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THE INTERPRETIVE PROCESS IN THE PSYCHOANALYTIC PSYCHOTHERAPY OF BORDERLINE PERSONALITY PATHOLOGY

While all patients become more concrete in their psychological functioning in areas of conflict, especially in the setting of transference regression, in the treatment of patients with severe personality pathology this process poses a particular clinical challenge. In the psychoanalytic psychotherapy of patients with severe personality pathology in general, and borderline personality disorder in particular, the interpretive process serves multiple functions. This process comprises a series of steps or phases that can be viewed as moving the patient further away from a single, poorly elaborated, and concrete experience in the transference, which dominates and floods subjectivity, and toward more fully elaborated, complex, stable, and integrated representations of the analyst and of what he or she evokes in the patient's internal world.

Clinicians across the theoretical spectrum have noted that when treating patients with severe personality pathology, the nature of patients' experience in the transference often makes it difficult for them to make use of conventional transference interpretations (Abend, Porder,

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and Willick 1968; Balint 1979; Bromberg 1998; Fonagy 1991; Joseph 1985; Kernberg 2004; Ogden 1988; Steiner 1993). While all patients become more concrete in their psychological functioning in areas of conflict, particularly in the setting of transference regression, in the treatment of patients with severe personality pathology this process poses a particular clinical challenge. In this paper we focus on the nature and functions of the interpretive process in the treatment of patients with severe personality pathology in general, and borderline personality disorder (BPD) in particular.

The poorly differentiated, concrete, and affectively charged nature of the BPD patient's experience during transference regression, combined with the tendency to express dominant transference dispositions through nonverbal channels rather than through free association, calls for modifications of standard psychoanalytic approaches to transference analysis (Kernberg 2004). The clinical approach that we present is embedded in Kernberg's psychoanalytic model of personality pathology and forms the backbone of transference-focused psychotherapy (TFP), a twice-weekly psychoanalytic psychotherapy for treatment of severe personality disorders developed over the past quarter-century by our group at the Personality Disorders Institute at Weill Cornell Medical College (Clarkin, Yeomans, and Kernberg 1999, 2006).

Though TFP makes use of analytic theory and principles, this treatment is to be distinguished from psychoanalysis proper; we have introduced technical modifications designed to meet the clinical needs of a severely disturbed group of patients who generally do poorly in conventional psychoanalytic treatment (Kernberg et al. 1972). Though at initial presentation these patients are not suitable for analytic treatment, they can do well with modified analytic approaches (Clarkin et al. 2007). Further, in some cases psychotherapeutic gains may prepare the patient for psychoanalysis. Because

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patients with borderline personality disorder are high utilizers of both inpatient and outpatient psychiatric services (Bender et al. 2001), the therapy we describe has enormous social relevance, offering an effective treatment option for an especially challenging group of patients. Transference-focused psychotherapy expands the domain of analytic treatment, and we have empirical evidence regarding its specific effectiveness relative to supportive psychodynamic and dialectical behavioral therapy (Clarkin et al. 2007).

TFP is to be distinguished from alternative long-term empirically supported psychotherapies for the treatment of borderline personality disorder. Dialectical behavior therapy (DBT; Linehan 1993) and schema-focused therapy (Young, Klosko, and Weishaar 2003) have emerged from cognitive-behavioral integrative approaches to treatment. In contrast, mentalization-based therapy (MBT; Bateman and Fonagy 1999, 2001, 2004) is a psychodynamically based treatment, emerging from attachment theory. These treatments share many important features, but there are also fundamental differences. (For a comparison of TFP with these alternative treatments, as well as with other psychoanalytic approaches to treating severe personality pathology, see Kernberg, Yeomans, et al. 2008.)

Our research demonstrates that TFP is an effective treatment for borderline personality disorder. This raises the question of which elements of the treatment contribute to positive outcome. While we have yet to directly test this empirically, an hypothesis underlying our theory of technique is that interpretation plays an essential role, both in overall therapeutic improvement and in the more specific improvement in reflective functioning (RF) demonstrated in patients with borderline personality disorder treated with TFP (Levy et al. 2006; Kernberg, Diamond, et al. 2008). In what follows we outline a theory of how the process of interpretation may serve a variety of essential functions in the treatment of patients with borderline personality disorder, resulting in enhanced RF and integration of the internal object world.

MANUALIZATION AND RESEARCH FINDINGS

TFP was the first long-term dynamic therapy for treatment of borderline personality disorder to be manualized. We began by studying videotaped therapies of patients with personality disorder conducted by expert analytic clinicians using Kernberg's conceptualization of borderline pathology. In viewing the tapes, we refined our understanding and description

of clinical technique, which we have since elaborated in accordance with ongoing clinical experience and empirical findings. (For a description of how our treatment manual was developed, see Clarkin et al. 2001.)

The TFP treatment manual and its companion text, *Handbook of Dynamic Psychotherapy for Higher Level Personality Pathology* (Caligor, Kernberg, and Clarkin 2007), are not how-to books. Rather, they provide specific descriptions and clear illustrations of basic clinical principles, embedded in an equally clear model of psychopathology. Conceptually, we organize our description of TFP in terms of the goals, strategies, tactics, and techniques of the treatment. The aim of the manual is not to tell the clinician what to do at any particular clinical moment or in any given clinical situation, but rather to provide the clinician with a way to systematically respond at any point in time to the internal question, How do I go about deciding what to do now?

The development of a clearly specified theory of technique, explicated in a treatment manual, set the foundation for us to embark on a series of studies investigating the impact of TFP on symptomatology, social adjustment, utilization of psychiatric and medical services, attachment organization, and reflective function in patients with borderline personality disorder. These studies and their findings have been described in detail in previous publications (Clarkin et al. 2001; Levy et al. 2006; Clarkin et al. 2007; Diamond et al. 2008). Here we will give a brief summary of our most recent and comprehensive findings insofar as they provide empirical support for the effectiveness of our approach and can be integrated with our conceptualization of the interpretive process.

With funding from the Borderline Personality Disorder Research Foundation, a randomized clinical trial of TFP (Clarkin et al. 2004) was conducted at the Personality Disorders Institute. The study compared TFP with an empirically supported cognitive-behavioral treatment, dialectical behavior therapy (DBT), and with a supportive treatment that though psychodynamically oriented did not use interpretation of the transference or of psychological conflict (SP; Appelbaum 2006). Ninety patients with borderline personality disorder were randomly assigned to one of the three treatment conditions. We found that that after a year of treatment, patients in all three manualized treatments showed significant clinical change in many domains of functioning, including diminution of depression and anxiety and improved psychosocial and interpersonal functioning. Patients in both TFP and DBT showed significant reductions in suicidality, whereas those in SP did not. Only patients in TFP showed

a marked diminution of factors related to aggression, such as impulsivity and verbal and direct assault (Clarkin et al. 2007).

