Insecure Attachment States: Their Relationship to Borderline and Narcissistic Personality Disorders and Treatment Process in Cognitive Analytic Therapy

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Currently little distinction is made in Cognitive Analytic Therapy (CAT) between groups of patients in terms of variations in therapeutic processes that they may require. Attachment theory and research may prove useful here. The Adult Attachment Interview (AAI) and its rating systems can be used to assess whether CAT patients are more preoccupied with, or dismissing of, affect in their 'core states'. It is suggested that 'narcissistic' patients need to access unexpressed 'core pain' to a greater degree than do more 'borderline' patients, who need to understand how and why they move between dissociated 'core states'. AAI research (a) supports Ryle's new model of borderline personality disorder, and (b) suggests that narcissistic problems may be understood in terms of defences against attachment. As attachment theory and the AAI become more widely known and used, the concepts of dismissing and preoccupied insecure attachment states may prove to be more meaningful than those concepts of personality disorders currently employed. Copyright © 2000 John Wiley & Sons, Ltd.

INTRODUCTION

Not all patients can be expected to show the same degree of improvement with a particular therapy, and cognitive analytic therapy (CAT) is no exception. Should there be variations in the therapeutic process of CAT to enhance its utility with particular groups of patients?

CAT was intended to be inclusive rather than excluding of patients, in contrast to e.g. psychodynamic psychotherapy, which has extensive exclusion criteria (e.g. Malan, 1979). Although CAT

is not currently recommended for actively psychotic patients, and its appropriateness for substance-abusing patients is debatable (Leighton, 1997), it was developed as a therapy appropriate for most neurotic and many personality disordered outpatients (Ryle, 1995a).

Recently the CAT literature has begun to address more specific therapeutic requirements of certain patient groups. For example, workers with eating disorder patients have addressed particular reciprocal roles and motivational difficulties in this population, to adapt CAT better to their needs (Bell, 1996; Treasure and Ward, 1997).

Ryle himself has oriented his recent theorizing and research in CAT towards the therapy of those diagnosed with borderline personality disorder

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(Ryle, 1997a and b). This work has generated a new model of procedures, and some encouraging, though as yet unpublished, outcome data on CAT with 'borderlines'. However, therapists treating patients with problems better described as 'narcissistic' rather than 'borderline' may find that this group is less responsive to the active collaboration which CAT requires (C. Tanner, presentation at the 3rd ACAT Conference, London, 1995).

This paper focuses on two groups of personality-disordered patients, described as borderline and narcissistic, as there is widespread acknowledgement of the extreme difficulties that these groups of patients can pose in treatment. CAT's tendency to place little emphasis on precise diagnostic classification is a strength of the method in clinical practice, enabling reformulations to be 'bespoke tailored' to the individual patient. As regards research, however, it may be a limitation, in that important distinctions between groups of patients can be obscured. Attachment theory and research suggest that these two personality-disordered groups may differ substantially as regards underlying attachment patterns, which can also impact on the process of therapy.

In a previous paper (Jellema, 1999) I argued that both CAT theory and practice would benefit from more account of attachment theory and patients' unassuaged attachment needs. Research using the Adult Attachment Interview, an attachment research instrument, suggests that there are marked and systematic differences in reciprocal roles (experienced as states), as regards the extent of access to attachment-related affect. This paper contends that to assess whether CAT patients show more dismissing or more preoccupied attachment patterns, or a mixture of both, and modifying the therapeutic process accordingly, should enhance the efficacy of CAT with difficult patients, especially those described as borderline or narcissistic.

Comprehensive accounts of CAT can be found (e.g. Ryle, 1990, 1995a), but key CAT concepts are described in the text. Holmes (1993) and Marrone (1998) summarize the work of Bowlby on attachment theory, and describe contemporary attachment research. The Adult Attachment Interview, the most important development in attachment research to date, is described in some detail, as it is currently only available through training courses.

A NOTE ON CERTAIN CAT CONCEPTS

For those less familiar with CAT, the following concepts are briefly described. *Procedures* in CAT are repetitive sequences of thought, emotion, perception, behaviour, etc., which are involved in the execution of our aims and intentions. (Three common forms of maladaptive on inefficient procedure described by Ryle (1985, 1990, 1995a) are the trap, dilemma and snag.) *Reciprocal Roles* (RRs) are generalized procedures governing a person's interaction with others; the analytic concepts of transference and counter-transference are examples of RRs (Ryle, 1998). The term *Reciprocal Role Procedures* (RRPs) may be used when the active, procedural or sequential aspects of role-relating are being referred to. Descriptions of behaviour, relationships and transferences provide evidence for the patient's RRs; maladaptive procedures, including RRPs, provide the focus for therapy. Further CAT concepts will be introduced and described within the text.

THE ADULT ATTACHMENT INTERVIEW AND 'STATES'

Most theories of personality and psychopathology feature concepts of a person's internal models of the self, the other and of relationships. Below, I outline attachment theory's 'states of mind with regard to attachment' (e.g. Crittenden, 1990), here referred to as 'attachment states'; and later, a CAT concept which has considerable correspondence to it, described by Ryle (1995a) as 'states'. The AAI, a research instrument designed to detect attachment states in adults, can inform our understanding of different types of states in CAT patients.

The Adult Attachment Interview (AAI)

The Adult Attachment Interview, or AAI (C. George *et al.*, unpublished data) was devised to differentiate internal working models of attachment in parents whose children undergo the Strange Situation (SS), a behavioural test of attachment in young children (Ainsworth *et al.*, 1978). Typically concordances between mother (AAI) and child (SS) as regards attachment status are between 70–80%. In the SS, the infants' responses to brief separations from and reunions with (usually) the mother and the experimenter are videotaped and analysed. Three major, stable patterns of children's behavioural responses to the SS have been described (Main, 1995); secure attachment (labelled B), insecure avoidant attachment (A) and insecure ambivalent attachment (C). Research by e.g. Main and Weston (1981) and Fonagy *et al.* (1994), has

established that children make attachment relation-ships with each parent independently of the relationship with the other parent; thus attachment is more accurately conceptualized in terms of role relationships than global personality traits, which reinforces its relevance to CAT with its concept of reciprocal roles (see also Bartholomew, 1997).

