destructive action. As they are prone to a loss of distance from their past experiences, intense

transference reactions are more likely to be experienced as based entirely in reality rather than as a result of mental representations stemming from earlier experiences. The anxiety that is stirred up in their interpersonal relationships can make it difficult for them to tolerate an ongoing relationship with their therapists. Some research has in fact indicated that patients with preoccupied and/or unresolved attachment statuses may not fare as well in exploratory psychodynamic treatments. Fonagy and colleagues (1996) demonstrated that patients rated as preoccupied on the AAI were less likely to show clinically significant improvement as measured with the Global Assessment of Functioning Scale (GAF) after one year of dynamically oriented inpatient treatment and had a higher drop-out rate than patients rated as dismissing.

Thus, a central task for these patients in psychotherapy is the growing capacity to manage and contain their intense affect. There are numerous indications that over the course of her year in treatment Alex grew in her capacity to tolerate intense and sometimes conflicting emotions. As is classically the case for patients with borderline pathology, Alex began treatment experiencing exceedingly high levels of self-reported state and trait anger. Her higher score on the anger-out scale than the anger-in scale suggests that she had a stronger tendency towards expressing her anger both verbally and physically than suppressing these feelings. At one year, Alex experienced a dramatic drop in her subjective experience of anger and gave indications that she was better equipped to suppress her anger as needed. The data from the State-Trait Anger Expression Inventory is consistent with the data from the Adult Attachment Interview in that in her initial AAI, Alex was rated as manifesting high levels of involving anger

towards her parents, which was a major factor in her receiving a secondary classification of Preoccupied. At the end of the year, while still somewhat resentful about some of the ways she was treated, she was less overwhelmed by anger and better able to present a more balanced, contextualized evaluation of her experience of being parented. She also endorsed a reduction in symptoms of hostility on the Brief Symptom Index.

Interestingly, in the PT-AAI at one year, her therapist commented on how Alex began treatment “with a very split off aggressive side that would burst forth in almost lethal ways.” He went on to say that “when she was not in the midst of that kind of outburst of self-destructiveness, she would seal over,” thereby disavowing her aggression. The heightened focus of the treatment on her aggression appears to have enabled her to better integrate it into her self-representation and minimized her compulsion to express it in more pathological ways.

It seems clear that Alex’s growing consciousness of her aggression was achieved in part as a result of her therapist’s ongoing confrontations of her more primitive defenses, such as acting out, splitting, devaluation, and passive aggression. By the end of treatment, overall she was relying more on higher level defenses than on the more primitive defenses characteristic of borderline functioning. Indices of passive aggression dropped out. Her use of devaluation, denial, and projection decreased. She appeared to be using self-observation, isolation of affect, and significantly more reaction formation. Interestingly, her use of undoing declined dramatically, which suggests that she grew more able to tolerate feelings and thoughts that were previously so threatening that she would repeatedly contradict herself and in the process invalidate her experience.

According to attachment theory, in an effort to achieve a sense of security in a new relationship, preoccupied patients are likely early in treatment to engage in emotional dramas that serve to heighten the therapist's attention to their wellbeing, thereby insuring the proximity of the attachment figure. This was certainly the case for Alex who within the first six months had three suicidal crises resulting in brief hospitalizations. The significant amount of attention given to clarifying the roles and responsibilities of the participants and the establishment of a individualized treatment contract in TFP undoubtedly served to provide an external and containing structure for Alex that at least temporarily substituted for her own paucity of internal organization and gave her a sense of stability. Reflecting on the impact of the treatment in the PT-AAI at one year, Alex stated,

"I guess, I feel a little more secure, in general. Just because he's been so kind of reliable- like just sort of as a steady influence almost. I kind of feel like I survive the unreliable things in day to day life better just because there's something that's sort of steady...that's kind of safe helps with all the things that aren't safe. I guess the way a home would ideally when you're a kid."

