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Attachment Theory and Psychoanalysis: A Single Case Study

Anna Buchheim & Horst Kächele

Department of Psychotherapy and Psychosomatic Medicine, University of Ulm

1. Introduction

When Daniel Stern published his monograph on the Interpersonal World of the Infant (1985) he has retrospectively opened a new phase in the history of psychoanalysis. There had been the immense work of many generations of clinicians to reconstructing their patients´ account of history in the clinical setting[1] underscoring the importance of development: This genetic point of

[1] These intensive endeavours created the clinical reconstructed baby – to be more specific created the many clinical babies one in each theory

„These descriptions are constructions created by fathers and mothers such as Freud, Abraham, Klein, Ferenczi, A. and M. Balint, Winnicott, Mahler, and Kohut. Everyone is aware that the various psychoanalytic babies differ greatly. The designers of the models must put up with the fact that their creations are compared. Kohut's tragic man lies as an infant in the cradle surrounded by an environment (the so-called selfobjects) which only partially reflects his innate narcissism. The fact that Freud's theory of narcissism was the godfather makes the tragedy almost inevitable, but it is nevertheless bathed in a relatively mild light: evil is not a primary force, and oedipal guilt feelings are avoidable, according to Kohut, if the early tragedy is limited and the narcissistic self discovers itself in the mirror of love (Kohut 1984, p. 13). In Kohut's theory, Freud's guilty, oedipal individual and his intrapsychic conflicts are the product of a narcissistic disturbance in early childhood. Without this disturbance, the oedipal conflicts of 3- to 5-year-old children would be principally pleasurable transitional phases, leaving no appreciable guilt feelings as long as a healthy self had already developed. Kohut's theory gives the individual the prospect of a future free of oedipal conflicts. It can be inferred from Kohut's late works that, provided the empathy of the selfobjects is good, the human tragedy also stays within reasonable bounds.

Klein's (1948, 1957) psychoanalytic infant is quite different. This time the godfather was Freud's death instinct, ensuring a malevolence whose early manifestations are unrivalled and which can only be endured by dividing the world into a good breast and a bad breast. The tragedy of the infant's later life is then profound, in contrast to Kohut's mild form, which may find expression in selfironic humor. Klein's adult was born as

view, however, is not in contrast with Kurt Lewins statement that only forces and conditions in the „here and now„ can have therapeutic effect. Rapaport (1960) pointed out that this means only that many events occuring now in an individual only can be understand by exploring his or her development.
There also had been, quite unknown by most psychoanalytic clinicians, a steadily growing field of developmental observational research triggered by new methodologies of „asking the baby„ and thus finding answers to questions nobody dared to pose before. This created the „observed infant„.

Our knowledge of developmental processes in early childhood has dramatically changed in the meanwhile. Manifold studies on the „Natural history of mother-child-relationship in the first year of life – to quote Rene Spitz 1965 – have led to new thoughts in constructing the the „clinical infant„. The new theories on early developments will integrate theories of communication and action and this will have considerable impact on all psychoanalytic orientations (Kächele et al. 2000). This impact of newer research on psychoanalysis is neatly described in a paper in the recent issue of Psychoanalytic Quarterly:

Sisyphus, condemned to eternal failure in his attempts to atone for the imaginary wrongs inflicted by hate and envy. Throughout life the processes of projective and introjective identification, and their contents, remain the basic vehicles of interpersonal processes, within families and between groups and whole peoples.

In restricting ourselves to the description of the essential features of two influential models of the psychoanalytic infant, we have highlighted dissimilarities and contradictions. This was our intention. Our current concern is not to advocate pragmatic eclecticism and recommend that the most plausible components be extracted from all the psychoanalytic theories of early childhood and amalgamated with elements of general developmental psychology or parts of Piaget's theory. Rather, we believe that productive eclecticism within psychoanalysis, and within neonatological research into interaction, is only possible if we also examine the aspects which are neglected in the different constructions. It is, after all, disturbing that similar empathic introspective methods — Kohut emphasized his closeness to Klein in this respect — should result in entirely different reconstructions of early childhood.

One possibility, of course, is that contradictory reconstructions originate in the treatment of different illnesses. However, the available literature does not support this hypothesis, which, incidentally, is seldom considered by the fathers and mothers of typical psychoanalytic infants. Sooner or later, the theoreticomorph creation is made the uniform model for explaining the deepest levels of all psychic disturbances: self defects, based on unsuccessful mirroring, and the schizoid-paranoid and depressive positions, founded in innate destructiveness, seem to be the root of all evil.„ (Thomä & Kaechele 1987, p.49)

„Freud´s legacy is our important heritage: there is a great deal in Freudian theory that informs our contemporary outlook. However I believe that Freudian theory can be enriched and enhanced by current information from developmental research. I have in mind specifically the affect-regulating function of the attachment system„ (Silvermann 2001, p. 325).

