Psychotherapy and Psychosomatics

Received: July 25, 2016
Accepted after revision: February 6, 2017
Published online: September 14, 2017

Psychother Psychosom 2017;86:314–316
DOI: 10.1159/000460257

Change of Unresolved Attachment in Borderline Personality Disorder: RCT Study of Transference-Focused Psychotherapy

Anna Buchheim[a], *Susanne Hörz-Sagstetter*[c], *Stephan Doering*[b], *Michael Rentrop*[d], *Peter Schuster*[b], *Peter Buchheim*[d], *Dan Pokorny*[e], *Melitta Fischer-Kern*[b]

[a]Institute of Psychology, University of Innsbruck, Innsbruck, and [b]Medical University Vienna, Vienna, Austria; [c]Psychologische Hochschule Berlin (PHB), Berlin, [d]Technical University Munich, Munich, and [e]Ulm University, Ulm, Germany

Psychotherapy is recommended as the primary treatment for borderline personality disorder (BPD) [1, 2]. Transference-focused psychotherapy (TFP) is a manualized treatment for BPD, focusing on symptoms, self-destructive behaviour, resolution of identity disturbance, and enhancing the patients' integration of mental representations of self and significant others by the analysis of the transference in the here-and-now therapeutic relationship in a structured treatment frame [3].

Aetiological models suggest that insecure attachment experiences impart greater risk for the maladaptive personality traits underlying BPD [1]. Adult attachment representations, which can be assessed with the Adult Attachment Interview (AAI) [4, 5], have been shown to be modifiable by psychotherapy [6]. BPD [7] or the sequelae of maltreatment [8] have been associated with increased occurrence of insecure and especially "unresolved" attachment, characterized by the failure to resolve the loss of an attachment figure or maltreatment, like sexual and physical abuse, evidenced in the participants' narratives [5].

A previous study [9] has demonstrated the efficacy of TFP in the treatment of BPD in a randomized clinical trial, showing a significantly lower drop-out rate and more reduction of borderline symptoms, as well as improvement of psychosocial functioning, personality organization, and reflective functioning compared to experienced community psychotherapy (ECP) [9, 10]. The aim of the present study was to assess changes in attachment representations, focusing on narrative coherence and resolution of unresolved attachment in the same dataset. We hypothesized that BPD patients with unresolved attachment would show impaired psychosocial functioning, more borderline symptoms, lower scores on personality organization, and higher incidence of lifetime PTSD at baseline. According to a previous study, we expected more participants to change from insecure to secure [11] and, moreover, from unresolved to organized attachment in the TFP than in the ECP group.

As previously described in detail by Doering et al. [9], 104 female patients with BPD, aged 18–45 years, were randomized to either ECP or TFP after obtaining written informed consent. As specified in the manual, TFP therapists explicitly focused on distorted mental representations of self and significant others in the therapeutic relationship along a structured psychodynamic treatment approach [3]. ECP therapists from different psychotherapeutic orientations worked rather with supportive, psychodynamic, or cognitive techniques, not following a treatment manual [9].

Scales rating symptomatic involvement and personality organization were administered at baseline and after 1 year of treatment (see results below for details). To assess attachment representations, patients were administered the AAI [4, 5] at the beginning and after 1 year of treatment. The AAI is a semi-structured interview designed to elicit thoughts, feelings, and memories about early attachment relationships. Verbatim transcripts are classified into the categorical groups secure (F), dismissing (Ds), preoccupied (E), and unresolved (U).

Double-rating by 2 blind judges showed agreement on 89% of 4 classifications ($\kappa = 0.84$) and on 94% of 2 classifications (organized vs. unresolved; $\kappa = 0.89$). The intra-class correlation coefficient of the coherence subscale (range from 1–9), as one major aspect of attachment security [5], was ICC21 (absolute) = 0.93 ($n = 36$, $p < 0.001$).

Since a number of participants were lost to the follow-up evaluation, we have controlled the observed cases (OC) results by the last observation carried forward (LOCF) approach. All reported significance levels are 2-sided.