It seems that Alex did come to view her therapist as a secure base, and that as a result was able to more effectively explore the contents of her existing mental representations as well as being open to alternative perspectives. Data from the ORI suggests that her representations of herself, her therapist, her mother, and her father became increasingly complex and differentiated, with a greater integration of positive and negative aspects.

One of the challenges in conducting psychotherapy with patients with a preoccupied state of mind is that the intensity of their emotional lives can be disorganizing and overwhelming for the therapist. Alex's therapist commented on this

dynamic in his PT-AAI when he spoke about his experience of her as seductive, noting that he had to be more on guard with her than he is with other patients to not get pulled out of his therapeutic role. His close attention to his counter-transference and his awareness of this dynamic appears to have helped him maintain his neutrality in a way that fostered Alex's ability to see herself and her feelings as separate from his and minimized the entanglement. This would explain Alex's marked improvement in her capacity for meta-cognitive monitoring and for reflecting on her own and others' mental processes and psychological states.

The tasks for a dismissing patient in treatment are fundamentally different than they are for preoccupied patients. Research by Dozier (1990) on dismissing patients' approach to psychotherapy suggests that as a group they may be more resistant to treatment, more reluctant to ask for help, and actively rejecting of help that is offered. Individuals with a dismissing attachment style are likely to enter treatment minimizing the impact of experiences of parental unavailability, neglect, rejection, and abandonment, for example, while enacting the effects of such experiences in their day to day lives and in the treatment. Slade remarks (1998), "In a very real sense, the representational systems of such patients seem particularly 'closed,' in the sense that their stories and self-experience do not appear open to change, presumably because the openness that would lead to change necessarily involves the retrieval and re-experiencing of painful emotions" (p.24). As a group, these patients might be expected to cling to fixed and rigid narratives of their lives.

Thus, for a patient with a dismissing attachment style, an essential component of therapy should involve the unpacking and deconstruction of defensively reified mental representations of self and others that have served to keep the emotional impact of difficult early experiences at a distance. This, in fact was a central thrust of Jen's treatment. In this light, it seems probable that what appears to be a regression in the level of separation-individuation in Jen's self representation reflects a loosening of a defensive foreclosure that would hopefully, especially in the context of more treatment, evolve into a more differentiated, complex self-representation. For this reason, it is important to note that progress in therapy cannot only be measured by increases in developmental level of object relations but sometimes by an expansion in the experiential continuum (Diamond et al., 1990; Kavanagh, 1985; Mitchell, 1988).

A related treatment goal for dismissing patients is the growing capacity to tolerate and acknowledge affect. Despite her efforts to keep a cool, self-protective distance from her therapist and from potentially disorganizing affect, Jen appeared to become better able to tolerate a wider range of affect over the course of treatment. In Jen's initial attachment interview, her active derogation of her parents served to shift her attention away from her hurt feelings and from the significance of these experiences to her. In contrast, at one year, she spoke poignantly about wishing she had felt more affection from her parents. In discussing the deaths of her grandparents, she was better able to talk about these relationships, what they meant to her, and how she misses them. Further evidence of her improved capacity for tolerating affect is seen in data from the State-Trait Anger Expression Inventory. Unlike Alex who endorsed high levels of trait anger that

diminished over the year, Jen did not begin treatment reporting high levels of trait anger and did not change in this regard after treatment. She did, however, after one year express an elevated score on state anger, indicating perhaps an improved capacity to access anger when situationally appropriate.

The therapist's interventions appear to have challenged Jen's tendency to distance herself from her affective experience in relationships and helped open up space for her better to explore the full range of her thoughts and feelings. Previous research has indicated that patients with dismissing attachment styles often become disorganized in therapy when confronted directly with emotional issues that they more typically set aside (Dozier, Lomax, & Tyrrell, 1996). There are in fact numerous indications that moving into this new territory was quite disorganizing for Jen and resulted in her retreating into private mental space much like she would hide as a child when upset. One of the ways in which this retreat was manifested was in Jen's resistance to taking in and grappling with the perspective of her therapist. Asked about how open he felt she was to new perspectives on herself, her therapist remarked, "She could tolerate hearing them because anything she didn't like, she just rejected... She generally didn't get upset because she'd just say, 'Oh, that's not true' or 'I don't believe you're right about that.' So she could tolerate hearing almost anything; she couldn't tolerate taking in almost anything." This may account for the fact that although security of attachment is strongly correlated with higher levels of reflective functioning, at one year, Jen's level of reflective functioning remained at the same low level as it was at the earlier assessment.