The AAI is a 1 h-long semi-structured interview focusing on the parents' descriptions of their own attachment experiences in childhood (as evidence of their current working models of attachment). It asks subjects to choose five adjectives describing the childhood *relationship* with each parent, rather than the parent's personality, and for specific mem-ories illustrating these adjectives. They are asked to describe what happened when they were upset in childhood, and if/how they were comforted; memories of separation, loss, threats, rejection and abuse; how their relationships with their parents may have changed since childhood; how they respond to their own children; and how they make sense now of their parents' behaviour towards them, including the effects they think their upbringing has had on their adult personality and relationships.

The interview is audiotaped and transcribed, including all hesitations, speech errors and incon-sistencies; the transcript is then rated for security or insecurity with respect to experiences, ideas and feelings surrounding attachment, using discourse analysis, with discourse markers such as lack of memory, idealization and overall coherence. Main and Goldwyn's manual (M. Main and R. Goldwyn, unpublished data) is normally used for rating pur-poses. (Their rating system can also be applied to e.g. therapeutic narratives (A. Jellema, unpublished data).) Assignment to a particular AAI category is always determined by the individual's current *state of mind* as regards attachment rather than the nat-ure of their past attachment experiences. Tran-scripts are rated numerically on 9-point scales, before being assigned to one of four classifications describing the *overall* current attachment state: *Secure* (F), *Dismissing of attachment* (Ds), *Preoccupied with past attachments* (E), or *Cannot Classify within this system* (CC). A fifth classification, *Unre-solved/disorganized with respect to loss or abuse* (U) can be assigned *in addition* to one of the other classifications. However, most normative tran-scripts can be assigned to one overall classification, which suggests that adults have usually developed an organized strategy for dealing with attach-ments. All classifications bar F describe forms of insecure attachment; Ds and E are the two major

insecure categories. U and CC will be described later. The AAI has adequate test–retest reliability, and discriminant and predictive validity, with interviewer effects being insignificant (Bakermans-Kranenburg and Van Ijzendoorn, 1993; Van Ijzen-doorn, 1995). De Haas *et al.* (1994) have confirmed that there is as yet no suitable alternative method (such as a questionnaire) to the AAI for assessing working models of attachment, and that such working models are independent of temperament.

Ds subjects ('Dismissing of attachment') are insecurely attached adults who devalue or cut off from attachment experiences, and minimize their importance in current life. (There are four sub-classifications, Ds_1 to Ds_4.) They see themselves as 'normal', independent and strong, and value activities, possessions and facts, rather than feel-ings and relationships *per se*. Idealization of attach-ment figures is common (denigration to a lesser extent), although typically their actual childhood experiences with parents as described in the inter-view have involved much criticism, rejection and role-reversal. Ds subjects deny or seem unaware of such discrepancies between their past experiences and current state of mind, or they may have little recall of childhood experiences. (Their infants are usually rated A (insecure–avoidant) in the SS, being not openly distressed when the mother leaves, and ignoring her when she returns.)

Some parents are classified as E on the AAI (described as 'Preoccupied/entangled'). The insecure E (preoccupied) pattern is opposite to the Ds, in that insecurely attached E adults show intense emotional enmeshment with their parents. One of three main affective patterns predominates; they are either confused and needing comfort; angry; or fearful, depending on subclassification (E_1, E_2 and E_3 respectively). They can describe very difficult, often chaotic experiences with parents but do not seem to have enough sense of autonomy and personal identity to detach emotionally from them. E interviews may be long, rambling and often feature vague, 'woolly' thinking. (The chil-dren of E parents are usually rated as C (insecure–ambivalent or insecure–resistant) in the SS, being very distressed when left, but angry and hard to comfort on the mother's return.)

B (secure) children in the SS are distressed on separation but can be comforted and return to their play; they tend to have mothers rated as F on the AAI ('Secure/Autonomous/Free'). The F (secure) pattern combines the valuing of attachment and depending on others of the Es, with the strength and independence of the Dss; and for this reason

F has also been described as a 'balanced' pattern (e.g. Crittenden, 1995a). Fs can freely explore difficult feelings and experiences during the AAI without becoming overwhelmed. Unlike the Ds and Es, the interviewer is left with the impression of few defences being at work when Fs discuss attachment; their accounts are both psychologically and factually believable to the reader. Some Fs give convincing memories of love and concern in childhood. Others (described as 'earned Fs') may have had childhoods of varying degrees of rejection, deprivation or abuse; but in comparison with Ds and Es, they can accept their own parts in relationship difficulties and are forgiving towards parents. Their AAI transcripts are usually thoughtful and highly coherent. As Eagle (1995) notes, secure attachment provides a safe base for 'exploration', not only of the external world but also of one's internal world (Bowlby, 1988). (There are five F subclassifications, from F_1 to F_5.)

Frequencies of these AAI patterns in normative Western samples are typically: F = 45–55%, Ds = 20–35%, and E = 10–15% (Goldberg *et al.*, 1995). Although the Ds and E patterns are not in themselves pathological, research indicates that insecure working models of attachment are risk factors for psychopathology (Rutter, 1995; Sroufe *et al.*, 1999) and major mediators of the effects of adverse life events, such as sexual abuse (e.g. Alexander, 1992).

Attachment States and 'States' in CAT

Attachment states on the AAI relate most closely to two concepts in CAT: reciprocal roles, and states. *Reciprocal Roles* (RRs) were defined above as generalized procedures governing our interaction with others. Originating in early relationships with attachment figures, but also developing later in life, RRs characterize the patient's relationships with others, with the therapist, and also his relationship to himself. Two roles develop and are defined in relation to each other, hence 'reciprocal'. Thus to acquire a submissive role in childhood, for example, requires the experience of an other who is dominating; later one is able to enact both roles, to some extent, and to predict and elicit the role of the other in relation to the self. CAT stresses the crucial importance of understanding the reciprocity of roles in psychopathology, as symptoms and harmful or ineffective reciprocal roles can be both elicited and maintained by the RRs of others.

Arising from his work on borderline personality disorder, Ryle has recently (e.g. 1995b, 1997b)

emphasized a further concept; a *state* in CAT refers to the subjective experience of a RR. I will refer to them henceforth as *core states* (Jellema, 1999).