Bowlby (1969) was the first psychoanalyst of his generation to use ethological terms to describe the infant's biologically predisposed availability of attachment to a main caregiver. He saw relatedness in early childhood as a primary and independent developmental goal that is not subservient to a physiological need such as hunger. From this point of view the infant is perceived from an interactional perspective focusing on relationship aspects. Attachment theory has taken up aspects of psychoanalytic theory and also developed some aspects further (Diamond & Blatt 1994). Fonagy (1999, 2001) demonstrates that the relationship between attachment theory and psychoanalysis is more complex than adherents of either community have generally recognized. In his excellent overview he proposes many points of contact, and significant points of divergence.

George & Solomon (1999) propose that a major difference between psychoanalysis and attachment theory falls in the description of the defensive processes themselves. Traditional psychoanalytic models provide a complex constellation of defenses to interpret a broad range of intrapsychic phanomenon, including phantasy, dream, wish, and impulse (e. g. Horowitz 1988, Kernberg 1994). According to George and Solomon (1999) Bowlby´s perspective conceives defensive exclusion in terms of two qualitatively distinct forms of information processing: deactivation (similar to repression) and cognitive disconnection (similar to splitting). These two defensive strategies provide the individual (infant and adult) with an organized form of excluding information from conscious awareness or seperating affect from a situation or person eliciting it. Regarding severe psychopathology Bowlby (1980) suggested that under certain circumstances these two forms of exclusion can lead to a disorganized form of representation, what he calls segregated systems. George and West (1999) conclude: „In order to understand the relationship between adult attachment and mental health risk we need to examine the attachment concepts of defense and segregated systems, the mental processes that define disorganization„ (S. 295). Suggesting that these representational structures have

developed under conditions of attachment trauma (abuse, loss) the concept of segregated systems is fruitful to explain some forms of relationship-based psychopathology in adults.

In the following chapter, we provide an idea about the utility of attachment concepts for our clinical work by using the cooperation of a clinician and an attachment researcher to improve the understanding of an individual case.

2. Attachment and Psychopathology

In 1988 Bowlby explicitly asserted that resilience to stressful life events in later life is influenced by the pattern of attachment developed during early years. Looking across the volumes of Bowlby´s trilogy (Attachment 1969; Separation 1973; Loss 1980) it can be seen that attachment theory rests on three constructs: 1. behavioral systems, 2. representational models, and 3. defensive exclusion.

1. The attachment system is viewed as an internal goal-gorrected system that permits attachment behaviors (crying, seeking proximity) to be organized flexibly around a particular attachment figure. Under certain conditions, the attachment system is strongly activated, leading the child to seek and to be satisfied with nothing less than close proximity to the attachment figure.
2. Bowlby proposed that the child builds representations of self and the attachment figure that he termed „internal working models„. The models reflect the child´s confidence in the self as acceptable and worthy of care and protection. These models, in turn, organize thoughts, memory, and feeling with regard to the attachment figure and serve to guide future behaviour and internal representations of attachment.
3. When attachment behavior (crying, calling) persistently fails to regain that attachment figure, the child is forced to develop defensive strategis that exclude this painful information from consciousness.

While substantial differences exist between studies, broadly it may be legitimately claimed that securely attached infants tend to grow up to be healthier in terms of emotional expression, and social relationships, more competent in terms of language skill and achievement, and to have a more positive self image than insecurely attached ones (Grossmann et al. 1999). Disorganised infants by contrast are more likely to develop substantial social problems at school, to exhibit aggression and a variety of psychiatric difficulties (Lyons-Ruth et al. 1993; Solomon & George 1999).

Bowlby never took a deterministic view on early attachment experiences. He saw the developmental path of attachment organisation as flexible and would not subscribe to the view that once an attachment relationship was secure it would always be secure (Bowlby 1988). Extreme emotional experiences due to separation or loss may change attachment quality and may lead to a change

in self-esteem (Zimmermann & Grossmann 1997). Similarly, it may be assumed that the inner working model of an early insecure attachment experience may be reorganised. This should be the case after a new positive experience with a partner or in psychotherapy (Fonagy et al. 1995).

The systematic description of childhood relationship experiences led to the construction of an attachment theory with a life-cycle perspective. Since early relationship experiences seem to influence adult relationships, there has been a growing interest in the attachment representations of adults. An essential step in this development was the so-called "move to the level of representation", which was taken by George, Kaplan and Main (1985). The authors have developed a semistructured interview, the Adult Attachment Interview (AAI), designed to elicit thoughts, feelings and memories about early attachment experiences and to assess the individual´s state of mind in respect to attachment: secure-autonomous, dismissing, preoccupied, and unresolved state of mind[2]. The interviews, transcribed literally, are rated along different scales e. g.: loving relationship with mother and father, quality of recall, idealization and derogation of relationships and most importantly coherence (Grice 1975) of the narrative. The AAI measures the current representation of attachment experiences in terms of past and present on the basis of narratives. The questioning technique aims at the extent to which a speaker is capable of spontaneously recounting his or her childhood history in a cooperative, coherent and plausible way.