We were also interested in examining the mechanisms of change—that is, how TFP brings about change, as compared with the other treatments (Levy et al. 2006). To pursue this research question, we used a measure of reflective functioning (RF; Fonagy et al. 1998), derived from the structured interview the Adult Attachment Interview (AAI; George, Kaplan, and Main 1998), to assess RF before and after a year of treatment with TFP, DBT, or SP. Reflective functioning is a measure of the capacity for “mentalization,” the capacity to reflect on one’s thoughts, feelings, and intentions, as well as on the thoughts, feelings, and intentions of others, in the setting of attachment relationships. RF involves the capacity to think in terms of intentional mental states and has been linked to secure internal working models of attachment relationships and to self- and affect regulation (Fonagy et al. 2002). In our study, we found that after a year of treatment, patients in TFP showed a significant increase in RF, whereas RF did not change significantly in the DBT and SP groups. Further, at the one-year mark there was a significant increase in the number of TFP patients classified with secure states of mind with respect to attachment (as shown on the AAI), but no such change in the other two treatment groups (Levy et al. 2006).

A MODEL OF BORDERLINE PATHOLOGY AND THERAPEUTIC CHANGE

The approach to interpretation we have developed is based on Kernberg’s model of personality organization and personality pathology. This model suggests that in patients with borderline personality disorder, internalized object relations are poorly integrated, are associated with crude, poorly modulated, and highly charged affect states, and are not coherently or stably organized in relation to one another to form an integrated sense of self or of significant others. This is the psychological organization underlying the syndrome of “identity diffusion,” which is characterized by an experience of self and others that is poorly integrated, unstable, idealized, or persecutory, and often chaotic. The goal of treatment is identity consolidation, which entails the integration of internalized object relations so as to provide a coherent, realistic, and stable experience of self and others. Identity consolidation is associated with the capacity to reflect on one’s internal states and motives and to accurately perceive the thoughts, feelings, and intentions of others (Kernberg, Diamond, et al. 2008).

In Kernberg's model, the structural and functional features of borderline pathology just described reflect the predominance of splitting-based, or dissociative, defenses (Kernberg 1984; Lenzenweger et al. 2001) that function to maintain the polarized, unstable, and contradictory internal and external experience so characteristic of borderline personality organization. This psychological organization is associated with paranoid tendencies, a weakening of ego boundaries, a limited capacity to self-reflect or to contextualize experience, affect dysregulation, and a tendency toward concrete thinking, all of which become more extreme with affect activation.

Our group has hypothesized that in borderline pathology there is a reciprocal relationship between splitting-based defenses and affect dysregulation, each a core feature of the borderline diagnosis (Levy et al. 2006). Specifically, faulty modulation of affective experience in the setting of predominant negative affect creates a psychological need to sequester and protect whatever positive affective experience is available.

Splitting-based defenses serve this function, but at the price of interfering with integrative processes that might offer the long-term possibility of better affect modulation. The result is a vicious cycle in which affect dysregulation evokes splitting, which is responsible for continued affect dysregulation.

The goal of the interpretive process is to interrupt this cycle of dysregulation and pathological defense, allowing for a positive cycle of enhanced affect regulation and decreased splitting. It is anticipated that these changes will lead to a progressive integration of dissociated aspects of experience and to resolution of the syndrome of identity diffusion. Identity consolidation will in turn be associated with further enhancement of the patient's capacity for affect regulation and symbolic management of psychological conflict, along with a shift toward the predominance of repression-based over splitting-based defenses, stabilization of ego boundaries, and enhancement of the capacity to self-reflect and to contextualize experience.

THE INTERPRETIVE PROCESS

Traditional psychoanalytic definitions of interpretation have focused on the process of generating hypotheses about the unconscious significance of conflictual aspects of the patient's conscious and unconscious thoughts, feelings, and behavior (Sandler, Dare, and Holder 1992). The interpretive

process often begins with bringing attention to aspects of the patient's communications that are vague, contradictory, or seemingly omitted. This process of clarifying the patient's communications tends to draw attention to areas of conflict, and leads naturally to the exploration of defenses and underlying conflictual mental contents. Within the model of dynamic conflict, defenses, motivations for defense, and mental contents defended against are explored as part of the interpretive process. Further, in psychoanalytic treatment of patients with higher-level personality pathology, it is usually repressed psychological material and related defensive operations that are the focus of interpretation, with the aim of facilitating the direct expression of repressed mental contents.

Kernberg (1984) has suggested that in the treatment of patients with borderline personality disorder, psychological conflict and defenses are often characterized by splitting-based, as well as repression-based, operations; descriptively, defense may be expressed not in terms of the stable repression of anxiety-provoking aspects of psychological experience, but rather in the dissociation between two aspects of experience that are in conflict with each other. In this setting, conflictual aspects of psychological experience may be fully accessible to consciousness, though at different times and in a dissociated fashion, or they may be expressed in action, dissociated from conscious psychological experience but nevertheless readily observable.¹ As a result, in TFP, for much of the treatment the focus is on the exploration of dissociated rather than stably repressed mental contents. In this setting, interpretation focuses on mutually dissociated aspects of experience that are either accessible to consciousness, though at different times, or that are enacted by the patient without being consciously experienced or mentally represented. As treatment progresses, repressive defenses gradually come to replace dissociative defenses, and the nature of interpretation shifts as well, coming to focus on repressed mental contents, as is typical of most analytic treatments.

Whether considering the psychoanalytic treatment of a patient with higher-level personality pathology or the psychotherapeutic treatment of

¹For example, a patient may at one moment experience the analyst as a savior, and only a moment later as an aggressive and dangerous enemy; while both experiences are consciously available, the patient may have no capacity to experience one view of the analyst while dominated by the opposing view. Alternatively, the patient may experience the analyst as an aggressive and dangerous enemy, while in fact behaving in an aggressive and threatening fashion toward the analyst. Here the patient's threatening behavior is dissociated from a self-experience of being the analyst's frightened or self-righteous victim.

a patient with a severe personality disorder, we find it useful to conceptualize transference interpretation as a series of interventions that build on one another. Sometimes it may take many sessions to complete a single cycle of interpretation. At other times the entire interpretive process can be repeated several times in a single session. Early in the treatment of patients with borderline pathology, the analyst may focus almost exclusively on the early phases of the cycle, deferring later phases for a time when the patient will be able to make use of more complete interpretation.