From the CAT perspective the *attachment state* concept, with its origins in experimental developmental psychology, is a relatively narrow one, when compared with the *core state*/RR concepts. Attachment states are deduced from discourse analysis of AAI transcripts, without taking speech tone or non-verbal communication into account. Unlike RRs, AAI attachment states are derived solely from evidence about the subject's current attachments to parents. AAI attachment states are more like 'bonds' than 'relationships'; they describe an individual's pattern of response to another, rather than a two-way interaction (Ainsworth, 1991), in contrast with the emphasis in CAT on reciprocity in relationships. Thus an AAI subject's overall attachment state might be described as Ds_1 (idealizing), but what the corresponding states of mind of his parents might be, is not assessed. However, it is important to stress that the overall perspective of attachment theory has always been essentially dialogic. For example, Ainsworth *et al.*'s (1978) pioneering investigation delineated not just differing attachment behaviours in infants, but also the corresponding behaviours in their parents which influenced those infant behaviours.

As yet, the concurrent validity of AAI attachment states (e.g. behavioural correlates) has not been established. Main and Goldwyn's (M. Main and R. Goldwyn, unpublished data) manual for classifying attachment states in the AAI also uses a fixed categorical approach, as opposed to the more individualized description of the patient's states developed with the therapist during a CAT assessment. Despite the narrowness of the attachment state concept in attachment theory, however, it is near enough to those of RRs/core states in CAT for the AAI to be of use in therapy, e.g. in assessing patients in the reformulation phase (A. Jellema, unpublished data). For example, the attachment state Ds_2 in Main and Goldwyn's system describes a derogatory attitude to attachment which is very close to the commonly described *contemptuous* RR in CAT (reciprocal to *contemptible*).

Dissociated Attachment Patterns

However, if the concept of attachment is to be of any help to CAT therapists and other clinicians in dealing with complex problems, attachment theory and measures should be able to encompass more

dissociated patterns of thinking, feeling and behaviour. Dissociation here is used to mean disturbances in the integration of consciousness, such that patients with high levels of dissociation can show major disruptions in e.g. identity, memory or affect, which can be accompanied by a sense of 'absence'. It is increasingly recognized as a phenomenon of major importance in clinical groups, particularly those who have suffered abuse and trauma (e.g. Herman, 1992; Kennerley, 1996; Ross-Gower et al., 1998). Ryle's recent theorizing on borderline personality disorder (1997a and b) is based on the concept of dissociation.

For the clinician, a major disadvantage of the Main and Goldwyn system is that it summarizes the subject's *overall* state of mind with regard to attachment (a further disadvantage being the length of time required to rate the interview—up to several hours). The AAI was developed on a low-risk middle-class Berkeley sample so its original classification system was not designed to account for very complex patterns of attachment, but recently its use has been extended to high-risk and clinical groups. Main and Goldwyn's classification system does allow for a limited degree of complexity in the patterning of attachment, via the U and CC categories, briefly outlined below.

A U (unresolved/disorganized) classification is given *in addition* to a Ds/E/F (or CC) classification if the person seems disorganized or disoriented when describing incidents of loss or abuse, possibly being in a dissociated state of mind, e.g. losing track of the interview context, 'reliving' the death as a 'flashback', or denying the reality of what is clearly an abusive experience (typical rates of U are 15–20%; Goldberg et al., 1995). Such parents who have unresolved experiences of loss or abuse tend to have infants who in the Strange Situation are 'insecure–disorganized' (D); they show complex mixtures of approach and avoidance in the Strange Situation with no coherent or organized behavioural strategy, e.g. approaching the parent with head averted (Main and Solomon, 1986). The majority of parentally-maltreated children show disorganized patterns of attachment, probably resulting from frightening parental behaviour (Main and Hesse, 1990; Main, 1996).

The CC (Cannot Classify) category (now also used in the Strange Situation) is rare in normal samples, but increasingly found in clinical AAI scripts, though as yet it is not employed widely in research. It is a new, distinct fifth attachment classification (Hesse, 1996), assigned when e.g. a subject shows a major shift in his/her attachment state of mind during the interview, e.g. from E_2 (angry) to Ds_1 (idealizing), or when discussing different people. Both the U and CC categories thus represent the breaking down of a singular state of mind with regard to attachment, into two or more semi-dissociated states or patterns; no overall attachment strategy is discernable.

The US attachment researcher Patricia Crittenden has begun to develop an alternative classificatory system to describe more comprehensively such complex, dissociated attachment states found in clinical, traumatized groups. Crittenden's attachment-based model of psychopathology is largely compatible with Ryle's recent theorizing (e.g. Ryle, 1985, 1990, 1995a); she describes the development of internal representational models of self and other from infancy onwards, with apparently 'maladaptive' models in adults having originated in the individual's active adaptation to early environments that may be not just insecure, but often actively dangerous for the child (Crittenden, 1985b, 1995a, 1997b; P. M. Crittenden, unpublished data).

ATTACHMENT PATTERNS IN CLINICAL POPULATIONS: CRITTENDEN'S RESEARCH

Crittenden includes Main and Goldwyn's (M. Main and R. Goldwyn, unpublished data) 'normative' categories, relabelled in her own system; to these she has added descriptions of other attachment states or patterns commonly found in adult clinical populations, also distinguished via discourse analysis. The 'clinical dismissing' patterns include two first described by Bowlby (1979) which the Main and Goldwyn system cannot encompass: compulsive caregiving and compulsive self-reliance. Her 'clinical preoccupied' patterns include feigned helpless, and obsessed with revenge. Crittenden retains the U category, and adds others, including depressed (Dp). Reliability and validity studies are in progress (P. M. Crittenden, unpublished data).

Crittenden's classificatory system permits allocation via discourse markers to more than one attachment classification simultaneously, rather than describing all such cases as CC overall. Thus, the AAI of a dissociated female patient was classified blind using Crittenden's clinical system as showing U loss, plus three clinical dismissing and two clinical preoccupied patterns. More disturbed patients tend to produce AAIs with larger numbers

of attachment patterns, and mixtures of dismissing/preoccupied states. However, the dismissing/preoccupied distinction is still fundamental in Crittenden's scheme. For simplicity, Main and Goldwyn's labels *dismissing* (Ds), *preoccupied* (E), and *secure* (F) will be used from here on, as these are currently more widely known than Crittenden's nomenclature.

