Adult Attachment Interview and Psychoanalytic Perspective: A Single Case Study

ANNA BUCHHEIM, M.D.
HORST KÄCHELE, M.D.

In this single case study we present a female patient diagnosed with a narcissistic personality disorder and a borderline organization. The interplay between attachment and psychoanalytic perspective will be focused. The analyst describes his impressions of the initial interview with the patient and essential steps during treatment. The patient was interviewed with the Adult Attachment Interview and classified as “insecure preoccupied” with an “unresolved state of mind” concerning loss and abuse. The analyst was asked to comment the AAI’s essential characteristics of this patient. We discuss converging and diverging aspects of clinical and attachment interpretation in this single case.

WHEN DANIEL STERN PUBLISHED HIS MONOGRAPH ON THE Interpersonal World of the Infant (1985), he opened a new phase in the history of psychoanalysis. There had been the immense work of many generations of clinicians to reconstruct their patients’ accounts of their history in the clinical setting underscoring the importance of

Anna Buchheim, M.D. and Horst Kächele, M.D. are Members, Department of Psychotherapy and Psychosomatic Medicine, University of Ulm, Germany.

These intensive endeavors 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
development: This genetic point of view, however, is not in contrast with Kurt Lewin’s 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 occurring now in an individual can be understood only by exploring his or her development.

There also has been, largely 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 on constructing the “clinical infant.” The new theories on early development will integrate theories of communication and action and this will have considerable impact on all psychoanalytic orientations (Kächele et al., 2000). The impact of newer research on psychoanalysis is succinctly described in a paper in the recent issue of Psychoanalytic Quarterly: “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” (Silverman, 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, with a focus on the relationships with primary attachment figures. Attachment theory has taken up aspects of psychoanalytic theory such as the developmental point of view and also developed some aspects further, particularly the delineation of the internal world (Diamond and Blatt, 1994). Fonagy (1999, 2001) demonstrates that the relationship between attachment theory and psychoanalysis is more complex than adherents of either psychoanalytic babies differ greatly. The designers of the models must put up with the fact that their creations are compared.
community have generally recognized. In his excellent overview he proposes many points of contact and significant points of divergence.

George and 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 phenomenon, including fantasy, 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 separating 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” (p. 295). Suggesting that these representational structures have developed under conditions of attachment trauma (abuse, loss) the concept of segregated systems is useful to explain some forms of relationship-based psychopathology in adults.

In the following chapter, we provide some ideas about the utility of attachment concepts for our clinical work by showing how the perspectives of a clinician and an attachment researcher may improve the understanding of an individual case.

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 (1969, 1973, 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-corrected 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 feelings with regard to the attachment figure and serve to guide future behavior 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 strategies 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). Disorganized infants by contrast are more likely to develop substantial social problems at school and to exhibit aggression and a variety of psychiatric difficulties (Lyons-Ruth et al., 1993; Solomon and George, 1999).

Bowlby, however, never took a deterministic view on early attachment experiences. He saw the developmental path of attachment organization 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 and Grossmann, 1997). Similarly, it may be assumed that the inner working model of an early insecure attachment experience may be reorganized 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.\textsuperscript{2} The interviews, transcribed literally, are rated along different scales—for example, loving relationship with mother and father, quality of recall, idealization and derogation of relationships, and, most important, 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, or shows factual or logical contradictions, rapid oscillations of viewpoint, or two or more story lines).
- **Quantity**—be succinct, 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 (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 and Goldwyn, 1996):

\textsuperscript{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.
• 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 on 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 and often nonobjective 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 pseudopsychological 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 and Goldwyn are conceptualized as strategies that involve maximization or minimization of attention toward 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 and Goldwyn, 1996) was developed in a nonclinical, transgenerational context, this system could be shown to discriminate between clinical and nonclinical populations (van IJzendoorn and Bakermans-Kranenburg, 1996). The effect size discriminating both groups (d = 1.03) was found to be strong. Ultimately, in a four-way analysis, 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 and 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” (p. 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 stemming from insecure attachment organization (Fonagy, 1991; Diamond et al., 1999).

What these findings mean in terms of the causal connection between attachment states of mind and psychiatric disorder is still unclear (Dozier et al., 1999). Clinical researchers (Patrick and Hobson, 1994; Cole-Detke and Kobak, 1996; Rosenstein and Horowitz, 1996) suggest that some “externalizing” disorders (e.g., eating disorders, conduct disorders) are
associated with a dismissing state of mind, and that an “internalizing” disorder (e.g., borderline disorder) is associated with preoccupied states. Dozier et al. (1999) demonstrated 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 of narcissistic personality disorder with a borderline organization. Clinically, patients with borderline personality have a notably unstable representation of self, undeveloped and unstable representations of others, (e.g., others are idealized at times and devalued at other times). A central issue for borderline patients is the fear of abandonment by an idealized other. Another criterion 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. For example, 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. Of borderline patients, 89% were classified as “unresolved” concerning abuse. In similar fashion, Patrick and Hobson (1994) found that all women with borderline personality were classified as “preoccupied,” and 10 of 12 were classified as E3, which often cooccurs with unresolved status. In this study, 75% of the borderline patients were classified as “unresolved.” In fact, the most consistent finding to date is the association of borderline pathology attachment disorganization or lack of resolution of loss and trauma on the AAI (Fonagy, 2001).