It is the latter part of the interpretive process as we conceptualize it that corresponds with what psychoanalysts tend to think of when we hear the word *interpretation*. Here the analyst proposes hypotheses about the anxieties, defenses, and unconscious, conflictual motivations embedded in the patient's experience, particularly of the analyst. The latter phases of the interpretive process address the unconscious motives that might explain why the patient experiences things in a certain way. This process involves bringing to the patient's attention aspects of his or her inner life that are not directly in awareness and, for defensive reasons, have not been accessible or acceptable; the latter phases of interpretation entail proposing hypotheses about the *meanings* of the patient's behavior and inner experience, and are dependent on the patient's capacity to observe, reflect on, and be curious about the nature of that experience.

In the treatment of patients with borderline personality disorder, interventions that precede the latter phases of interpretation play an especially important role. Here the interpretive process focuses on efforts to help clarify the patient's conscious emotional experience in the transference, elaborating the representations of self and object that are enacted with and projected onto the analyst at any given moment. The next step is to bring the patient's attention to the unstable and contradictory nature of his or her experience in the transference across time. It is only after the patient has developed an appreciation of and a curiosity about the dissociated and contradictory nature of this experience that we will voice hypotheses with regard to motivations for splitting-based defenses and denial. Finally, as treatment progresses, exploration and interpretation of repressed conflicts come to play a central role in the clinical process.

Our focus on the early phases of the interpretive process in the treatment of patients with severe personality disorders emerges in response to a difficulty frequently encountered in the treatment of these patients; as primitive object relations take form in the transference, the borderline

patient's experience of the analyst often becomes not only grossly distorted and highly affectively charged, but also very concrete. When we use the word *concrete* in this setting, we refer to the patient's limited capacity to appreciate that there is a distinction between internal experience and external reality; as thinking becomes progressively more concrete, a patient might move from feeling "I am frightened because I believe that you might hurt me" to "I can see that you are trying to hurt me" and finally to "You are hurting me." At other times, the patient's experience in the transference may show a predominance of affect (e.g., terror and/or hatred), without an accompanying cognitive representation of the object relation activated in the transference (e.g., as someone who is hurting the patient). Regardless of whether the patient's experience is cognitively represented and experienced in a concrete fashion, or is inchoate, during these clinical moments the patient is unable to establish any distance from or perspective on his or her immediate experience in the transference, intense affect floods the clinical setting, and analyst and patient alike may experience a sense of confusion and anxiety. To further complicate matters, transference dispositions may at such moments be most clearly expressed in the patient's behavior and in the countertransference, rather than in the patient's verbal communications (Clarkin, Yeomans, and Kernberg 2006).

Under these circumstances the patient is often unable to make use of interpretations of the underlying anxieties and defenses organizing his or her experience, and is in fact likely to experience any sort of intervention as at best a criticism and at worst an assault (Joseph 1985; Steiner 1993). At these times, the patient may, however, be able to make use of more basic interventions that serve to promote first a capacity to cognitively represent and in this process contain affective experience, and then a capacity to symbolically manage and reflect on experience in the transference.

When we refer to the *cognitive containment* of affective experience, we draw on the clinical observation that when the psychological experience of a BPD patient is flooded by intense affects not linked to conscious mental contents, the experience tends to be especially overwhelming for the patient; as affects are linked to specific mental representations of self and other, anxieties come to feel more focused and focal, and less overwhelming. In this process, the intensity of affective experience is to some degree attenuated or contained. We consider some degree of affect containment a necessary condition for subsequent levels of interpretation,

which support moment-to-moment in the microprocess, as well as over the course of the treatment, in the macroprocess, the patient's capacity to symbolically manage psychological experience in the transference. Here we refer to the patient's capacity to view experiences of and thoughts about the analyst as existing *in his or her mind*, which is to say, corresponding with but not literally the same as the material reality of their interpersonal exchange. Appreciation of the symbolic nature of experience opens up the possibility of considering alternative perspectives and makes it possible to reflect on one's experience in a meaningful fashion. We therefore consider the capacity to appreciate the symbolic nature of experience a prerequisite for making genuine (in contrast to intellectualized or "pseudoanalytic") use of traditional approaches to transference interpretation. In this paper we describe ways in which the early phases of the interpretive process function to provide affective containment and to support the patient's capacity to symbolically manage his or her experience in the transference.

Before proceeding, we would like to make clear that we view the limited capacity of BPD patients to cognitively represent and symbolically manage their emotional experience as dynamic rather than fixed. It is important to keep in mind that some BPD patients function quite well in certain areas of their lives, and that in limited areas of functioning they may be creative and productive individuals. In these realms their thinking and experience are typically far from concrete. This is to say that we do not see patients with borderline pathology as simply unable to symbolically manage their emotional experience. Rather, we see them as having developed this capacity to some degree but in a way that is too easily compromised in the face of psychological conflict and the activation of peak affect states.

In sum, it is our belief that in the psychoanalytic psychotherapy of patients with borderline personality disorder, early phases in the interpretive process should support their capacity to cognitively represent and symbolically manage emotional experience in areas of conflict, bringing them closer to functioning in ways that are less anxiety-provoking and affectively charged. This is to say that the therapeutic goal of the early phases of the interpretive process as we conceive it is to help the patient optimize, stabilize, and consolidate capacities that he or she already possesses in some degree, rather than to develop capacities that are entirely lacking. In contrast, the therapeutic goal of the overall interpretive process

is to help the patient develop *new* psychological capacities. We conceptualize the latter development in terms of the integration of dissociated, projected, denied, and ultimately repressed aspects of the patient's inner world into dominant self-experience (Joseph 1992; Steiner 1996). In our model, the achievement of new psychological capacities, corresponding with the integration of dissociated aspects of experience of self and other into a coherent identity, as well as the integration of repressed aspects of experience into a core sense of self as it develops during the course of treatment, requires the entire interpretive process, including interpretation of the unconscious anxieties underlying defensive operations, leading to insight.

A MODEL OF TREATMENT

Our psychotherapeutic approach is based on standard analytic technique, but with modifications to accommodate the clinical demands of the patient with borderline personality disorder. These technical modifications include (1) establishing and maintaining the treatment frame through negotiation of a treatment contract and limit-setting as needed; (2) maintaining consistent attention to the patient's life outside the treatment hours, together with a focus on the here and now in each session; (3) modifying standard analytic approaches to interpretation to place greater emphasis on the early phases of the interpretive process and on the containing functions of the analyst's interventions; (4) consistently analyzing how the patient interprets the analyst's interventions. Because setting limits to protect the patient's life and the treatment setting deviates from technical neutrality and maintaining a sharp focus on the patient's external life situation may distort the spontaneous flow of the transference, consistent analysis and interpretation of the patient's experience of these interventions adds a special dimension to the analyst's interpretive function when treating borderline pathology (Clarkin et al. 2006).