Grice (1975) identified rational or coherent discourse as following an overriding „Cooperative Principle„ which normally requires adherence to four maxims that can be summarized as follows:

Quality - be truthful, and have evidence for what you say
This principle is violated when a person is vague, shows factual or logical contradictions, rapid oscillations of viewpoint or two or more story lines
Quantity - be succint, and yet complete
This principle is violated when a person gives more or less information than necessary
Relation - be relevant to the topic at hand

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[2] The first three states of mind are the organized forms of exclusion, the fourth one is the disorganized form, what Bowlby (1980) calls segregated systems.

This principle is violated when a person is going off track, inserts personal experience, or jumps from past to present
Manner - be clear and orderly
This principle is violated when a person uses jargon, filler words, odd phrases, or run-on-sentences.

The identification of a specific organization of speech by discourse-analytic technique leads to one of the following states of mind with respect to attachment (Main & Goldwyn 1996):

- Adults with the classification secure (F) give open, coherent and consistent accounts of their childhood memories, regardless of whether they were positive or negative. They are able to integrate their various experiences into a unitary whole and to reflect upon their accounts during their interviews. These persons have free access to the topics asked about and show a feeling for balance.

- Adults with the classification dismissing (Ds) give incoherent incomplete accounts of the experiences and often show gaps in memory. As defense against the surfacing of painful memories, they minimize the importance of attachment. These people insist on normality and inner independence from others. Attachment figures are mostly presented positively without being able to give concrete examples for this. Possible negative influences are denied.

- Adults with the classification preoccupied (E) recount in an excessive, often non-objective, and angry way, the conflicts experienced with their attachment figures. They appear enmeshed and give the impression that past experiences are currently occurring, and that they are unable to distance themselves from them. They describe conflict-stricken events and offer exaggerated pseudo-psychological analyses of them. Characteristic of preoccupied people is the oscillation between positive and negative evaluations, without being conscious of the inherent contradiction. In general, their language seems confused, unclear and vague.

To summarize: It is suggested that „secure„ discourse can be understood in terms of a capacity for fluid shifting attention between memories and

maintenance of coherent discourse with the interviewer. The differing forms of *organized* but „incoherent„ (insecure) discourse identified by Main & Goldwyn are conceptualized as strategies that involve maximization or minimization of attention towards attachment-related topics (Hesse 1999).

The categories of *secure, dismissing and preoccupied* have been found to classify adequately more than 80% of all individuals. In addition to these three main categories, a fourth classification *unresolved* state of mind has been developed in order to account for experiences of trauma and loss.

- Adults with the classification unresolved (Ud) show temporary lapses in the monitoring of reasoning or discourse during discussion of potentially traumatic events. Specifically, lapses in reasoning - for example, indications that a speaker believes that a deceased person is both dead and not dead - may indicate parallel, incompatible belief and memory systems regarding a traumatic event that have become dissociated. Lapses of monitoring of discourse, such as sudden change into eulogistic speech, suggest the possibility of state-shifts.

Though the Adult Attachment Interview (George et al. 1985; Main & Goldwyn 1996) was developed in a non-clinical, transgenerational context this system could be shown to discriminate between clinical and non-clinical populations (van IJzendoorn & Bakermans-Kranenburg 1996). The effect size discriminating both groups (d = 1.03) was found to be strong. Ultimately, in a four-way-analyses, only 8% of members of clinical samples were judged secure. Furthermore the „unresolved status„ is the most overrepresented state of mind among persons with psychiatric disorders (Dozier et al. 1999). Recently George & West (1999) conclude that „in summary the attachment contribution to mental ill health is not the product of avoidance, but rather the product of attachment disorganization that results in repeated experiences of dysregulation and breakdown of defense„ (S. 298).

Attachment representation has emerged as an important construct in understanding the development of psychopathology and in targeting areas for intervention (Bowlby 1988). A number of studies have suggested that measures of attachment status provide an index to pathology of object relations in clinical populations and to changes in such pathological self and object representations that are expected to occur in the course of psychotherapy. Attachment

constructs have increasingly been used to understand etiology, treatment, and prognosis of severe personality disorders, like borderline pathology (Fonagy 1991, Fonagy et al. 1995, 1996; Diamond et al. 1999). Clinical researchers have understood fundamental aspects of borderline conditions such as unstable, intense interpersonal relationships, feelings of emptiness, bursts of rage, chronic fears of abandonment, and intolerance for aloneness, as stemmming from insecure attachment organization (Diamond et al. 1999; Fonagy 1991).

What these findings mean in terms of the causal connection between attachment state of mind and psychiatric disorder is still unclear (Dozier et al. 1999). Clinical researchers (Rosenstein & Horowitz 1996; Cole-Detke & Kobak 1996, Patrick & Hobson 1994) suggest that some „externalizing„ disorders (i. e. eating disorders, conduct disorders) are associated with a dismissing state of mind, and that an „internalizing„ disorder (i. e. borderline disorder) is associated with preoccupied states. Dozier et al. (1999) discussed that inconsistent results in the literature (e. g. studies with depressive patients) point to the importance of diagnostic issues when one is considering linkages between attachment status and heterogeneous disorders like depression (unipolar/ bipolar) or anxiety (phobia/generalized anxiety).