'Information-Processing' in Insecure Attachment

Although Fairbairn (1944) argued that psychological 'processes' and 'structures' are inseparable, depending on one's purpose it can be more helpful to emphasize one metaphor over the other. Although patterns of attachment can be described as 'states', increasingly internal working models of attachment have been conceptualized as structured processes or active strategies, rather than as static representations (Bretherton, 1985; Main *et al.*, 1985; Main, 1990). This is advantageous for therapists who seek to help patients change, and who therefore need to know what it is that patients intend and do, which maintains their distress. In a previous paper (Jellema, 1999) I argued that CAT should re-emphasize the procedural (i.e. active and intentional) aspects of reciprocal role relating. (The terms *procedures* and *reciprocal role procedures* (RRPs) convey this more clearly than does *reciprocal roles* (RRs).) The term *states* in CAT implies a static quality, which is not always appropriate; Ryle (1990) made clear that procedures are aim-driven and (with varying degrees of consciousness) intentional. However, I will retain this term here, as it is currently accepted parlance within CAT.

In the remainder of this paper I focus primarily on the application of the two major insecure attachment classifications—dismissing (Ds) and preoccupied (E)—to CAT, as Crittenden describes them as radically different, active *strategies* for processing attachment-related information. 'Strategies' suggests a degree of flexibility in relating, which 'classifications' does not. The aim of each strategy is different, and so their respective AAI discourse patterns serve different functions. Her work is an extension of Bowlby's (1980, 1988) concept of 'defensive exclusion', in her rewriting of defence mechanisms in information-processing langauge, similar to Ryle.

Crittenden (1997b), drawing on the work of neuroscientists such as Joseph LeDoux, describes information relevant to attachment security as being processed in two different ways. The most basic transformation of incoming information is processed by the midbrain, on the basis of temporal order, and is labelled by Crittenden as 'cognitive' information. When events occur in sequence we assume one thing causes another, even though this may not be true; such processing enables us to protect ourselves when conditions may be dangerous (this is the basis for operant conditioning). In contrast, Ryle (1990) employs the term 'cognitive' in a much broader sense, as meaning to do with higher mental functioning (*including* emotion or affect), and the organization of action plus unconscious mental processes. I will use Crittenden's restricted meaning of 'cognitive' here.

'Affective' information, to Crittenden, refers to feelings of anxiety, comfort and safety (initially processed by the limbic system). Such feelings occur in situations associated with greater or lesser risk to the individual, e.g. in the dark and in unfamiliar surroundings, with fight/flight/freeze reactions possible if anxiety is provoked. As with cognitive information, affect can be modified through learning (including classical conditioning). Crittenden argues that affective information processing tends to err on the side of caution to protect us from danger; the mind will 'choose safety over truth' under conditions of threat (1997a).

'Defended Against Affect' Versus 'Defended Against Cognition'

Crittenden then relates the three major attachment categories to different strategies for managing cognitive and affective information, explaining their development in terms of learning theory (Crittenden, 1995a and b, 1997b). Drawing on Ainsworth *et al.*'s (1978) experimental work with the Strange Situation, she describes how through patterns of reinforcement, parents teach children how to use their minds, and thus what kinds of information about themselves and others are important. When processes of perceiving and organizing information become distorted or limited, children are likely to develop in dysfunctional ways.

Dismissing subjects (Ds) are described as avoidant of or defended against affect (feelings) and rely predominantly on cognitive information to make sense of the world. This is a 'think rather than feel' pattern. As children, they have been consistently punished, in effect, for emotional displays, by maternal inattention, rejection or exasperation; if the mother is consistently unresponsive, displays of emotional distress will be extinguished. Dismissing adults find it difficult to perceive and/or to express emotions. Crittenden

summarizes the dismissing strategy as 'defended against affect' (1995a); its aim is to detach emotionally from others, often (but not always) to avoid negative affect.

This is in contrast with the *preoccupied* (E); their attachment strategy consists of splitting anger, from fear, and desire for comfort, and displaying one set of feelings in an exaggerated form while inhibiting the others. This may be regarded as partial dissociation of affect. The mothers of typical E infants respond inconsistently to their children, or with emotional enmeshment, or have differential tolerance for particular displays of emotion. These infants are on schedules of intermittent or partial reinforcement, which are very powerful in terms of eliciting and maintaining particular behaviours at high levels for long periods of time (Crittenden, 1995b; P. M. Crittenden, unpublished data). Es have typically learnt from unpredictable, inconsistent experiences of being parented, that to achieve security, they cannot trust or rely on what people tell them; the aim of the E strategy is therefore to coerce people to stay or attend to them by intensifying displays of feeling (whining, clinging, throwing tantrums, etc.). Coercive strategies typically involve blame and projection, in that the cause of one's own behaviour is typically attributed to the other, not the self; this is in contrast with Ds strategies, which are more likely to be introjective and self-blaming. Crittenden describes the preoccupied E strategy as 'coercive affect', but she has also labelled it as 'defended against cognition' (1995a). Whether the preoccupied are necessarily 'defended', is a contentious point, but perceiving cognitive sequences, i.e. cause and responsibility in relationships, is certainly difficult for Es. (Crittenden (1997b) goes further, describing those particular transformations in the processing of cognition and affect—falsifications, omissions, distortions, and errors—which result in the clinical dismissing and preoccupied patterns, but these are beyond the scope of this paper.)

Preoccupied Es disattend to the sequencing of events, while the dismissing Ds disattend to affective information. The E person maximizes rather than minimizes their focus on attachments, unlike the Ds. What is needed, for the development of greater emotional security in adulthood, is some *balancing* of the emotional engagement of the Es, with some more dismissing, distancing Ds qualities, which Fs have developed through predictable, positive reinforcement of their affective signals by others. Conversely, those rated as Ds require greater emotional engagement to help

develop secure attachment; they have learnt in the past to selectively *in*attend to affective information. As Ds and E individuals have developed opposing strategies or defensive exclusions, with regard to access to and expression of emotions, it is doubtful whether these two insecure groups should be treated similarly in therapy.

DEFENSIVE EXCLUSIONS, CORE PAIN, CORE STATES AND THE THERAPEUTIC PROCESS

In a previous paper (Jellema, 1999) I described the changing use of the word 'core' in CAT. It was argued that, for clarity and consistency, 'core pain' should refer to patients' unexpressed, unassuaged attachment needs; the residue of difficult early experiences, which have not been adequately processed or contained, and characterized by intense feeling. I suggested that the term 'core states' (rather than just 'states') could describe patients' experiences of expressed, enacted reciprocal roles.