In this paper we focus on the nature of interpretive work, with special attention to early phases of the interpretive process. As noted earlier, we conceptualize the interpretive process as comprising a series of interventions, each step promoting a higher level of psychological integration and affective containment. In both the microprocess, within a single session or across several sessions, as well as in the macroprocess, across the trajectory of the entire treatment, the degree of integration provided by any given phase of the interpretive process facilitates the patient's capacity to

make use of the succeeding level of interpretation. Sometimes the patient will respond to a particular intervention as it was intended, making use of it to attain, at least transiently, a higher level of integration, opening the door for the next level of interpretation. At other times the patient will respond with anxiety and regression, calling upon the analyst to return to an earlier phase in the interpretive process. This is to say that we are describing not a linear sequence, but rather a process that, while involving much back-and-forth, at the same time follows a particular trajectory, in both the micro- and the macroprocess, which we describe below.

TECHNIQUE

We outline four levels of intervention that can be identified in the interpretive process, and discuss our conceptualization of the functions served by each. This outline is intended as a theoretical framework, a description of clinical principles that analysts can use to organize their experience and conceptualize the clinical interaction overall, and to guide their selection of interventions moment to moment, not as a prescription for clinical intervention, or as a monolithic or rigid conceptualization of the clinical interaction.

We have selected clinical vignettes spanning many sessions to illustrate the techniques we are describing; we do not report detailed clinical process. Currently we are performing detailed analyses of the clinical process in our research treatments, in order to study systematically the impact of specific interventions on clinical process and outcome. This paper is not written with the aim of convincing readers of the accuracy or even utility of any particular interpretation, or of the validity of our understanding of the interpretive process. This is a preliminary communication, intended to illustrate a specific technical approach that we have developed and adopted, and that we are subjecting to further study.

First Phase of the Interpretive Process: Defining the Dominant Object Relation

Clinical illustration. Ms. N, thirty years old and single, had been fired from her job as a waitress; still unemployed, she was living in her mother's home. At the insistence of her mother, Ms. N applied and was accepted to a randomized clinical trial for treatment of borderline personality disorder.

Ms. N was large, overweight, and overbearing. She dressed in baggy sweatpants and presented herself in an imposing and threatening fashion.

As the weeks passed, Ms. N became openly hostile and paranoid. Her feelings seemed to be organized around the requirement to attend sessions regularly and to begin and end on time. Eventually she began to skip sessions. When she did attend, she generally arrived late and often left early.

A month into the treatment, Ms. N began a session by immediately launching into a description of a fight she was having with her mother. From what the analyst (a woman) could gather, Ms. N was angry at her mother, who had decided to fence their cat out of the living room. The analyst was having difficulty understanding what was happening at home, and felt unclear as to how Ms. N was experiencing her mother. When the analyst asked for clarification, Ms. N became more agitated. It turned out that the cat was old, now incontinent, and that Ms. N's mother was trying to avoid the cat's soiling her rugs. Ms. N began to rant about her mother's inconsiderate behavior, calling her a "selfish bitch" and saying "she doesn't give a shit about the cat or about anyone else's needs or feelings." Ms. N became increasingly agitated, and the analyst realized that she felt threatened; she was acutely aware that Ms. N quite easily could physically overpower her. Ms. N glared at the analyst and went on to exclaim, "I can't live in her house, even if she's supporting me. I can't stand her, selfish fucking bitch. If it were my house I could do whatever I want." Ms. N went on to say that she wasn't going to let her mother "get away with it." She planned to open the gate and let the cat back into the living room, as soon as her mother left the house to go to work.

The analyst responded by pointing out to Ms. N that she seemed to see her mother as someone who had power and abused it, doing whatever she wanted while caring nothing about the needs of others; her mother didn't care about the cat's needs, and when she insisted that Ms. N stick with her therapy, it seemed she didn't care about Ms. N either. The analyst could see that Ms. N had been listening to her, and sensed that she was feeling less agitated. The analyst pointed out that what was happening between Ms. N and her mother seemed also to be happening between Ms. N and herself, perceived as yet another person who was abusing power.

To this Ms. N responded, "That is *exactly* what I've been telling you! You make me come twice a week when I only want to come once—twice a week is too stressful for me. I keep telling you but you don't listen." The analyst responded that she could see that meeting twice weekly was difficult, but that it seemed the problem went beyond the analyst's asking

Ms. N to do something difficult. When the analyst insisted on regular appointments and on starting and stopping on time, she became in Ms. N's eyes just like Ms. N's mother with the cat—selfish, controlling, and caring only about her own needs. In this situation, Ms. N had only two choices: she could feel powerless and afraid, like the cat, or rebel by coming late and skipping sessions.

Comment. Preliminary stages in the interpretive process are organized around the analyst's efforts to clarify and make sense of the patient's verbal and nonverbal communications and of the countertransference. These three channels of communication are often dissociated and contradictory, and the early phases of the interpretive process will typically require the analyst to integrate disparate and often contradictory communications in order to identify and describe the object relation currently dominating the patient's experience in the transference.

In this setting, and very much in contrast to the analytic treatment of patients with higher-level personality pathology, the analyst cannot sit back and wait for latent content to emerge over time through the patient's free associations. In the treatment of BPD patients, the intense affects linked to primitive polarized object relations that are almost immediately activated in the here and now of the therapeutic relationship may lead to disruptions or treatment-threatening behavior that must be anticipated and addressed by the therapist. When primitive defenses predominate, the analyst must be more active, asking for greater detail and specific explication from the patient, searching out and attempting to organize in his or her mind the content and narrative embedded in the behavior and in the dissociated and vague verbal communications of the patient (Kernberg 2004). In this setting, the countertransference becomes an essential source of information about the object relations activated in the transference.

The analyst's initial efforts at clarification typically lead to anxiety, and often paranoia, on the part of the patient with borderline personality disorder. By calling attention to omissions, contradictions, areas of vagueness, and dissociation between verbal and nonverbal communications, the analyst is implicitly confronting primitive denial and dissociation. We have found that this process typically leads quite quickly to activation in the transference of the primitive object relations and associated highly charged affect states underlying the patient's dissociated verbal and nonverbal communications. In essence, as acting out is limited by the treatment frame and contract, and as the analyst consistently focuses on and

attempts to understand the patient's verbal and nonverbal communications, the patient's affect states and behavior patterns are transformed into specific object relations that begin to take form in the transference (Clarkin, Yeomans, and Kernberg 2006). It is the central task of the first phase of the interpretive process to identify and elaborate these object relations.