Reflecting on the treatment after it ended, her therapist remarked,

“I always felt that she was afraid that if she revealed too much, that I would either see her as crazy or somehow in the process, she might become crazy. So, there was just this sense that she was almost there against her will because she had to be in therapy...She gave the sense that she was being interrogated but giving as little as she could to get through the experience.”

Jen's tendency to withdraw and disengage did in fact lead her therapist to sometimes aggressively pursue her much like the mothers of avoidant infants have been found to be intrusive in response to the infant's aversion of his or her gaze (Beebe & Lachman, 1998). The treatment was characterized in part by her therapist's continuous efforts to break through her defensive armor to get at her underlying self and other object representations that locked her into maladaptive relational patterns, such as alternating between feeling rejected by others and actively shutting others out, thereby perpetuating her dissatisfaction in relationships.

Throughout the treatment, Jen relied most strongly on intellectualization and repression, defenses which have been found to be characteristic of individuals with a dismissing attachment style (Slade, 1993). While Jen showed a trend towards using increasingly higher level defenses over the course of treatment (albeit with a slight drop at one year around termination), she was nevertheless rated as using defenses more frequently in the latter half of the year. It appears that Jen felt an increasing need to protect herself from challenges to her fixed beliefs and assumptions. Interestingly, while Jen showed a higher frequency of use of defenses, she was using a narrower range of defenses at one year than Alex, reflecting less flexibility in her adaptation.

Like Alex, Jen experienced a decrease in her self-reported levels of symptomatology from the initial assessment to one year. Jen endorsed a higher level of

depressive symptomatology at the start of treatment and while her symptoms of depression diminished over the course of the treatment year, they remained at a higher level than Alex's at the one year point. This is especially interesting in light of the fact that previous research on individuals with dismissing attachment styles highlights their tendency to underreport symptoms because of their tendency toward defensive exclusion of distress (Kobak & Sceery, 1988; Dozier & Tyrell, 1998; Pianta, Egeland, & Adam, 1996). The bulk of previous research on individuals with dismissing attachment styles, however, has been conducted with non-clinical samples. Little is known at this point about how attachment intersects with more severe psychopathology. In the present study, however, in addition to her borderline pathology, Jen began treatment with a comorbid depressive disorder that probably accounts for her higher scores on the BDI across treatment.

There have been a growing number of studies exploring the relationship between attachment strategies and type of symptom presentation in clinical samples which suggest that dismissing patients tend more towards externalizing indices of distress, such as eating disorders, conduct disorders, and substance use while preoccupied patients more frequently manifest symptoms characterized by high levels of subjective distress such as depression and borderline personality disorder (Allen, Hauser, & Borman-Spurell, 1996); Cole-Detke & Kobak, 1996; Patrick, Hobson, Castle, Howard & Maughn, 1994; Rosenstein & Horowitz, 1996). Although given her self-report of symptoms of depression, Jen appears to fall outside of this trend for dismissing patients, she does have a history of both alcohol abuse and an eating disorder. Furthermore, while Jen was able to

acknowledge the existence of symptoms of depression on a self-report, there is other evidence to suggest that on an affective level, she has a tendency to keep intense emotions out of awareness from both herself and others. For example, as was mentioned earlier, prior to admission into this study, Jen had been in treatment with another therapist who was utterly surprised when Jen overdosed on her medication in a suicide attempt because she had not voiced either a change in her level of distress nor any indications of suicidal ideation.