The case we present in the following is a female patient with the diagnosis „narcissistic personality disorder with a borderline organisation„. Clinically patients with borderline personality have a notably unstable self, representations of others are undeveloped and unstable, such as others are idealized at times and devalued at other times. A central issue is the fear of abandonment by an idealized other. Another criteria is the presence of serious anger and rage manifested in intense outburst (Kernberg 1996). Borderline pathology is generally associated with exaggeration of symptomatology and of negative affect, as well as a „preoccupation„ with concerns about current and previous relationship difficulties.

Two studies with the Adult Attachment Interview (George et al. 1985) indicated that borderline patients may be distinguished from other clinical groups by their propensity to be classified as fearfully preoccupied (E3) with respect to attachment-related traumas:

- Fonagy et al. (1996) found that 75% of persons with borderline personality disorder had „preoccupied„ states of mind, and that half of those fell in a rarely used subgroup, fearfully preoccupied (E3) with

respect to traumatic events. 89% of borderline patients were classified as „unresolved„ concerning abuse.

- Patrick & Hobson (1994) found that all women with borderline personality were classified as „preoccupied„, and 10 of 12 were classified as E3, which often co-occurs with unresolved status. In this study 75% of the borderline patients were classified as „unresolved„.

According to the work of Rosenstein & Horowitz (1996) variations in attachment classification may discriminate among subtypes of borderlines. Some studies indicate that those with antisocial and/or narcisisstic and paranoid features tend to be classified as dismissing, while those with histrionic, obsessive-compulsive, affective, or schizotypal features tend to be classified as preoccupied (Levy & Blatt 1999). Chronically self-injurious or parasuicidal borderline patients tend to be classified as unresolved with respect to potentially traumatic events.

Diamond et al. (1999) discussed that although physical and sexual abuse have been repeatedly implicated as etiological factors in borderline disorders, several studies show that a family climate of emotional violence and neglect in conjunction with insecure attachment is more strongly associated with the development of borderline personality than the specific trauma of sexual abuse. The authors suggest that further research is needed to clarify the complex interconnections between intrafamilial abuse, familiy chaos, and insecure attachment in borderline personalities.

3. Case of a female narcissistic patient with a borderline organization

The clinical material

A well educated 50 year old female teacher working at a grammar school directly approached me (HK) as chief of the university psychotherapy department. Before coming to the first appointment she delivered a carefully typed long letter to me describing not only her complaints but including also excerpts from psychoanalytic papers. In the patient´s view these contained her basic psychodynamic issues. She described a state of intractable psychic pain, that resulted from years of unresolved anger and sorrow about being caught in a distinctly sado-masochistic love relationship and then deserted by her lover.

Her painful mental state and manifold somatic correlates had been slightly mitigated by a five year long supportive psychotherapy with a supportive elderly female therapist. The former therapy had helped her to control her suicidal ideation. However from time to time she returned to stating that „if this feeling can´t be changed I´m going to kill myself. But when this happens I shall take two or three other persons with me.„ Her intense, easily activated anger was directed at her ex-lover and two chiefs of psychotherapeutic hospitals that had treated her. In her point of view both of them had maltreated her. Against one of them she had filed a law suit and achieved a reimbursment of 50% of the bill for his not doing his job properly.

During the initial interview I met a clear thinking, politically well educated woman, who kept a watchful eye on me along with her demanding friendliness. She had selected me – coming from a regional town – as an expert who was known to her by the Ulm textbook on psychoanalytic therapy that I had co-authored with Dr Thomae. Despite her seeming positive orientation to me, the psychometric forms she had been asked to fill out were filled with critical, devaluating remarks. „where are we - is this a concentration camp?„ She regarded filling out the forms as an „act of rape„. The dynamics of the initial interview confirmed her written description of herself as having been a traumatised person early in her life but having managed well for a considerable period. She studied political science and German and became a teacher in the regional town close to her home village. She was married while still a student to a ten year older colleague that taught at the school where she later also became a teacher.

My attitude – quite soon a heroic mixture of scepticism and curiosity – was determined by her emotional statements like: „never use the term transference and never talk about my father or mother. Whenever when I hear those words, I get sick.„

She accepted a twice weekly psychoanalytic therapy in a face-to-face setting. The diagnosis of a narcissistic personality disorder with a borderline organisation structure was based on her intense angry responses to her intimate partners accompanied with intense states of inner emptiness. Situations of loss of control led to rapid interruptions of relationships – a capacity that in her successful career as a local politician was of great use. Since childhood she suffered from a fear of darkness, a symptom I learned about later in treatment. Her positive resources consisted of a creative altruism and a capacity for adaption and work. Helping victims like pupils in school,

or poor female employees in the local government brought forth her talents. With her slightly chronically anxious husband she shared musical talent that she developed to a level of semi-professional competence. For many years she and her husband lived in a relative social and intimate stability. They engaged in little sexual activity with her being the activator. Based on her dissatisfactions, their stabilty was gradually undermined, she began to engage successfully in local politics. Her existential crises began at age 41 when she got involved in a romantic relationship with a married musician, with whom she also performed. As long as she resisted his offers she felt well, but when she finally fullfilled his wishes, it turned out to be a nightmare for her. He suddenly became rarely available and her fights to get at least his voice on the phone left her feeling crazy.