Typically, as primitive object relations begin to emerge, the patient's experience in the transference is highly affectively charged and concrete (Ms. N was aware only that she was, from her perspective, rightfully enraged), serving as a source of confusion and anxiety to patient and analyst alike. At these times the representational components of the underlying object relations may be inchoate or only poorly elaborated, or they may be expressed in behavior, entirely dissociated from the patient's dominant conscious experience. To the degree that an object relation can be identified, the roles of self and object may be rapidly oscillating. Alternatively, the patient may be consciously identified with one role while enacting the other.

The first task of the analyst at these times is to tolerate a sense of confusion and anxiety and to resist the impulse to respond reactively to the patient's affects, behavior, and projections. Rather, the analyst should identify what he or she is feeling, and trying not to feel, in the countertransference, and then reflect on the relationship between this experience, the behavior of the patient, and the experience of the patient. This process will allow the analyst to begin to develop a formulation of the object relation being enacted in the transference. As the representations embedded in the patient's affects and behavior begin to take shape, the analyst will feel less controlled by the patient's projections. The initial phase of the interpretive process culminates in the analyst's putting the patient's experience of the analyst into words. Except in the most extreme situations, preliminary descriptions of the patient's experience of the analyst can be expanded to include the patient's self-experience in relation to the analyst so that the analyst is describing the entire object relation currently dominating the transference.

This initial phase and function of the interpretive process corresponds with what Steiner (1993) has referred to as an "analyst-centered" interpretation and builds on Bion's constructs of alpha function (1962a) and containment (1962a,b, 1967). These interventions are described as analyst-centered because the emphasis is on putting the patient's concrete and affectively charged experience of the analyst into words, without calling

it into question or suggesting that the patient might see it differently, and without suggesting that the patient has anything to do with the experience. With Steiner, we think of this kind of intervention, describing and elaborating the patient's experience of the analyst, as providing cognitive containment of concretely experienced affect states that are dominating the patient's experience in the transference.

In sum, the goal of this initial phase of the interpretive process is to help the patient articulate internal experience, first—in the analyst's mind—transforming internal states that have been dissociated, ignored, or poorly represented into specific object relations that begin to take form in the transference and, second, identifying, describing, and elaborating the dominant object relations in as clear a fashion as possible. This process provides cognitive containment of the patient's experience of the analyst in the transference, while at the same time providing the patient the experience of being understood (Steiner 1993) and of the analyst as genuinely attempting to understand (Schafer 1997).

Second Phase in the Interpretive Process: Identifying and Pointing out Role Reversals within a Particular Object Relation

Clinical illustration. Ms. N skipped the session following the last one described, and did not call. Thirty minutes into the hour the analyst called her. Ms. N's mother picked up the phone and told the analyst that her daughter was in bed, eating and watching TV. Ms. N had told her mother to tell the analyst she wasn't feeling well and would not come to the phone. The analyst's reaction was to feel frustrated and helpless, irritated and devalued. It occurred to her that Ms. N might drop out of treatment and that she did not want her to.

Ms. N arrived early for her next appointment. The analyst brought up the issue of her not having kept her last appointment and not having called to cancel. When the analyst inquired, Ms. N acknowledged that she had enjoyed feeling in control, that she could do whatever she wanted; the analyst couldn't make her come to the phone or to her session, and couldn't tell her what to do. Ms. N then raised the issue of the analyst's having started "late." What emerged was that Ms. N had thought their appointment was scheduled for 4:00, though they regularly met at 4:15. When the analyst did not come to get her until 4:15, Ms. N had understood that she was purposely kept waiting in retaliation for not having come to the previous session; the analyst was showing Ms. N who was in control.

The analyst clarified the confusion about the starting time. She then commented that when Ms. N had skipped her appointment, and instead

lay in bed eating and watching TV, she had enjoyed being in control. It was her turn; she could do whatever she wanted and the analyst's needs meant nothing. At the same time, Ms. N expected that this would leave the analyst feeling angry, and she believed that the analyst had retaliated by keeping her waiting, as if to show her who was in control. Ms. N acknowledged that this was indeed how she had felt when the analyst hadn't come out to get her.

Sensing that Ms. N was listening, the analyst pointed out that the relationship they had just played out—Ms. N self-serving and in control, the analyst resenting that and retaliating by keeping her waiting—was familiar to them. The analyst suggested that if Ms. N thought about it, it seemed to be the same relationship they had talked about in the previous session, but this time with the roles reversed. The analyst reminded Ms. N of their discussions about scheduling; she said that when she insisted Ms. N keep regular appointments, Ms. N saw her as controlling and selfish, as having no concern for her needs or her comfort, and would seek to regain control by skipping sessions or coming late. The analyst also reminded Ms. N of how it had been the same story when her mother had locked the cat out—her mother was selfish, cruel, and in control, and Ms. N was furious and wanted to rebel. The analyst suggested that it was as if Ms. N had an image in her mind of two people interacting—one partner powerful, controlling, and selfish, potentially cruel, the other powerless and depreciated, enraged and rebellious. (The analyst noted to herself, but felt it premature to comment on, the latent positive-dependent transference associated with the patient's wishes to receive help from the analyst, as well as her fears of receiving help, mirrored in the analyst's countertransferential anxiety about losing Ms. N as a patient.) The analyst went on to say that in the therapy, most of the time, it was the analyst who seemed powerful and in control, while Ms. N was enraged and rebellious. But by missing the session and staying home in bed, Ms. N had had that experience with the roles reversed—she had taken control and acted in a self-serving way, doing exactly as she pleased, and she expected that the analyst, feeling powerless, would be enraged and looking to retaliate. The analyst pointed out that it seemed Ms. N experienced this relationship pattern many times over: "The roles can flip, but the pattern remains the same."

Comment. At any given moment, the patient will be consciously identified with one half of the object relation activated in the transference, while experiencing the therapist in the complementary role.

However, with BPD patients this configuration tends to be unstable; the roles attributed to self and object can be seen to flip, and at times to alternate rapidly. Further, at the same time that the dominant object relation can be identified with patient and analyst in a particular configuration, enactment of the complementary relationship pattern can often be discerned in split-off aspects of what the patient is saying and doing, dissociated from the patient's dominant experience, and often first noted in the countertransference. This entire process, in which the roles of self and object are poorly differentiated and easily exchanged, reflects the ongoing impact of generalized splitting mechanisms, and in particular of projective identification, on the clinical situation.

The second phase in the interpretive process entails pointing out instances in which the roles of self and object that the patient has attributed to patient and analyst in the transference flip, with the analyst now in the role previously attributed to the self and vice versa. Role reversals can be identified within a single session or across several. This phase of the interpretive process makes use of previous descriptions of the object relations dominating the transference, now bringing to the patient's awareness the fluidity or instability of his or her identifications with each side of those object relations.