At baseline, both treatment groups ($n = 45$ ECP and $n = 47$ TFP patients) were characterized by the high prevalence of unresolved attachment and near absence of secure attachment (ECP group: 4 F, 6 Ds, 9 E, 26 U; TFP group: 2 F, 12 Ds, 7 E, 26 U), as in previous studies [7], but with no significant differences between the treatment groups ($p = 0.436$, Fisher exact test). Similarly, there was no significant difference in fulfilled lifetime PTSD diagnosis (SCID-I [12]) between treatment groups ($p = 0.497$, Fisher exact test).

As expected, unresolved BPD patients showed lower scores in psychosocial functioning (Global Assessment of Functioning, GAF, $p = 0.003$, U test), lower levels of personality organization [13] ($p < 0.001$), and more borderline symptoms (SCID-II [12], $p = 0.012$). There was an association between the fulfilled lifetime PTSD diagnosis and unresolved attachment, observed in 21 out of 25 (84%) unresolved and in only 31 out of 67 (46%) organized patients ($p < 0.002$, Fisher exact test).

Table 1 shows the changes in attachment status in both treatment groups. Both for attachment security (a) and unresolved trauma (b), there were no significant changes by the exact McNe-

KARGER

E-Mail karger@karger.com
www.karger.com/pps

Anna Buchheim, PhD
Institute of Psychology, University of Innsbruck
Innrain 52
AT–6020 Innsbruck (Austria)
E-Mail anna.buchheim@uibk.ac.at

Table 1. Changes between insecure and secure respective unresolved and organized attachment representations and coherence scale outcome (intent-to-treat LOCF and OC analyses)

	ECP						TFP						Group comparison		
	exact McNemar test OC = LOCF						exact McNemar test OC = LOCF						*N*	*z*	*p*
(a) Security			T2						T2						
			Ins	Sec	all				Ins	Sec	all		OC		
	T1	Ins	21	0[a]	21		T1	Ins	24	12[a]	36		63	3.260	0.001
		Sec	1[b]	3	4			Sec	0[b]	2	2		LOCF		
		all	22	3	25			all	24	14	38		92	3.719	<0.001
			McNemar – 0:1 $p = 1.000$						McNemar – 12:0 $p < 0.001$						
(b) Unresolved trauma			T2						T2						
			U	Org	all				U	Org	all		OC		
	T1	U	10	3[a]	13		T1	U	4	17[a]	21		63	2.709	0.012
		Org	0[b]	12	12			Org	0[b]	17	17		LOCF		
		all	10	15	25			all	4	34	38		92	3.411	<0.001
			McNemar – 3:0 $p = 0.250$						McNemar – 17:0 $p < 0.001$						
(c) Coherence scale	Baseline 1 year		*t* test pre-post			Effect size	Baseline 1 year		*t* test pre-post			Effect size	Interaction effect		
	mean ± SD		*t*	df	*p*	d	mean ± SD		*t*	df	*p*	d	F	df	*p*
OC			($n = 25$)						($n = 38$)				($N = 63$)		
T1 T2	2.88±1.24 3.24±0.97		2.377	24	0.026	0.32	2.71±1.06 4.11±1.13		9.381	37	<0.001	1.27	21.964	1, 61	0.048
LOCF			($n = 45$)						($n = 47$)				($N = 92$)		
T1 T2	2.80±1.14 3.00±1.02		2.283	44	0.027	0.18	2.64±1.03 3.77±1.29		7.796	46	<0.001	0.97	29.462	1, 90	<0.001

Group comparison was done with the exact Mann-Whitney *U* test. T1, baseline; T2, after 1 year of treatment; ECP, experienced community psychotherapy; TFP, transference-focused psychotherapy; Ins = insecure, Sec = secure, U = Unresolved, Org = organized (non-U); OC, observed cases, LOCF, last observation carried forward; *p*, significance (2-sided); *t*, *t*-statistic for the paired *t* test; df, degrees of freedom; d, Cohen's effect size. [a] worsened, [b] improved.

mar test within the ECP group but significant improvements within the TFP group. Differences between treatment groups in improvement scores were significant in both cases (exact Mann-Whitney U test).