The patient had paid for the supportive treatment privately in order to maintain an illusion of being a „non-patient„. Although for practical reasons, the therapists prefer private payment, I insisted on the formal procedure of insurance coverage in order not to facilitate her disavowal. The treatment was complicated right from the beginning. A stabile therapeutic alliance or an observing and experiencing ego (in the sense of Sterba) was hard to realize. Rapidly generated intense idealization of my „superb technical qualities„ would suddenly be ruptured by psychic depressive breakdowns stirred by comments she regarded as unsuitable. After such sessions she would send me a fax threatening never to come back. With the help of telephone conversations about what has happened we survived many crises and slowly achieved a more stabile therapeutic alliance. The therapeutic process was characterized by ups and downs, that resulted from rapid changes of identifications. Sudden primitive defenses of splitting all-good and all-bad from one moment to another caused a breakup of her psychic capacity for integration. The same process took place in her bodily complaints of intractable somatic pains that could disappear at once when the therapeutic relationship had been restabilised. Therapeutic work mainly focused on the current relationship to her mother. She was taking care of her 81 year old demanding mother who still could not find any positive feature in her daughter. By and by the biographical perspective on the mother-daughter relationship opened a way to help the patient work through her unconscious masochistic involvement in repeated efforts to get support and recognition from her mother.

After two years the patient´s state had considerably changed. Instead of continously searching out the badness of the world, and especially that of her

mother, she had reached a sort of „Nachdenklichkeit„, what Peter Fonagy describes as an increase in self-reflective function. Now she could observe that whenever my words did not conform to her ideas, she would get furious and helpless. We could differentiate her and her mother´s part in the relationship, and she decided to accept the help of a geriatric service for the mother.
The concept of transference in terms of her life long experiences made it possible to understand her experience of my maltreating her. Her sense of powerlessness as her core experience became well identifiable. References to her father were rare; she once mentioned a dream in which a strange person appeared looking like a fatherly figure. In the first two years, she denied any connections with this unknown person, but later her father entered the treatment.

4. The Adult Attachment Interview of the patient

The patient was interviewed with the AAI by the first author 6 months after beginning the psychoanalytic treatment. She was classified as „preoccupied„ and additionally with an „unresolved state of mind„. In the following we will give parts of the AAI-transcript to clarify the coding-procedure:

Transcript-example: Preoccupied state of mind

I: hmm hm how would you describe the relationship to your parents, your mother and father, when you were a child?

P: -- hm- this long silence says a lot (laughs), I couldn´t rely on them, I couldn´t rely on them, never.

I: hmhm

P: I still can´t, my mother needs to be cared for today, and other people have to coordinate with me all the time, the neighbours and the social institution, they have to check if it´s right what she is saying or is she lying, these are experiences with her, I would say „aggressive caregiving„, I was not able to be ill, and when I was ill, then, these teas, I didn´t like, that´s why I am not able to drink these herbal teas up to now, just without sugar, something like that, hm being ill was really a mess for me, hot potatoes around my neck, hm I would say aggressive caregiving, I tried to be healthy again as fast as possible, today I can be more generous with myself in that case very slowly, being ill, but that costed me many years, with my father I didn´t have a good relationship either, I can´t report something positive, very little, my

mother always told my father what I did wrong, she did that probably also with my ten year older brother, she told my father, and when he came back in the evening he hit us, something like that, it just happened yesterday, two weeks ago I got frightened, he always scared me when I was a child, I still suffer of that, it happens often today that I get frightened when somebody is in the same room though I know who is present. I don´t have any feeling of security, and I always thought, some day we will have a break down and my father will be unemployed, he was popular in his job but as a child I always had that feeling that everything can fall apart very fast and I worked in early years, also in the holidays, and tried to earn some money, I always had the feeling there is no security, nothing to rely on.

This passage shows that the patient is still struggling with her past and she can´t present an objective picture of her childhood experiences. She accuses her mother in an angry manner and oscillates between past and today. She is scared by her father, and still suffers from a stable insecure feeling. She doesn´t provide a coherent speech, often looses track, and gives too much information. She violates the criteria of quantity and relevance.

According to Main & Goldwyn´s (1996) criteria, an individual should be classified as „unresolved„, when during discussions of loss or abuse, he or she shows striking lapses in the monitoring of reasoning or discourse:

<u>Loss:</u>

- Indication of disbelief that the person is dead
- Indication of confusion between self and dead person
- Disorientation with respect to time and space
- Psychologically confused statements
- Extreme behavioral reaction to a loss

<u>Abuse:</u>

- Unsuccessful denial of the occurence or intensity of the abusive experience
- Feelings of being causal in the abuse and deserving it
- Disoriented speech

The patient shows two of these aspects in the AAI, which were an indicator of her unresolved state of mind: 1. she denied being abused (hitting) by her mother, 2. she forgot the day when her father was dying.