By bringing attention to the shifting roles attributed by the patient to analyst and patient, the analyst moves the therapeutic process a step beyond what is provided by the straightforward, in-the-moment clarification or description of the patient's experience. Now, for the first time, the analyst is introducing a new perspective on the patient's experience, one that does not correspond exactly with that of the patient. When the analyst points out role reversals, making a connection between an experience the patient is currently having and an experience she has had in the past, or points out contradictions between the patient's current experience and current behavior, the analyst is inviting the patient to transcend her immediate, concrete experience in the moment and to begin to form cognitive links between aspects of her experience that have been dissociated. At the same time, by drawing attention to a particular relationship pattern in which the patient can identify with either role, the analyst has taken a preliminary step toward suggesting that the patient has an *image* of a relationship *in her mind*. In pointing out role reversals, the analyst is suggesting that the patient has an internal world, and that this world has organized features that can be the subject of inquiry, in contrast to the more concrete experience in which what the patient experiences is the way things are and there is no room, need, or reason to consider it further.

In the first phase of interpretation, Ms. N is helped to represent and cognitively contain her affectively charged experience, but she has little or no perspective on this experience; this is to say that the analyst does not question the patient's highly concrete experience of the object relations enacted and described. In contrast, the second phase of interpretation supports the patient's capacity to appreciate that her experience in the transference is both internal and symbolic. As the analyst offers a new perspective on the patient's experience by drawing attention to role reversals, she is implicitly inviting the patient to step back and observe herself. At the same time, embedded in this intervention is the communication that the *analyst* is able to step back and observe her own interaction with the patient and to reflect on it and on its relation to interactions they have had in the past. This capacity to triangulate internal experience and observe oneself across time is a capacity that patients with borderline personality disorder lose in the face of anxiety; the capacity to retain perspective in the face of conflict is a goal of the treatment.

We suggest that the second phase in the interpretive process provides the opportunity for BPD patients to identify with, or internalize, the therapist's capacity to observe their interaction, and it encourages patients to observe themselves. It implicitly suggests to them the possibility of making a distinction between the fluctuating, moment-to-moment experience of the therapeutic interaction and an outside perspective on that interaction, while providing awareness of their identification with two sides of an object relation and with aspects of their experience that have been projected. Even though the patient's experience remains split, poorly differentiated, and highly affectively charged, we are supporting a developing capacity for the triangulation of thought in conflictual areas of experience. This capacity to reflect on fluctuating identifications with both poles of an object-relational dyad is in our view an essential precursor for the development of the capacity for mentalization (Kernberg, Diamond et al. 2008).

Third Phase in the Interpretive Process: Identifying Splitting and Dissociation among Different Object Relations

Clinical illustration. In keeping with the initial treatment contract, Ms. N began a vocational training program to learn computer skills. It was frustrating, and she found it humiliating, but she stuck with it. She became less irritable in session. Now three months into the treatment, the analyst had a sense that things were significantly better for Ms. N, yet it seemed that she didn't want to openly acknowledge this to the analyst, or to focus on

it herself. Instead, she focused in session on her frustrations and humiliations outside the treatment and on how difficult and inconvenient it was to be in the treatment.

The analyst pointed out to Ms. N that she seemed to be carrying on two different relationships with the analyst and the therapy, relationships she saw as entirely separate from one another. One relationship, which Ms. N was comfortable talking about freely, was a largely hostile one; in this relationship, because the analyst cared about the research protocol, her role was to insist that Ms. N respect the treatment frame with regard to coming to sessions, and it seemed the analyst didn't care that this was difficult, frustrating, and at times humiliating. Ms. N's role in this relationship was to feel angry and suspicious and to complain about the analyst.

The analyst went on to suggest that there was another side to things, which Ms. N didn't talk about as openly. This other side had to do with why in the end Ms. N had stuck with the treatment, even though she found the experience so unpleasant. In this view of their relationship, the analyst was someone extremely powerful who could use her power to transform Ms. N if she chose to, acting on Ms. N in an almost magical way to enable her to function better in her life. In Ms. N's mind, this view of their relationship was connected to the material gains Ms. N had made since beginning treatment. Over the ensuing months she and the analyst explored and became familiar with the cognitive and affective components of these two, dissociated experiences of their relationship. They also discussed various ways in which the idealized version of the relationship interfered with Ms. N's making efforts on her own behalf and with taking credit for her accomplishments.

Comment. The third step in the interpretive process entails pointing out the relationship between two contradictory object relations (typically idealized and persecutory experiences of self and other) that have been defensively dissociated. Whereas earlier phases entail identifying role reversals and dissociation within the same object relation, the next phase involves calling attention to dissociation between two entirely different, polarized, and generally contradictory aspects of experience that are defensively split off from each other. Typically this level of intervention addresses a fundamental division between paranoid, aggressively charged object relations associated with frustration and hatred, and idealized object relations associated with gratification, safety, and idealized attachments. This phase of the interpretive process builds on previous interventions that have

described the cluster of core object relations that tend to dominate the patient's experience in the transference. As before, the analyst's interventions for the most part make use of conscious and preconscious material, staying close to the patient's dominant, moment-to-moment experience in the transference and linking it to dissociated, contradictory experiences that have also been either fully conscious or expressed in the patient's behavior.

This third phase in the interpretive process goes beyond the second in that the therapist begins to address the fundamental divisions that characterize the patient's emotional experience in the transference. At this level of intervention, as we conceptualize it, the analyst does not yet focus attention on the motivations that may account for the activation of the patient's defensive operations. Rather, emphasis is on inviting the patient to observe and reflect on the polarized and contradictory nature of his or her experience of the analyst. In classical ego psychological terms, this kind of intervention functions as a confrontation of the patient's defensive operations. The third phase of the interpretive process builds on earlier interventions focused on role reversals, both relying on and further supporting in the patient a capacity to view one's experience across time, to step back and observe oneself, and to appreciate the subjective nature of one's experience. The analyst's interventions, focusing now on the clinical manifestations of splitting-based defensive operations, also invite the patient's curiosity, introducing the possibility of exploring the motivations for, and the meanings of, his or her behavior and experience. Though this phase in the interpretive process may initially cause anxiety, it at the same time supports the patient's reality testing and self-reflective capacity, setting the stage for the next phase of the interpretive process.