Although some standard lists of core states (experienced RRs) are in use (e.g. Ryle, 1990; C. Tanner, unpublished ms) they are not distinguished or grouped in any systematic way. Beard (quoted in Ryle, 1995a) provides a checklist for distinguishing different core states, with feelings about others and the self (or their absence) being central to the list. Here, I suggest that patients with predominantly dismissing or predominantly preoccupied attachments show systematic differences in their core states according to the degree of affect expressed (from absent, to intense) and its function (to disengage from or engage with another, respectively).

As core states refer to what is *overtly* expressed, then dismissing patients should enact reciprocal roles featuring relatively little affect. Such patients may have considerable difficulty in accessing strong emotion in relationships, including in therapy. In CAT language, the unexpressed affect here can be described as core pain. In contrast, preoccupied patients can be expected to express one or more strong emotions in their RRs, to an exaggerated degree. As Crittenden describes the functions of Ds and E discourse as serving respectively to detach emotionally from or to engage intensely with others, one would also expect major differences in and effects on the transference relationship with the therapist, with dismissing or preoccupied patients. This can be seen very clearly, for example, by comparing a dismissingly angry

patient with a preoccupied angry one (Main and Goldwyn Ds_2 and E_2 classifications respectively). The dismissingly angry (Ds_2) may curtly describe having 'no relationship' with a parent, and attempt to move the therapist on to another topic. In contrast the preoccupied angry patient (E_2) expresses anger at great length. He/she strives to get the therapist on his/her side. By the use of phrases like 'don't you think?', 'you know what I mean, of course', the therapist is invited to collude in blaming the parent.

What then are the implications for therapeutic change with these two different types of patients? There is less written on the therapeutic change process in CAT than in e.g. the extensive cognitive therapy literature. Ryle (1995a) lists the '3 Rs' of CAT as reformulation, recognition and revision, with reformulation (in the forms of letters and diagrams) being constantly addressed throughout Ryle's writings. How best to help patients recognize their procedures and RRs is beginning to be addressed by e.g. Dawn Bennett's research into an 'ideal' model of making procedural links in therapy sessions (quoted in Ryle, 1995a). However, little systematic attention has been given to revision, i.e. the identification and development of exits from procedural loops and reciprocal roles. CAT therapists may use techniques derived from almost any major therapeutic approach, with the main determinant of the therapeutic method being what the patient is responsive to.

Crittenden's work implies that exits for Ds patients should involve accessing previously dismissed affect; while the Es will need to develop cognitive (i.e. causal/sequential) understandings. We can assume that there is less unexpressed core pain in preoccupied patients, who are able to access and express affects in their RRs, than in dismissing patients. CAT therapy with the preoccupied therefore should pay particular attention to RRs, and their sequencing. However, in the therapy of dismissing patients, greater emphasis needs to be on accessing the core pain, with the aim of its eventual expression in RRs.

I suggest, then, that CAT therapists routinely assess their patients as to whether their RRs appear to be predominantly dismissing, predominantly preoccupied, or involve a mixture of both. This will help indicate just what is being excluded—and thus what requires to be integrated. Much of the 'affective' skill of a therapist in providing a 'secure base' (Bowlby, 1988) lies in moving sensitively between more or less emotional engagement, so that the patient feels neither intruded on,

nor unheard. Attachment theory also suggests, like Ryle, that some patients may require 'cognitive' help to develop emotional security.

INSECURE ATTACHMENT: THE RELATIONSHIP WITH BORDERLINE AND NARCISSISTIC PERSONALITY DISORDERS

These attachment theory concepts of dismissing and preoccupied insecure attachment are also relevant to the understanding and treatment of CAT or borderline and narcissistic personality disorders. In attachment theory as in CAT, personality disorders are seen as disorders of *interpersonal* relatedness (West *et al.*, 1993; Brennan and Shaver, 1998). Empirical research with the AAI indicates that certain personality disordered (DSM Axis II) groups differ as regards attachment strategy, which may have important clinical implications for CAT. The attachment perspective also suggests important distinctions between narcissistic and borderline personality disorders which are insufficiently considered in psychoanalytic thinking. (These disorders are considered in their 'pure' forms; it is acknowledged that there can be considerable comorbidity with other personality disorders within clinical practice. See e.g. Widiger and Frances, 1985; Perris, 2000.)

The Relationship Between BPD and NPD in Psychoanalytic Thinking

The terms 'borderline' and 'narcissistic' originated in the psychoanalytic literature, each with an extensive history and being employed by different authors in very divergent ways. Rycroft (1968) describes various meanings of 'narcissism' in analytic thinking. Higgitt and Fonagy (1993) summarize the diverse meanings of 'borderline', including clinical syndrome, personality type and attenuated psychotic illness.

According to the influential psychoanalyst Otto Kernberg, borderline and narcissistic personalities are essentially similar (Kernberg, 1967, 1975). Their personality structures are described in terms of 'borderline personality organization' (BPO). BPO is primarily diagnosed in terms of ego-structure pathology rather than typical symptoms (such as free-floating anxiety and polysymptomatic neurosis). The BPO structural criteria include non-specific manifestations of ego weakness (such as lack of anxiety tolerance), and defences such as splitting,

primitive idealization, excessive projection and projective identification, and omnipotence associated with devaluation. (Fonagy *et al.* (1996) in an empirical study, have recently confirmed that BPO is a more inclusive concept than is the DSM-III-R BPD concept.)

Kernberg differentiated narcissistic personality disorder (NPD) from borderline personality disorder (BPD) in terms of character traits (e.g. grandiose self-concept with an inordinate need for recognition from others). Ryle's major CAT text (1990) followed Kernberg in seeing both borderlines and narcissists as having poorly integrated personalities, with two or more distinct sets of reciprocal roles. Like Kernberg, Ryle saw NPD as one subtype of borderline personality organization; in CAT it is primarily distinguished from BPD by the relative stability of narcissistic reciprocal roles, and by narcissists being out of touch with deep feeling.

A recent psychometric study supports the differentiation between borderline and narcissistic defences (Greene, 1996); see also Higgitt and Fonagy (1993). The attachment theory perspective also suggests that BPD and NPD (as defined by DSM-IV (American Psychiatric Association, 1994) criteria) are more distinct than both current analytic and CAT thinking would indicate. Empirically established links between preoccupied/unresolved attachment and BPD, and dismissing attachment and NPD, are outlined below.