Transcript-example: Unresolved state of mind with respect to abuse

I: Have you ever felt being threatened by your parents when you were a child?

P: no, being threat, no I haven´t felt like that, I can remember that I always thought, when I feel too bad, I can commit suicide, hm this change, when my mother hit me, I thought she hits me to death, when I came home too late, I had a lot of anxiety, to be hit like that, but when it happened I thought I will survive, that was the feeling I told you before, this kind of inner emigration, death was never scary for me but a solution in a way.

She continues later

P: I really can´t say that I felt threatened, it wasn´t too closed for that, I could go out in the air, maybe there were some situations where I felt threatened, I don´t know.

The patient shows a logical contradiction when being asked of any abuse in childhood. She oscillates between memories having enormous anxiety, when her mother hit her, and a disbelief that she felt threatened by that. She is judging death simultanously as a solution and a terrifying event. A crucial criteria for the coding-procedure is, that she doesn´t remark on this contradiction by herself, which highlights the unresolved process.

The next passage shows her unresolved state of mind with respect to the loss of an important attachment figure. Also in this passage the patient doesn´t realize her lapses of thought and reasoning.

Transcript-example: Unresolved state of mind with respect to loss

After being asked about losses in childhood and later life, the patient remembers the loss of her grandfather, the loss of her singing teacher, and the loss of her brother´s son. She is talking about these several losses in detail and didn´t show any laspes. She then insisted on not having experienced another

loss. So the interviewer came to the next questions in the AAI. Being then asked about any changes of the relationship to her parents, she suddenly says:
P: now I don´t know, I don´t dare my feeling, that thing with my father is so new, this is something, I really don´t know when he died, is it 10 years 15 years but I haven´t cried when he died, that was a pretty neutral feeling, not to feel anything, when we came into the crematory, I didn´t have any methods to get in contact with him, with the interest, how does it happen that a human being changes after having died, one day to the other, how does the body change, such things, how are the feet, and so.

Here the crucial aspect for coding is that the patient first forgot her father´s death, when asked about all important losses in life cycle, which is an indication for her denial. Further she shows a disorientation in time while thinking about the year of death (10 years, 15 years). Characteristically she remembers a strange little detail, his feet, which implies an unresolved quality of speech.

5. Convergent and divergent aspects of attachment and psychoanalytic perspective

In summarizing the main characteristics of the patient in the AAI we will introduce some convergent and divergent aspects of the attachment and psychoanalytic perspective in this single case. The procedure followed was: the attachment researcher (AB) gave her „AAI-diagnosis„ to the analyst (HK) and he commented on these summaries from his clinical perspective:

AAI-characteristics of the patient

- She often accuses her mother in an angry manner „I couldn´t trust my mother, until now„ , „it was aggressive caregiving„ , „I still suffer„, „I could cry thinking about it„.
- She remembers only negative adjectives with respect to the relationship to her parents in childhood „not understanding„, „not honest„, „torturing„

Commentary of the analyst:

„As an analyst I am really not satisfied with this finding. Though it is true and it has been one of the patient´s main attitude towards specific objects, it is surprising and calls attention to the need for the analyst to find where and how she hides her positive longings. She does it by vicarious identification, that is, by acting in a caregiving way to pupils or to the daughter of her brother, she unconsciously identifies with the objects of her benevolent treatment„.

- She often violates the criteria of coherence (quantity, quality)

Commentary of the analyst:
„This feature seems very dominant in the verbal exchange at times when our working alliance has been endangered. Then the sophisticated person she can be all of a sudden turns into a menacing angry women talking too much and displaying little logic„.

- She is often not able to find an adequate distance from the immediacy of her experiences; „I can´t make peace with my experiences, though I feel a change„

Commentary of the analyst:
„My approach entails the question of the functional value of her not being able to make peace. As an analyst I ask myself: At the present moment is it good for her to confront me with my inability to help her to find peace?„

- She is oscillating between past and actual memories, with little differentiation between past and today

Commentary of the analyst:
„The AAI finding made me more aware of this peculiarity of style of discourse organization; maybe as clinicians we take this downplay or disregard problem as it happens so often in our work. I learned that colloquial style may be more indicative of pathology than has been usually assumed„.

- She is not really able to reflect or to mentalize in an objective or forgiving manner, rather she shows a pseudopsychological analysis of her childhood experiences, e g. with the term „inner emigration„

Commentary of the analyst:
„The pseudopsychological style appears to me to be a feature of her long time struggle to accomodate to her early experience by using later devices, for example borrowing from her studies in politics where „inner emigration„ was an important expression. From my point of view it could be a capacity for use of metaphor that has helped to mentalize experiences in her way„.

- She speaks of a role-reversal: „my mother was a neglected child, I had to care for her. She abused me as a parent-like object„

Commentary of the analyst:
„From my perspective these are products of „sub-optimal„ solutions the patient has found; it was part of my task to help her to undo the role reversal and to accept that she might want to be cared for too„.