Jen chose at the end of the research year to terminate treatment rather than to continue, which would have entailed her paying for treatment when she had recently decided to leave her job. When pressed by her therapist to explore her decision to discontinue the treatment after one year despite the gains she seemed to be making, Jen was constricted in her exploration, stating repeatedly that her decision was simply on account of not wanting to get a job that would enable her to afford the therapy. It seems likely that in a very fundamental way, the treatment had jostled Jen's longstanding rigid way of being in the world. She was feeling more previously disavowed emotions and less organized, such that it felt intolerable for her to continue in treatment at this time.

In sum, Jen made significant progress during this year of treatment. Perhaps her greatest achievement was an improved capacity for tolerating and more adaptively expressing her feelings, particularly anger. As can be seen on both the AAI subscale and the STAXI ratings, Jen expressed a greater awareness of anger towards others. Although the therapy pushed her to grapple with parts of herself, especially the presence of difficult affect, that she had previously kept out of awareness, she did not engage in any

physical self-injurious behavior or substance abuse in an effort to mute her feelings during the course of the year. Furthermore, overall, she reported a reduction in psychiatric symptoms at the end of the year. One could argue that in asserting herself the way that she did at the end of the year by refusing to continue in therapy, Jen was trying out a new role. Her therapist had persistently commented on the extent to which Jen altered herself to meet the needs of others. She had assumed the role of the good girl to minimize the likelihood that she would be rejected. In the process, however, she would disappear. She lost sight of who she was, what she felt, and what she wanted for herself. While in the big picture it would have been to her advantage to remain in treatment, it is possible that her insistence on terminating reflects an evolving facet of her emerging identity, a way in which she was practicing asserting her autonomy in the context of a secure attachment.

Limitations of the Study & Additional Directions for Future Research

While the findings present a multi-faceted perspective on the dynamic and evolving nature of internal character structure as it is influenced by a psychodynamic treatment, there are a number of limitations which need consideration. The most obvious limitation of this research is the small sample size.. While the fact that this research focused on the clinical course of two patients allowed for a more in depth study of clinical process and outcome, the findings cannot be generalized to a larger sample. On a related note, although empirically validated instruments were used in the assessments of these patients, the small sample size precluded statistical analyses of the findings. It is my hope that this study might be replicated with a larger number of subjects diagnosed with

borderline personality disorder. Another direction for future research would be to expand the study to examine the patterns of intrapsychic and symptomatic change in borderline patients from different ethnic, cultural, and clinical backgrounds.

While the findings demonstrate that both patients changed in considerable ways after one year, and it has been suggested that such change occurred as a result of their year in TFP, it is in fact impossible to know precisely what accounts for their progress without appropriate controls. In conjunction with her individual therapy, Jen was treated by a psychiatrist with an anti-depressant. It is likely that the medication and her relatively limited contact with this psychiatrist contributed to some degree to her clinical improvement. Jen, however, had been on anti-depressant medication at the time of her initial assessment, thereby minimizing the likely role medication played in the progress reported. In fact, both patients had had various psychiatric treatments prior to this study which is likely to have set the stage or planted the seeds for the type of work which was done during the research year. Furthermore, because no assessments were made after the first year, it is impossible to determine whether the patients maintained their gains past the year of research².

Thus, a further limitation of this research is the fact that the patients were studied for only one year. While both patients were found to have made significant improvements, one year of treatment for patients with this degree of pathology is

² Because Alex remained in treatment with the same therapist after the research year ended, I know from personal communication with her therapist that she continued to make significant improvements. Jen's future after the treatment year ended is unknown. It is impossible to know whether the gains she made during the treatment year were maintained (or ideally improved upon) outside of the treatment and without the ongoing relationship with the therapist in the study.

relatively short. The treatment manual suggests that major changes in the patients' identity diffusion and use of primitive defense mechanisms, for example, are not expected in the early phase of treatment which prioritizes the containment of destructive behaviors, including those that threaten the continuity of the treatment (Clarkin et al., 1999). Under optimal conditions, there is a gradual shift from predominant psychopathic and paranoid transference paradigms (caused by the primitive, split-off self and other representations) to depressive transference patterns more characteristic of patients functioning at a neurotic level of organization. According to the authors of the treatment manual, it is not until the more advanced phase of treatment that borderline patients respond to interpretations of their defenses by reflecting more freely and deeply about their experience corresponding with their being better able to tolerate and own previously projected representations. The patients' observations of their own and others' behavior have a less obviously distorted quality. In sum, although in one year, both patients in this study made substantial changes in both intrapsychic and symptomatic domains, it would be a worthwhile endeavor to conduct a similar study in which the patients could be assessed into the more advanced phases of treatment.