Borderline Personality Disorder (BPD), Preoccupied (E) and Unresolved (U) Attachment

Fonagy *et al.* (1997) state that the most common shared characteristic of individuals described as borderline, is impaired attachment relationships. The affective intensity of BPD patients suggests preoccupied attachment. West *et al.* (1993), using questionnaires rather than the AAI, found evidence for predominantly preoccupied attachment in female borderline outpatients. Empirical research using the AAI (Main and Goldwyn's classifications) supports this. For example, Patrick *et al.* (1994) compared borderline with dysthymic patients. They found a significant association between BPD and the E classification. The E_3 category is rare in low-risk populations (approximately 3%) but 10/12 patients were E_3 (fearful attachment), and 8/10 of these were also classified U (abuse or loss). A further study by Fonagy *et al.* (1996) with Cassel Hospital inpatients found that 47% of BPDs (DSM-III-R diagnosis) were E_3, with 89% of BPDs rated also as U. However, neither study employed

the CC category, which could have better described the complexity of attachment patterns in these patients. George and West (1999) have also reviewed suggestive evidence for the importance of disorganized attachment (including U) in severe relationship disturbance, including BPD.

Narcissistic Personality Disorder (NPD) and Dismissing (Ds) Attachment

NPD according to DSM criteria is less common than BPD (Roth and Fonagy, 1996), which may account for the paucity of empirical research on NPD. However, Rosenstein and Horowitz (1996), using the AAI and the MCMI, concluded that adolescents with a dismissing (Ds) attachment organization were more likely to have a narcissistic (or antisocial) personality disorder, and self-reported narcissistic traits. (Adolescents with preoccupied (E) attachment in this study were more likely to have a borderline personality disorder.)

Thus, although there may be structural similarities in BPD and NPD patients, attachment research suggests that their procedures for dealing with attachment are very different. So can attachment theory and research support or help develop current CAT theory and practice with borderlines and narcissists?

BPD, PREOCCUPIED/UNRESOLVED DISSOCIATED ATTACHMENT AND CORE STATES

Ryle (1995b, 1997a and b) has recently begun to employ the term *self-state* to refer to the concept of a *pair* of two RRs/core states in relation to each other, e.g. *angrily controlling* to *submissively compliant*.

His recent model of borderline personality disorder (Ryle, 1997 a and b) contends that much of the variability of these patients can be understood in terms of switches between partially dissociated self-states, resulting from childrearing inconsistencies and disruptions, and especially from traumatic experiences of abuse and neglect (see e.g. Herman *et al.*, 1989). His model of BPD relates to a new general CAT model describing three 'levels' of procedures. (Ryle has recently made clear (A. Ryle, personal communication) that these are *not* hierarchical levels of the procedural repertoire; for which, see Ryle, 1984.) The 'multiple self-states model' of BPD outlines how such patients are damaged at all three levels.

Ryle's Model of Borderline Personality Disorder

Level 1: Restriction and Distortion of the Procedural Repertoire

Level 1 describes the repertoire of the patient's reciprocal role for organizing relationships with others and with the self. The main source of damage at this level in BPD stems from abusive relationships in childhood, generating a number of extreme, maladaptive RRs in borderline adults that are markedly damaging to the self and others. Ryle's model (1997a) outlines some typical self-states, made up of maladaptive RRs, commonly found in borderlines (e.g. *abuser* to *victim*; *emotionally blunted* to *unavailable*). Using the AAI, it is possible to assess these as to whether the underlying procedural aims are more to dismiss and detach from relationships (Ds), or to engage emotionally (E).

The AAI research with BPD quoted above on E/U patterns indicates preoccupied affect with some degree of dissociation. Crittenden (P. M. Crittenden, personal communication) has described the Main and Goldwyn E_3 classification (fearful) as being not a simple pattern but a complex, partially dissociated one as E_3 transcripts usually contain a mixture of *three* distinct types of discourse markers: those typical of E_1 (passive, wanting comfort), E_2 (angry), and one or another kind of Ds (dismissing) pattern. Some of Main and Goldwyn's numerous U criteria appear to describe essentially dismissing affect, while others appear more affectively preoccupied.

Fonagy (1991) refers to the 'claustro–agoraphobic' dilemma of borderlines in relationships; from the attachment perspective, Melges and Swartz (1989) describe oscillations in BPD between 'attachment and disengagement'. In Strange Situation studies of infants, mixed approach/avoidance patterns are associated with both abuse and neglect (Crittenden, 1985a). In CAT terms, this suggests the development via trauma of dissociated core states and self-states, which may persist into adulthood and manifest eventually as borderline behaviour.

Crittenden's system, though still under development, is better able to describe mixed Ds/E/U attachment patterns than Main and Goldwyn's. In an unpublished single case study (A. Jellema, unpublished data), an AAI of a CAT patient (administered prior to reformulation) was classified post-therapy by an independent rater using Crittenden's system. This abused, depressed female patient in her 30s also met DSM-IV criteria for BPD (affective instability, intense anger, suicidal behaviour and threats, unstable and intense interpersonal relationships, and identity disturbance). Correspondences with four of the five self-states later diagrammed on her SDR were found in her initial AAI. (SDR in CAT—the *sequential diagrammatic reformulation*—is the diagrammatic representation of RRs/states and procedures.) Of these four self-states, one related to U (loss) on the AAI (*abandoning* to *abandoned*); and one featured intense, preoccupied (E) affects (*abusing* to *abused*). However, *two* self-states featured dismissing (Ds) attachment, with relatively little affect exhibited in either role; these were described on the SDR as *perfectly caring* to *perfectly cared for*, and *contemptuous* to *contemptible*. Analysing the RRs of other borderline patients according to AAI criteria has also indicated complex mixtures of preoccupied, dismissing and unresolved core states and self-states (sometimes with one preoccupied RR in relation to an RR which is dismissing, e.g. *yearning* to *invalidating*, as with e.g. the patient who says that her desperate attempts to win a distant parent's love are 'like squeezing blood out of a stone'). These are not patients who can be adequately described using Main and Goldwyn's 'overall category' system.

As the first task of the therapist is not to collude with the patient (Ryle, 1995a), CAT should pay attention to whatever particular exclusions, restrictions and distortions can be found in RRs/core states and address these specifically in therapy.