According to the work of Rosenstein and Horowitz (1996), variations in attachment classification may discriminate among subtypes of borderlines. Some studies indicate that those with antisocial, narcissistic, or 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 and 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, family chaos, and insecure attachment in borderline personalities.

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 approached me (HK) directly 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 sadomasochistic 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 an elderly female therapist. The former therapy had helped her to control her suicidal ideation. From time to time, however, 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 lawsuit and achieved a reimbursement 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 of demanding friendliness who kept a watchful eye on me. 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 coauthored with Thomä (Thomä and Kächele, 1987, 1991). Despite her seemingly positive orientation to me, the psychometric forms she had been asked to complete were filled with critical, devaluing remarks such as, “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 traumatized person early in her life who nonetheless had managed well for a considerable period. She studied political science and German and became a teacher in a regional town close to her home village. She was married while still a student to a colleague ten years older who taught at the school where she later also became a teacher.

My attitude—quite soon a heroic mixture of skepticism and curiosity—was determined by her emotional statements such as, “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 organization 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 chronically slightly anxious husband she shared musical talent that she developed to a level of semiprofessional competence. For many years she and her husband lived in relatively social and intimate stability. They engaged in little sexual activity with her being the activator. Based on her dissatisfactions, their stability was gradually undermined, and 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 fulfilled 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 “nonpatient.” Although therapists prefer private payment for practical reasons, I insisted on the formal procedure of insurance coverage in order not to facilitate her disavowal. The treatment was complicated from the beginning. A stable therapeutic alliance or an observing and experiencing ego (in the sense of Sterba, 1934) 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 happened, we survived many crises and slowly achieved a more stable 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 restabilized. 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 continuously searching out the badness of the world, and especially that of her mother, she had reached a sort of Nachdenklichkeit, what 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 lifelong 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.

*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 regarding loss and trauma. 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: hmm.

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 neighbors 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 cost 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 from 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 breakdown 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 pervasive feeling of instability. She doesn’t provide a coherent speech, often loses track, and gives too much information. She violates the criteria of quantity and relevance.

According to Main and 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:

**Loss**

- 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.

**Abuse**

- Unsuccessful denial of the occurrence 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 (physical assault, hitting to death) by her mother, and (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 threatened by your parents when you were a child?

P: No, being threatened—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 would hit 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:

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 about any abuse in childhood. She oscillates between memories of having enormous anxiety, when her mother hit her, and a disbelief that she felt threatened by that. She is judging death simultaneously as a solution and a terrifying event. A crucial criterion 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. When asked about losses throughout her 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 losses in detail and does not show any lapses. She insists on not having experienced another loss. The interviewer came then to the next questions in the AAI. When the patient was asked about any changes in the relationship to her parents, she says suddenly:

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 didn’t cry when he died; that was a pretty neutral feeling, not to feel anything, when we came into the crematory. I didn’t have any way 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.

Here the crucial aspect for coding is that the patient, when asked about all the important losses in her life, forgot her father’s death, which is an indication of 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.

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 was as follows: 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.”

Analyst’s Commentary. “As an analyst, I am really not satisfied with this finding. Although it is true that exclusive focus on the negative aspects of relationships has been one of the patient’s main attitudes toward 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. Hence, she unconsciously identifies with the objects of her benevolent treatment.”

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

Analyst’s Commentary. “This feature of incoherence 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 who talks too much and displays 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.”

Analyst’s Commentary. “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.

Analyst’s Commentary. “The AAI finding made me more aware of this peculiarity of style of discourse organization; maybe as clinicians we tend to downplay or disregard this, as it happens so often in our work. I have 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, for instance, with the term “inner emigration.”

Analyst’s Commentary. “The pseudopsychological style appears to me to be a feature of her long-time struggle to accommodate 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.”

**Analyst’s Commentary.** “From my perspective these are products of “suboptimal” 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).

**Analyst’s Commentary.** “The role of the father is still quite opaque. Here the AAI helped to understand the power of her denial concerning the father. By now I learned from her that only after her father’s death did she 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 inability 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 strengths and resources, 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 “hyperanalytical” 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, p. 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 criterion 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 clinicians might learn from reading word-for-word transcripts of sessions that reveal defensive processes in a much more evident way (Thomä and Kächele, 1987, 1991).

In general, the classifications “unresolved state of mind” and “preoccupation” of this case fit in the data of the two attachment studies (Patrick and Hobson, 1994; Fonagy et al., 1996) and seem 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 correspondence 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 elicits further aspects for the observation of therapeutic change.

In summary, we may say that treating patients being investigated by the AAI leads to a realistic appreciation of 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


Department of Psychotherapy and Psychosomatic Medicine
University of Ulm, Germany
buchheim@sip.medizin.uni-ulm.de
kaechele@sip.medizin.uni-ulm.de