Fourth Phase of the Interpretive Process: Exploring the Psychological Conflicts Embedded in and Defended against by the Patient's Experience in the Transference

Clinical illustration. After exploring Ms. N's initial reaction to the analyst's pointing out the dissociation of a paranoid from a relatively idealized experience of their interaction, the analyst offered a suggestion about why Ms. N might need to experience things this way. The analyst said she had been thinking about why it might be that Ms. N felt it important to keep her positive feelings about the treatment and the analyst, and about herself as well, a secret. The analyst asked Ms. N if she wanted to hear her thoughts about this. Ms. N nodded. The analyst went on to say

that she thought Ms. N might be keeping the positive, almost magical relationship secret in order to protect the relationship from attack; that if Ms. N acknowledged she thought the analyst was helpful, and felt she was benefiting from the therapy, it created a problem in her mind. If the analyst was helpful, it made her powerful. As a result, though it might at any moment seem the analyst was using her power on Ms. N's behalf, the analyst could just as easily become self-serving and abuse her power; if Ms. N acknowledged the analyst's help, the analyst could quickly become an enemy. So Ms. N kept the whole thing secret, as a way to sustain her connection to the analyst as someone magically helpful, and to protect that relationship from attack.

In later sessions the analyst suggested that just as Ms. N experienced her as an external enemy, she also struggled with an internal enemy, a powerful and controlling tyrant within that wanted to destroy the possibility of her making use of the treatment. With time, Ms. N and the analyst came to explore various anxieties underlying Ms. N's need to reject help and to actively rebel against opportunities to make gains; these concerns included fear of attack from an envious, cruel, and aggressive parental figure, fear of losing a helpful parental figure were she to allow herself to depend on the analyst, and unconscious guilt in relation to wishes to triumph over her highly successful older brother.

Comment. In the advanced phases of the interpretive process, the analyst explores hypotheses about the *meanings* of the patient's experience in the transference, focusing in particular on the motivations and anxieties underlying defensive operations (in the example above, the patient's use of dissociation and denial in relation to her positive, to some degree idealized view of her relationship with the analyst and her negative, paranoid view of it). This level of interpretation corresponds with traditional approaches to interpretation, organized around exploration of motivations and conflicts underlying defensive operations.

As we have discussed, in the treatment of patients with borderline personality disorder, traditional approaches to interpretation—absent the kinds of preliminary interventions we have outlined—often fail to promote the clinical process. Early in treatment, patients may feel attacked by “patient-centered” interpretations, which may fail to provide adequate affective containment. Later in treatment (or in the treatment of patients who begin treatment with better affect regulation), misguided use of conventional approaches to interpretation may lead to the intellectualized

pseudoexploration of psychological conflicts, dissociated from the patient's affective experience and from a process of genuine self-reflection (Bateman and Fonagy 2004). It is our belief that the early levels of interpretation as we have outlined them prepare the patient for making use of transference analysis.

At moments when the patient is to some degree capable of self-observation, to reflect on inner experience and to consider, at least fleetingly, its symbolic nature, it becomes possible to interpret in depth the anxieties that have been activated in the transference. Consistent with Steiner's view (1993), we believe that this advanced phase of interpretation is a necessary component of the therapeutic process. Even though significant gains can be made on the basis of earlier interventions, which provide containment and the opportunity to identify with the analyst as an observer, we believe that the working through of anxieties that motivate splitting-based and repressive defensive operations plays an essential role in the progressive integration of the patient's internal world.

In our model, repeated analysis of the patient's conflicts and anxieties as they interfere with psychic integration leads to the gradual relinquishment of projective and splitting-based defenses and to identity consolidation. Here our understanding of the techniques and functions of the interpretive process overlap with those described by Steiner (1993, 1996) and Joseph (1985, 1992). Finally, interpretation and working through of the anxieties motivating dissociative defenses flow naturally into exploration and interpretation of conflictual aspects of the patient's psychological life that have been repressed.

DISCUSSION

We have presented a model of the interpretive process in the treatment of patients with borderline personality disorder. Our approach has evolved over many years, in light of our clinical experience and empirical research, as well as parallel developments, within and outside of psychoanalysis, in the treatment of severe personality disorders. We began our journey with the observation that patients with borderline pathology often poorly tolerate regression in the transference; these patients are rapidly swamped with highly affectively charged and concrete or poorly elaborated experiences in the transference, as they are in other relationships, that often lead the patient to destructive behavior and/or treatment disruption. We, as others (e.g., Steiner 1993; Bateman and Fonagy 2004), have found that in this

setting conventional transference interpretations generally prove unhelpful. Instead we have developed a modified approach to interpretation, designed to address the specific clinical needs of BPD patients, while retaining the centrality of the interpretive process in this psychodynamic treatment.

We now have empirical support for the effectiveness of our treatment approach, including improvement in reflective function, relative to dialectical behavior therapy (DBT) and supportive psychotherapy (SP). It is our impression that the process of interpretation as we have outlined it, in the setting of a stable treatment frame and therapeutic relationship, plays a central role in the therapeutic gains made by BPD patients in TFP, particularly with regard to the integration and modulation of object relations and an increased coherence and stability in the experience of self and others, both of which underlie the consolidation of identity.

Identity consolidation, which presupposes the integration of split, polarized self- and object representations into an overarching stable concept of the self and significant others, provides stable coherent working models of self and others against which fluctuating mental states can be assessed and evaluated. Thus, identity consolidation is inextricably linked to the capacity to reflect on internal states of self and others in a meaningful fashion (Kernberg, Diamond, et al. 2008; Fonagy et al. 2002). In this paper we have attempted to outline our understanding of how the interpretive process might lead to changes in the representational world and how these changes might in turn foster improvements in reflective functioning (see also Kernberg, Diamond, et al. 2008).

We emphasize that ours is one of many effective treatments for borderline personality disorder; there are many overlapping features between our approach and alternative treatments. Most relevant to this paper is our relationship to mentalization-based therapy (Bateman and Fonagy 2004), which is the other empirically supported long-term psychodynamic treatment for borderline personality disorder. MBT is based on a model of borderline pathology that posits that BPD patients suffer from a core deficit in the capacity to “mentalize,” to be cognizant of and reflect on their own internal states and those of the people they interact with. In support of this model, Fonagy and colleagues (Fonagy et al. 1996) found that the Adult Attachment Interviews of borderline patients were distinguished from those of other psychiatric patients not only by significantly higher ratings on the lack of resolution on the trauma AAI subscale, but by significantly lower ratings on the reflective function scale (RF), a measure of mentalization in attachment relationships.