Level 2: Disruption of Integrating Procedures

Level 2 procedures are those which mobilize, sequence and integrate the level 1 RRs. In BPD the normal smooth sequencing of RRs can be grossly disrupted; e.g. the patient can switch instantaneously from compliance, to intense fury with the therapist, to 'blanking out'. Ryle interprets such a pattern in terms of the alternating dominance of various partially dissociated core states and self-states, hence the 'multiple self-states model'. The development of level 2 procedures is said to be impeded by parenting that is disrupted or inconsistent; Ryle also suggests that sequences of extreme RRs/core states develop through trauma-induced dissociation. Again, attachment theory is consistent with Ryle's model (see e.g. Sroufe *et al.*, 1999). Liotti (1992), building on Main and Hesse's (1990) research, theorizes that parents who frighten their children, or show incompatible or rapidly switching affects, induce in their children multiple models of the other and the self (dissociated self-states, or level 1 procedures to Ryle). In stressful situations involving the parent, children will

switch back and forth between the models, so that the child's capacity to integrate these models is overwhelmed, with massive dissociation arising (disruption of integrating level 2 procedures to Ryle) (see also Ogawa *et al.*, 1997, and George and West, 1999).

In BPD, it is affect, rather than memory, which tends to be discontinuous between core states (or level 1 procedures according to this new model). If borderlines have been traumatized, they are likely to cope with the extreme emotional intensity engendered by the trauma itself plus memories of the trauma by 'cutting off' in various ways, e.g. by controlling all affect, 'spacing out'. Although there is no corresponding AAI category to 'cutting off', in attachment theory terms it could be seen as a state or strategy involving the dismissing of affect (Ds). Thus in BPD, we should *expect* preoccupied core states at times to be followed by dismissing core states. These dismissing states can involve mental 'absence' to such a degree that the patient is re-victimized in such a state, leading to a further preoccupied state, and so on, as the patient struggles to attain a degree of intimacy in relationships that is neither too intense (preoccupied), nor too distant (dismissing). Thus, one abused borderline patient seen by the author, when feeling lonely, isolated and needy (preoccupied E affect), would go out walking alone in the early hours in a fugue state (dismissing Ds affect). On one such occasion she was sexually assaulted, and then pleaded for re-admission to hospital (preoccupied). On being re-admitted, however, she avoided discussing her trauma with the ward staff (dismissing) (Ross-Gower *et al.* (1998), have confirmed the role of dissociation as a major mediator in the development of psychological disturbance following sexual abuse).

To aid integration at level 2, CAT therapists should consider whether level 2 procedures linking particular states (level 1) are also more dismissing or preoccupied in aim.

Level 3: Deficient and Disrupted Self-reflection

Ryle's level 3 procedures are those of conscious self-reflection, which enable us to monitor and alter level 1 and 2 procedures. Self-reflection is usually absent from many core states in BPD, which is marked by emotional impulsivity and lability. Insufficient self-reflection develops, according to Ryle, when parents are over-concerned with appearance or performance, rather than with the subjective experience of the child; self-reflection can also be disrupted by major discontinuities

between core states, producing a variable sense of self and other. Attachment theory would suggest that shifts between level 1 dismissing and pre-occupied affects are particularly disruptive.

Fonagy (1991) describes BPD patients as defensively avoiding thinking about the hostility of their caregivers. Ryle (1997b), however, contends that borderline deficiencies at level 3 are more attributable to cognitive deficiencies and dissociation, than to conflict and defence. Crittenden lends some support to Ryle here; although she describes pre-occupied states overall as 'defended against cognition', she attributes the development of preoccupied affects to parental inconsistency, which results in difficulties in perceiving causal links (i.e. cognitive deficiencies). Although further research is needed, there is some empirical support for a connection between maternal inconsistent availability and preoccupied affect in their children (see Cassidy and Berlin, 1994). Any comprehensive account of the aetiology of BPD will require the concepts of both conflict and deficit.

In attachment theory, self-reflection is considered to be an important means of achieving secure attachment. The most secure AAI scripts, rated F, often feature 'metacognitive monitoring' (Main, 1991; M. Main and R. Goldwyn, unpublished data). This refers to the subject's ability to monitor and comment on their own memories and thought-processes while the interview is taking place, e.g. by saying, 'now that I think of it, I want to qualify what I've just said about my mum'. Fonagy and associates (P. Fonagy *et al.*, unpublished data) are developing a more inclusive scale to assess 'mentalization', the Reflective Functioning (RF) scale, which measures the clarity of an individual's representation of others' mental states, as well as their own. They contend that access to some meaningful relationship which allows the development of mentalization should prevent the development of severe personality disorder in those who have been abused (Fonagy *et al.*, 1997). Metacognitive monitoring and reflective functioning can thus be described as level 3 procedures in Ryle's model. Detailed descriptions of e.g. reflective functioning procedures in secure subjects can provide CAT and other therapists with some indications as to how to improve the self-reflection (and therefore integration) of borderline patients.

NPD, DISMISSING ATTACHMENT AND CORE PAIN

Recently, CAT has focused its attention increasingly on borderline personality disorder (Ryle,

1997a and b) to the relative neglect of NPD, but this latter group also poses severe challenges in treatment (see e.g. Kernberg, 1984; C. Tanner, presentation at the 3rd ACAT Conference, London, 1995). Despite the rarity of patients meeting full DSM NPD criteria (0.4% lifetime prevalence; Roth and Fonagy, 1996), many patients, especially those diagnosed with depression and eating disorders, present with major narcissistic personality features, such as grandiosity, lack of empathy and covert shame and rage in response to criticism.

As with the term 'borderline', the concept of 'narcissism' originated in the analytic literature, with Freud. Useful summaries of changes in the concepts and theories of narcissism can be found in e.g. Davis (1990), Mollon (1993), Symington (1993) and Livingstone Smith (1995). The concept may be broadly described in terms of over-concern with the self, associated with absence of love or concern for others. Via the work of Kernberg (e.g. 1975, 1984) and Kohut (e.g. 1971), the more specific concept of a 'narcissistic personality disorder' emerged (e.g. DSM-IV, American Psychiatric Association, 1994). The term is rarely mentioned in the attachment literature, and analytic papers rarely refer to Bowlby, but theorizing on narcissistic difficulties has gradually shifted towards acknowledging the importance of attachment-related issues in the origin and maintenance of these problems. Thus Russell (1985) sees narcissism as self-adoration, combined with a denial of the need for others. The Rosenstein and Horowitz (1996) research finding of dismissing attachment in narcissistic adolescents was anticipated by the work of Bowlby (e.g. 1979, 1980, 1988).