- She denies being abused by her mother (hitting) and she forgets the death of her father (unresolved state of mind)

Commentary of the analyst:
„The role of the father is still quite opaque. Here the AAI helped to understand the power fo her denial concerning the father. By now I learned from her that only after her father´s death she did discover that he also had been politically active. Using this information in the treatment as a first step of clarifying that she might have something in common with him opened up a new phase in the yet open-ended treatment„.

Looking at the commentaries, the analyst has a consistent *divergent approach* in treating the patient´s tendency to evaluate parental objects in a negative manner and in estimating her capacity to reflect. The analyst gives less weight to anger and aggression toward her mother. He focuses more on her positive identifications, and interprets her inabilty to make peace with her mother in a functional context. In the clinical material the analyst describes his difficulty „holding„ this preoccupied individual in treatment. Obviously the analyst´s attitude in tolerating her aggressive states of mind, and in searching for her ressources, had an important impact on establishing a secure base.

When AAI-criteria gave hints of the pseudopsychological style, that characterizes preoccupied subjects, the analyst regarded her strategy of

distancing as largely adaptive in the psychodynamic context. From an attachment perspective, persons are judged as „hyper-analytical„ when „the subject comes across as psychologically-minded but in studying the narrative his/her reflections are mostly irrelevant to the task ... the transcript reflects a state of affairs where the search for insight is quite compulsive, yet unproductive. Mentalization spins like a car wheel which has lost contact with the ground„ (Fonagy et al. 1998, page 43). In our case this description fits the patient´s way of reflecting her experience in an „overproductive manner„. But this also shows that we have to assume that the semistructured interview situation produces other tasks than the therapeutic one does, and moreover the criteria of coherence or self-reflective function might be „too strict„ for clinical subjects.

Nevertheless the advantage of the AAI-procedure lies in its careful analysis of single expressions, the focus on logical contradictions, and on the subject´s cooperation in producing and reflecting attachment relevant topics. In the AAI, the patient´s negative affects preoccupied her attention and „disturbed„ her capacity for cooperative principles. The analyst agrees that the patient showed unpredictable oscillations in the transference relationship as well. The AAI criteria confirmed his awareness of her sudden changes between all-good and all-bad, past and present. We believe that clinicans might learn from reading word by word transcripts of sessions that reveal defensive processes in a much more evident way (Thomä u. Kächele 1987, 1991);

In general the classification „unresolved state of mind„ and „preoccupation„ of this case fits in the data of the two attachment studies (Fonagy et al. 1996; Patrick & Hobson 1994), and seems to be a „classic combination„ of attachment-patterns in patients with borderline-pathology. For the analyst the „observable„ recognition in the AAI of the patient´s repression of her father´s death and its significance to her is his strongest argument for the application of this measure in the beginning of the therapeutic process. This information validates the opaqueness of the patient´s father in the treatment. In correspondance with Bowlby´s thoughts about segregated systems as a crucial aspect in understanding psychopathology, here the patient´s breakdown of defense during the discussion of loss and also abuse, elicites further aspects for the observation of therapeutic change.

Summarizing we may say that treating patients being investigated by the AAI leads to a realistic appreciation how strong childhood patterns are shaping our patients´ style of discourse and coping. The closeness of object relations and

attachment theory formulations becomes evident in the links between secure attachment (basic trust) and therapeutic alliance, disorganization and the clinical observation of projective identification, the notion of coherence and the notion of narrativization of one´s history (Fonagy 1999). According to Fonagy, on the one hand, clinical observations of patterns of relationships between patient and therapist could enrich studies on attachment, because therapeutic relationships can be conceptualized as an attachment relationship; on the other hand, attachment classifications of psychoanalytic patients could be helpful in the evaluation of the psychoanalytic process. Following the work of Mallinckrodt et al. (1995) the nature of psychotherapeutic strategies, and the transferential feelings engendered, are likely to be determined by the nature of the primary attachment ties.

References

Bowlby J (1969) Attachment and loss. Vol 1: Attachment. New York: Basic Books.

Bowlby J (1973) Attachment and loss. Vol 2: Separation. New York: Basic Books.

Bowlby J (1980) Attachment and loss. Vol 3: Loss. New York: Basic Books.

Bowlby J (1988) A Secure Base: Clinical Applications of Attachment Theory. London: Routledge

Cole-Detke H, Kobak R (1996) Attachment processes in eating disorder and depression. Journal of Consulting and Clinical Psychology 64: 282-290

Diamond D, Blatt S (1999) Prologue: Attachment Research and Psychoanalysis. Psychoanalytic Inquiry 19: 424-447

Diamond D, Clarkin J, Levine H, Levy K, Foelsch P, Yeomans F (1999) Borderline conditions and attachment: A preliminary report. Psychoanalytic Inquiry 19: 831-884

Dozier M, Chase Stovall K, Albus KE (1999) Attachment and psychopathology in adulthood. In: Cassidy J, Shaver P (eds) Handbook of Attachment. New York: Guilford, pp 497-519

Fonagy P (1991) Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient. Int J Psycho-Anal 72: 639-656