The capacity to mentalize is normally developed in early childhood in the setting of a secure attachment relationship, and is viewed by Fonagy et al. (2002) as a prerequisite for the development of a coherent sense of self and others. Empirical investigations of reflective function (RF) in children and adults indicate that deficits in RF may be at the base of insecure representational states with respect to attachment (Fonagy et al. 2002), and conversely that high RF is more likely to be associated with secure representational states with respect to attachment in adults and secure parent-child attachment behaviors in children (Fonagy, Steele, and Steele 1991; Fonagy et al. 1996, 1998). A number of empirical studies have now linked attachment security with optimal personality, psychosocial, and cognitive functioning throughout development, including the quality of peer relationships and cognitive functioning in childhood (Suess, Grossmann, and Sroufe 1992); the quality of intimate relationships in adolescence and of romantic relationships in early adulthood (Sroufe et al. 2005); and reasoning about emotions at age six (Steele and Steele 2008). The capacity for RF has also been found to be a protective factor in individuals with histories of trauma or abuse linked to insecure attachment. Fonagy and colleagues found that individuals with a history of abuse were less likely to have BPD if they had high RF (Fonagy et al. 1996). Other studies have shown that mothers classified with lack of resolution of loss or trauma were more likely to have children classified with secure attachment if they (the mothers) had high RF scores on the AAI, while their counterparts with low RF were more likely to have children classified with disorganized attachment status (Slade et al. 2005). Thus, the capacity for RF may moderate the negative impact of a traumatic early attachment history and potentially guard against the transgenerational transmission of insecure attachment patterns. In sum, improvements in RF may be particularly important for borderline patients, who are likely to have low RF in the context of insecure attachment histories.

Given our findings of enhanced RF in patients treated with TFP relative to DBT and SP, the relationship between TFP and MBT bears consideration. It is important to note that TFP does not target RF per se, but rather the integration of the split, polarized representational world of those with BPD. We believe, however, that the approach to interpretation that we have outlined functions to promote the development of reflective function at the same time it promotes the integration of split-off, polarized, and unstable experiences of self and others. Indeed, even though TFP and MBT are based on different models of pathology and therapeutic action,

there is a great deal of overlap between the technical approach of MBT and the early phases of the interpretive process in TFP. Notably, in both treatments the therapist maintains a consistent focus on understanding the patient's inner states and accompanying internal representations, and helps the patient identify what in the interpersonal context has stimulated his or her feelings and behavior; in this process, the therapist also focuses on his or her own internal experience. Insofar as MBT stresses the importance of helping patients to clarify their self state and to infer the internal experience of others, as well as to "bridge the gap" between their primary affective experience and its symbolic representation (Bateman and Fonagy 2004), there is significant overlap between interventions made by MBT and TFP therapists.

However, it is of great interest to us that while interventions made in MBT overlap to a significant degree with the early phases of the interpretive process as employed in TFP, MBT does not make use of the final phases of the interpretive process as we have outlined them, those that involve the linking of dissociated psychological states and the interpretation of the motivations and conflicts underlying defensive mechanisms. Whereas both of these interventions are central to the interpretive process in TFP (Clarkin, Yeomans, and Kernberg 2006), as well as to traditional approaches to interpretation, they are not employed by the MBT therapist, who by and large avoids interpretation of psychological conflict (Bateman and Fonagy 2004). Instead the MBT therapist consistently attempts to define accurately what the patient is feeling and doing in the here and now, and to identify what in the interpersonal environment the patient is responding to. The goal of this process is to help the patient develop a capacity to understand inner experience and its relation to external events. Consistent with this view, MBT does not rely on analysis of transference in the usual sense until late in treatment, if at all. Instead the therapist attempts to contain the patient's projections without interpreting them, taking the position that as the patient's capacity for mentalization increases, the projections of inaccurate internal representations will be replaced by an accurate appreciation of the patient's own mind and the minds of others, and that this process will lead naturally to a more robust sense of self. Exploration of the transference is used primarily to demonstrate alternative perspectives on shared experience. Thus, while in the early phases of the interpretive process (phases one and two as we have outlined them) the technical approaches of TFP and MBT are quite similar, when it comes to the latter aspects of the interpretive process (phases three and four) involving exploration of psychological conflict as a necessary step

toward the achievement of an integrated self, TFP has retained a traditional approach to interpretation where MBT has not.

The differences between TFP and MBT with regard to interpretation must be understood within the context of other differences in how the two treatments are structured. TFP is a twice-weekly psychodynamic treatment with a minimum duration of one year; patients often continue beyond the research year, offering therapeutic soil for the cultivation of a highly focused, intense, and rich transference relationship, which offers opportunities for more advanced phases of interpretation. Ancillary treatments such as psychopharmacological intervention, substance abuse programs, and other specialized group treatments are added only when necessary to stabilize the patient's symptoms. By contrast, MBT combines once-weekly individual and once-weekly group psychotherapy, often within a partial hospital setting for a minimum of eighteen months, with follow-up of twice-weekly outpatient mentalizing group psychotherapy offered as an option (Bateman and Fonagy 2008). In this highly structured and integrated program, the transference may be spread within the team, and the intense activation of the attachment system is ameliorated by systematic efforts across the treatment modalities to promote an understanding of behavior in terms of underlying mental states (Bateman and Fonagy 1999, 2001, 2008). This diffusion of the transference relationship may in turn lessen the emphasis on the latter stages of interpretation, particularly exploration of the psychological conflicts embedded in and defended against by the patient's intense experience of the transference. It is important to note that the difference in the two treatment approaches may also stem from different understandings of the etiology and nature of borderline pathology (for a more comprehensive discussion of this issue, see Kernberg, Diamond, et al. 2008). We anticipate that studying these two treatments in relation to each another will shed further light on the functions of interpretation in general, and of transference interpretation in particular, in the psychodynamic treatment of borderline personality disorder.

CONCLUSION

Part of the difficulty in treating BPD patients in analytic treatments is that unless patients have some capacity to observe themselves and to appreciate, at least fleetingly, the symbolic nature of their thinking and the subjective nature of their experience, transference interpretations are of limited utility. We suggest that in the psychotherapeutic treatment of patients with

borderline personality disorder, the early phases of the interpretive process support the capacity to cognitively contain and symbolically manage their emotional experience in the transference. Thus, the early phases of the interpretive process can pave the way for meaningful exploration of anxieties underlying defensive operations.

In sum, we conceptualize the interpretive process as comprising a series of steps, or phases, which we have outlined. Each phase can be viewed as moving patients further away from a single, poorly elaborated, and concrete experience in the transference that dominates and floods their subjectivity and toward a more fully elaborated, complex, stable, and integrated appreciation of the role played by the analyst in their internal life. This conceptualization may shed light on the mechanisms by which analytic therapy in general, and the interpretive process in particular, can promote psychological integration in patients with borderline personality disorder. Our work represents an effort to bridge the gap between empirically supported manualized treatments and psychoanalysis.

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