Finally, I'd like to address limitations of this study related to the particular measures that were used and to the timing at which they were administered. The Adult Attachment Interview (AAI) and its accompanying scoring system was not designed to be an outcome measure. This study demonstrates how the AAI can be used to assess clinical change, but more research is needed to establish its reliability as an outcome measure. In addition, as was mentioned above, the bulk of previous research conducted

with the AAI has been done with non-clinical samples. When this study was initially conceived, it was predicted that given their severe psychopathology, the patients might not have been readily classifiable using the current system. It is important to be cautious in generalizing findings from studies conducted with normal populations using the AAI to those assessing more disturbed populations. Further research is needed to determine what if any differences exist in how adult attachment strategies are manifest in individuals with more psychopathology. Given the limited extent to which the AAI had been given to clinical populations and the emotionally challenging nature of its questions, a decision was made to administer the interview at four months into the treatment rather than at admission into the study. While it is possible that their narratives might have been different before four months of TFP, it is unlikely that their major classifications would have been different.

It would also have enriched the study to have had an additional measure of the quality of the attachment between the patients and the therapist and between the patients and significant others. In the time since this dissertation was conceived, Diamond and colleagues have developed a scoring system for the Patient-Therapist Adult Attachment Interview (PT-AAI) that attempts to classify the attachment status of patient and therapist within the dyad. The PT-AAI offers another way of examining the role attachment plays in influencing transference-countertransference dynamics and the quality and nature of the therapeutic alliance (Diamond, Clarkin, Stovall-McClough, Levy, Foelsch, Levine, & Yeomans, in press).

Another instrument that was used in the present study that warrants further discussion is the Defense Mechanism Rating Scale (DMRS). The empirical investigation of defense mechanisms is relatively new and further work is needed to improve upon the validity and reliability of these instruments (Greene, 1996). One obvious limitation of the DMRS is that it assesses the presence of different types of defenses but does not measure the degree or intensity of the defense. Another is related to the use of the overall defense maturity score in a study with only two subjects. In this study, the overall level of defensive maturity ratings appears to have been too crude a measurement to capture the changes in the patients' use of defenses. It proved more valuable to look more closely at the level of the individual defenses rather than aggregating the scores. Another factor to be considered is the fact that sessions were rated on the basis of transcripts alone rather than audio or videotapes. Thus, certain defenses that might have been picked up had the rater had access to the patient's tone of voice or body language were not detected. Affect can be difficult to detect in the absence of emotionally laden words. For example, dissociation, which although it has been associated with the unresolved attachment status was not detected in any of Alex's sessions, might be easier to detect with the presence of audio data because it is often accompanied by a change to a softer, wispier, and distant tone of voice (Perry, 1990). Furthermore, in the current study, one session was rated every four months, which is a relatively small sampling of the overall number of psychotherapy sessions. Certain defenses, particularly some of the more primitive defenses, such as splitting, might have been more easily detected across a number of continuous psychotherapy sessions.

Conclusion

This dissertation adds to the growing body of support validating the effectiveness of transference focused psychotherapy in ameliorating the disturbances in attachment and object relations believed to underlie borderline personality organization. While both patients were rated as having shifted from insecure to secure states of mind with respect to attachment, findings from the other measures of their object relations, defenses, and symptomatology paint a more nuanced picture of their trajectories of change. The findings suggest that the complexity of intrapsychic change is best captured through the use of multiple empirically validated measures. The two cases used in this research were studied individually and in relation to one another. The findings demonstrate the ways in which patients' attachment styles not only influence the nature of the therapeutic relationship that is likely to develop but also forecast the quality and direction of change one would expect to see as a result of a successful treatment.