Fonagy P (1999) Psychoanalysis and attachment theory. In: Cassidy J, Shaver P (Hrsg) Handbook of Attachment. New York: Guilford, pp 595-624

Fonagy P (2001) Psychoanalysis and attachment theory. Karnac, London

Fonagy P, Leigh T, Kennedy R, Mattoon G, Steele H, Target M, Steele M, Higgit A (1995). Attachment, borderline states and the representation of emotions and cognition in self and other. In: Emotion, cognition and

representation. Cicchetti D, Toth S (eds). Rochester, NY: University of Rochester Press
Fonagy P, Leigh T, Steele M, Steele H, Kennedy R, Mattoon G, Target M, Gerber A (1996). The relation of attachment status, psychiatric classification and response to psychotherapy. J Consult Clin Psychol 64: 22-31.
Fonagy P, Target M, Steele M, Steele H (1998). Reflective-functioning manual: For application to Adult Attachment Interviews. Confidential document (Version 5.0). London: University College.
George C, Kaplan N, Main M (1985). The Adult Attachment Interview. Unpublished Manuscript. Berkely: University of California.
George C, Solomon J (1999) The development of caregiving: A comparison of attachment theory and psychoanalytic approaches to mothering. Psychoanalytic Inquiry 19: 618-646
George C, West M (1999) Developmental vs. social personality models of adult attachment and mental ill health. British Journal of Medical Psychology 72: 285-303
Grice HP (1975). Logic and Conversation. In: Syntax and Semantics. Cole P, Moran JL (eds). New York: Academic Press; 41-58.
Grossmann KE, Grossmann K, Zimmermann P (1999) A wider view of attachment and exploration: Stability and change during years of immaturity. In: Cassidy J, Shaver P (Hrsg) Handbook of Attachment. New York: Guilford; 760-786
Horowitz MJ (1988) Introduction to Psychodynamics. Basic Books: New York
Kächele H, Buchheim A, Schmücker, G, Brisch KH (2000) Development, attachment and relationship: new psychoanalyic concepts. In: Helmchen H, Henn FA, Lauter H, Sartorius N (eds) Contemporary Psychiatry. Springer, Berlin, Heidelberg, pp
Kernberg OF (1996) A Psychoanalytic Theory of Personality Disorders, In: Clarkin J, Lenzenweger MF (eds) Major Theories of Personaltiy Disorder. New York: Guilford, S 106-140
Kernberg P (1994) Mechanisms of defense: Deveopment and research perspectives. Bull Menninger Clin 58: 55-58
Levy K, Blatt S (1999) Attachment theory and psychoanalysis: Further differentiation within insecure attachment patterns. Psychoanalytic Inquiry 19: 541-575
Lyons-Ruth, K., Alpern, L. & Repacholi, B. (1993). Disorganized infant attachment classification and maternal psychosocial problems as predictors of hostile-aggressive behavior in the preschool classroom. Child Development, 64, 572-585.
Main M, Goldwyn R (1996). Adult Attachment Scoring and Classification Systems. Unpublished manuscript. Berkeley: University of California

Mallinkckrodt B, Gantt D, Coble H (1995) Attachment patterns in the psychotherapeutic relationship: Development of a Client Attachment to the Therapist Scale. Journal of Counseling Psychology 42: 307-317

Patrick M, Hobson RP (1994). Personality disorder and the mental representation of early social experience. Development and Psychopathology: 375-388.

Rapaport D (1960). The structure of psychoanalytic theory. A systematizing attempt. (Vol. Psychological issues). New York: Int Univ Press.

Rosenstein D, Horowitz HA (1996) Adolescent attachment and psychopathology. Journal of Consulting Clinical Psychology 64: 244-253

Silverman DK (2001) Sexuality and attachment: A passionate relationship or a marriageof convenience? Psychoanalytic Quarterly 70: 325-358

Spitz R (1965) The first year of life. Int Univ Press, New York

Solomon J, George C (1999) Attachment disorganization. New York: Guilford

Stern D (1985).The interpersonal world of the infant. New York: Basic Books.

Thomä H, Kächele H (1987). Psychoanalytic Practice Vol 1: Principles. Berlin Heidelberg New York: Springer,

Thomä H, Kächele H (1991). Psychoanalytic Practice Vol 2: Clinical Studies. Berlin Heidelberg New York: Springer,

van IJzendoorn MH, Bakermans-Kranenburg MJ (1996). Attachment representations in mothers, fathers, adolescents and clinical groups: A meta-analytic search for normative data. J Consult Clin Psychol 64: 8-21.

Zimmermann P, Grossmann KE (1997) Attachment and adaptation in adolescence. In: Koops W, Hoeksma JB, van den Boom DC (Hrsg) Development of interaction and attachment: Traditional and non-traditional approaches. North-Holland, Amsterdam, S 271-280

Adress for correspondance:

Dr. Dipl.- Psych. Anna Buchheim

Prof. Dr med. Horst Kaechele

Department of Psychotherapy and Psychosomatic Medicine

University of Ulm, Germany

buchheim@sip.medizin.uni-ulm.de