The coherence scale (c) was significantly improved within both groups. According to the observed effect sizes, this improvement was considerably higher within the TFP group and, according to the interaction effect in the ANOVA model, the between-group difference was significant. In all outcome variables (a, b, c), LOCF analysis confirmed the OC findings.

The findings of high impairment levels and worse psychosocial functioning in unresolved BPD patients suggest that unresolved attachment might constitute an aggravating factor in BPD and constitutes an important target of change in psychotherapy. Replicating the findings of a previous study [11], TFP was superior in revealing changes from insecure to secure attachment. However, no previous study had shown TFP to achieve a change from unresolved to organized attachment, suggesting its effectiveness in treating patients with consequences of severe maltreatment, abuse, and loss.

The significant shift from insecure to a secure attachment status in many of the BPD patients in TFP implies that this treatment was able to enhance the patients' coherence, attachment-related autonomy, and flexible integration, a capacity called "earned security" [5]. In comparison to the ECP setting, the highly structured, interactive, and emotionally intense stance of the TFP therapist may provide a safer setting for reflecting on attachment relationships [3]. Our finding is consistent with the putative mechanisms of change in TFP that might result from the integration of polarized affect states and self-other representations into a more coherent whole [3]. Such intra-psychic changes might be relevant for long-term treatment benefits [2].

References

1 Leichsenring F, Leibing E, Kruse J, New AS, Leweke F: Borderline personality disorder. Lancet 2011;377:74–84.
2 Stoffers JM, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K: Psychological therapies for people with borderline personality disorder. Cochrane Database Syst Rev 2012;8:CD005652.
3 Clarkin JF, Yeomans FE, Kernberg OF: Psychotherapy for Borderline Personality. Focusing on Object Relations. Arlington, American Psychiatric Publishing, 2006.
4 George C, Kaplan N, Main M: The Adult Attachment Interview (unpubl. manuscript). Berkeley, University of California at Berkeley, 1985.
5 Main M, Goldwyn R: Adult Attachment Scoring and Classification System, version 6.0 (unpubl. manuscript). Berkeley, University of California at Berkeley, 1998.
6 Taylor P, Rietzschel J, Danquah A, Berry K: Changes in attachment representations during psychological therapy. Psychother Res 2014;25:222–238.
7 Bakermans-Kranenburg MJ, van IJzendoorn MH: The first 10,000 Adult Attachment Interviews: distributions of adult attachment representations in clinical and non-clinical groups. Attach Hum Dev 2009;11:223–263.
8 Joubert D, Webster L, Hackett RK: Unresolved attachment status and trauma-related symptomatology in maltreated adolescents: an examination of cognitive mediators. Child Psychiatry Hum Dev 2012;43:471–483.
9 Doering S, Hörz S, Rentrop M, Fischer-Kern M, Schuster P, Benecke C, Buchheim A, Martius P, Buchheim P: Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomized controlled trial. Br J Psychiatry 2010;196:389–395.
10 Fischer-Kern M, Doering S, Taubner S, Hörz S, Zimmermann J, Rentrop M, Schuster P, Buchheim P, Buchheim A: Transference-focused psychotherapy for borderline personality disorder: change in reflective function. Br J Psychiatry 2015;2:173–174.
11 Levy KN, Meehan KB, Kelly KM, Reynoso JS, Weber M, Clarkin JF, Kernberg OF: Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. J Consult Clin Psychol 2006;74:1027–1040.
12 Wittchen HU, Zaudig M, Fydrich T: Structured Clinical Interview for DSM-IV, Axis I and II. Göttingen, Hogrefe, 1997.
13 Clarkin JF, Caligor E, Stern B, Kernberg OF: Structured Interview of Personality Organization (STIPO). New York, Weill Medical College of Cornell University, 2004.