APPENDIX A

Reflective Function (RF) Scale Points

Scale Point -1: Negative RF

An overall rating of -1 is given to interviews where the subject consistently resists taking a reflective stance. The subject is either hostile to the notion of reflection which is expressed in derogation and dismissal of the interviewer's attempts to elicit such reflection or is so confused about their attempts at reflection that their comments are viewed as bizarre, unintegrated, and inappropriate.

Scale Point 1: Absent but not repudiated RF

An overall rating of 1 is given to interviews where reflective-functioning is almost totally absent. Mental states may be alluded to but are not elaborated upon such that the speaker gives no sense of recognition of his or her own or others' beliefs and feelings underlying behavior. Mental states are either ignored or are distorted and self-serving.

Scale Point 3: Questionable or Low RF

An overall rating of 3 is given to interviews that contain a rudimentary level of consideration for mental states. For example, the subject may consider developmental or intergenerational elements but is not specific enough to warrant higher ratings. References to mental states may be either naïve (simplistic) or over-analytical (hyperactive RF).

Scale Point 5: Ordinary RF

An overall rating of 5, the most common rating in a high functioning, non-clinical sample, is given to interviews in which the speaker shows a number of convincing indications of having a coherent model of the mind of both self and caregivers. The subject either gives consistent evidence of level 5 RF or combines highly reflective remarks (characteristic of a scale point 7) with more rudimentary, superficial ones (characteristic of a scale point 3).

Scale Point 7: Marked RF

An overall rating of 7 is applied to interviews where the subject gives abundant evidence of reflective functioning, showing awareness of the mental states of others and explicit attempts at identifying mental states underlying behavior. The subject readily supplies detail about his or her own and others' thoughts and feelings. A developmental and intergenerational perspective is characteristic of these interviews.

Scale Point 9: Exceptional RF

An overall rating of 9 is given only rarely but is warranted when the subject shows exceptional sophistication in his or her understanding of mental states. Subjects show a consistent, integrated, and fresh reflective stance across contexts.

The above description of the reflective function scale points was adapted from Fonagy, Target, Steele, & Steele's (1998) Reflective-Functioning Manual (Version 5) for Application to Adult Attachment Interviews.

APPENDIX B

Self-Other Differentiation and Relatedness Scale Points

Scale Point 1:

Self-other boundary confusion (physical): Basic sense of physical cohesion or integrity of representations are lacking or are breached.

Scale Point 2:

Self-other boundary confusion (intellectual/affective): Self and other are represented as physically intact and separate, but feelings and thoughts are amorphous, undifferentiated, or confused. Description may consist of a single global, impressionistic quality or a flood of details with a sense of confusion or vagueness.

Scale Point 3:

Self-other mirroring: Characteristics of self and other, such as physical appearance or body qualities, shape or size, are virtually identical.

Scale Point 4:

Self-other idealization or denigration: Attempt to consolidate representations based on unitary, unmodulated, idealization or denigration. Extreme, exaggerated one sided descriptions.

Scale Point 5:

Semi-differentiated self and other (rapprochement): Tenuous consolidation of representations through splitting (polarization) and/or by an emphasis on concrete part properties. Marked oscillation between dramatically opposite qualities.

Scale Point 6:

Emergent, ambivalent constancy of self and an emergent sense of relatedness: Emerging consolidation of disparate aspects of self and other in a somewhat hesitant, equivocal, or ambivalent integration. A list of appropriate, conventional characteristics that is lacking a sense of uniqueness. Tentative movement toward a more individuated and cohesive sense of self and other.

Scale Point 7:

Consolidated and constant (stable) sense of self and other in unilateral relationships: Thoughts, feelings, needs and fantasies are differentiated and modulated. Increasing tolerance for and integration of disparate aspects. Distinguishing qualities and characteristics. Sympathetic understanding of others.

Scale Point 8:

Cohesive, individuated, and empathically related self and other: Cohesive, nuanced, and related sense of self and others. A definite sense of identity and an interest in interpersonal relationships and a capacity to understand the perspective of others.

Scale Point 9:

Reciprocally related, integrated, unfolding self and other: Cohesive sense of self and others in reciprocal relationships that both transform both the self and the other in complex, continually unfolding ways.

Scale Point 10:

Intersubjective (constructive) self and other: Creative, integrated constructions of self and other in reciprocally attuned relationships with an appreciation that one contributes to the making of meaning in complex, interpersonal relationships.

APPENDIX C

The Defense Mechanism Rating Scale

Coping Mechanisms

Level 7: High Adaptive Defenses

Affiliation- Turning to others for help or support when conflicted or under stress

Altruism- Dedication to fulfilling the needs of others instead of focusing on one's own conflict and stresses

Anticipation- Anticipating and experiencing future distress mentally by joining the disturbing ideas and feelings and developing or rehearsing alternative solutions

Humor- Focusing on amusing or ironic aspects of conflicts or stresses

Self-assertion- Direct expression of feelings and thoughts to achieve goals without coercion or indirect manipulation

Self-observation- Reflecting on one's own thoughts, feelings, motivations, and behavior to see oneself in interpersonal situations as others do; use of insight to handle conflicts or stresses

Sublimation- Channeling, not inhibiting, potentially maladaptive feelings or impulses into socially acceptable behavior

Suppression- Temporary and volitional delay of contemplation of disturbing problems, wishes, feelings, or experiences until the appropriate time to deal with them

Mental Inhibitions (Compromise Formations)

Level 6: Obsessional Defenses: defenses that minimize affect without distorting reality

Intellectualization- Excessive use of abstract thinking to avoid experiencing disturbing feelings

Isolation- Inability to experience cognitive and affective components of experience simultaneously by keeping affect outside awareness

Undoing- Negation of previous thoughts, feelings or actions or use of symbolic behavior to make amends

Level 5: Hysterical Defenses: defenses that keep unacceptable ideas or stresses out of awareness

Displacement- Generalizing or redirecting a feeling or response to an object onto another usually less threatening object, often without awareness of doing so

Dissociation- Temporary alteration in the integrative functions of consciousness or identity to keep conflictual affect, impulses or thoughts outside awareness

Reaction Formation- Substitution of behavior, thoughts, or feelings which are diametrically opposite to unacceptable thoughts or feelings

Repression- Inability to remember disturbing wishes, feelings, thoughts, or experiences

Level 4: Narcissistic Defenses: defenses that reflect minor image distortion

Devaluation- Exaggerated attribution of negative qualities to self or others

Idealization- Exaggerated attribution of positive qualities to self or others

Omnipotence- Acting superior to others as if one possessed special powers or abilities

Level 3: Disavowal Defenses

Denial- Refusal to acknowledge some aspect of one's own experience or external reality which is apparent to others

Rationalization- Use of reassuring or self-serving but incorrect explanations for one's own behavior or that of others to avoid experiencing the associated affect

Projection- False attribution to others of one's own unacknowledged feelings, impulses, or thoughts

Level 2: Borderline Defenses: defenses that reflect major image distortion

Autistic Fantasy- Substitution of excessive daydreaming for human relationships or more direct and effective action or problem-solving

Projective Identification- Projection of an unacceptable affect or impulse onto someone else as though the other person originated it

Splitting Image of Self or Others- Failure to integrate into cohesive images the positive and negative qualities of oneself or others, often with alternation of positive and negative aspects

Level 1: Action

Acting Out- Acting without reflection or regard for negative consequences

Passive Aggression- Indirect and unassertive expression of aggression toward others often with overt compliance and covert resistance

Hypochondriasis (Help-rejecting complaining)- Repeated complaining with an ostensible request for help. which is rejected and thereby expresses covert hostility or resentment toward others

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