Bowlby (1988), writing on emotional detachment, stated that what is being excluded, are signals, arising from both inside and outside the person, which would activate attachment behaviour and that would allow them both to love and experience being loved. This is a description of the pattern elaborated by Main and Crittenden as dismissing attachment. Bowlby then links this pattern with Winnicott's concept of the 'false self' and pathological narcissism (though also connecting it with 'borderline personality'). Winnicott's description of the 'false self' is often seen as one type of narcissistic difficulty (by e.g. Mollon, 1993). For Winnicott, intellectual processes become the location of the false self, so that there develops a dissociation between intellectual activity on the one hand, and bodily and emotional experience on the other (Winnicott, 1949, 1960); this is reminiscent of Crittenden's description of the Ds pattern as

relying on cognition while defending against affect. Winnicott's work calls to mind several 'clinical dismissing' patterns described by Crittenden, particularly compulsive caregiving, compulsive compliance, and compulsive self-reliance (P. M. Crittenden, unpublished data).

As described e.g. by Holmes (1993), Bowlby was disregarded, even ostracized by the analytic community, especially the Kleinians who considered he placed insufficient emphasis of fantasy and innate aggression in the development of psychopathology. However, Neville Symington's (1993) influential book on narcissism shows some rapprochement between psychoanalytic and attachment theories. Symington shares with Ryle and with Leiman (1997) a dialogic view of the self, as inherently relational. He sees narcissism as a 'chosen' response to trauma in relationships (i.e. consciously or unconsciously intentional). According to Symington, all psychoanalytic models of narcissism feature the ego taking itself as its own love object, rather than another person. Symington acknowledges his debt to Bowlby's description of three stages of the infant's relation to loss (i.e. protest, despair, detachment) in understanding how narcissism develops; he proposes that, in desperation as a result of profound loss or disappointment, the person may opt for a 'narcissistic solution' of cutting off from relationships, of refusing to relate. In this view, narcissism is reconstrued as dismissing defences against attachment.

Ryle's thinking about narcissism is derived from the work of Kohut and Kernberg (Ryle, 1990). The CAT account of NPD rests on two major self-states, which Ryle (1995a) describes as *admired* to *admiring*, and *contemptuous* to *contemptible*. All four reciprocal roles are essentially dismissing. In Main and Goldwyn's AAI classification system the admiring role has a clear counterpart in the dismissing attachment state Ds_1 (idealizing of a parent, plus dismissing of others' and one's own hard to manage negative emotion). The Ds_2 Main and Goldwyn pattern is characterized by a derogatory attitude to attachment figures and experiences, close to the contemptuous RR. Apart from the Rosenstein and Horowitz (1996) study there appears to be no research using the AAI with NPD patients, but obviously empirical tests are possible.

As there is thus a good case for linking dismissing attachment with NPD, what might be the implications for CAT? Following Crittenden's conception of dismissing attachment, narcissists are defended against affect. As this is a 'think, don't feel' pattern, in CAT terms this implies that little

affect should be present initially in core states, i.e. expressed overtly; instead, the 'missing' affect can be described as unexpressed core pain. Patients with dismissing core states, whether or not they are diagnosably narcissistic, should require a therapeutic process in which the core pain is accessed and no longer excluded from core states.

Attachment theory, as a developmental theory, places particular emphasis on changes and developments occurring in sequence, for example Bowlby's (1969) well-known 'protest–despair–detachment' model of phasic reactions to loss. With dismissing patients, we should expect them to temporarily show very *preoccupied* core states, as they access their core pain, on the way to achieving greater emotional security. For example, several CAT patients have been seen in the author's department presenting with depression and 'workaholic' tendencies. Their reciprocal role repertoires at the start of therapy could each be described as showing a narcissistic structure (Ryle, 1990), in which each RR featured predominantly *dismissing* (Ds) affect (e.g. *grandiose* to *admiring*, and *controlling contempt* to *controlled striving*). For each of these patients, the middle to end phases of a 16-session CAT were characterized by major act-outs, featuring the sudden emergence of intense *preoccupied* (E) anger or emotional neediness (e.g. envious verbal attacks on partner, physical attacks on a bully, desperate panic and confusion), with some integration of this affect beginning by the end of therapy, and good outcome at 3-month follow-up.

CONCLUSION

In a previous paper (Jellema, 1999) I suggested ways in which attachment theory could enhance CAT theory and practice. The attachment research presented here (a) supports Ryle's new BPD model, and (b) provides a different 'slant' on narcissistic disturbances. The clinical applications of attachment are as yet in their infancy and thus not widely understood by clinicians. The interested reader is referred to e.g. Goldberg *et al.* (1995), Atkinson and Zucker (1997), Svanberg (1998); Crittenden and Claussen (2000); and to the work of Peter Fonagy, much of which builds bridges between attachment and psychoanalytic object relations theories.

The diagnostic concepts of 'borderline' and 'narcissistic' disorders are so various that it may be more helpful to therapists in future to consider whether a given patient's attachment strategy is mainly dismissing, preoccupied, or mixed. Perris (2000) has suggested grouping personality disorders in relation to the type of dysfunctional attachment pattern which predominates, which seems sensible, given the high incidence of personality disorder comorbidity in patients.

Much developmental psychology research relies on classificatory approaches in order to address issues of reliability and validity; these reflect a degree of stability and consistency in the conception of 'personality' which many clinical researchers would dispute, and which are obviously of less importance to therapists who seek to help patients *change*. However, CAT can take something from the attachment perspective without swallowing it whole. Dismissing of and preoccupation with affect are better conceived of as strategies, and dimensions, rather than categories in clinical situations. They have also long been acknowledged in the psychoanalytic literature, albeit under other guises, and without sufficient recognition of their significance, which attachment theory emphasizes.

There is no doubt that key concepts from attachment research and CAT practice have been derived in different ways. Main and Goldwyn's AAI attachment state categories were developed primarily via discourse analysis of the utterances of parents whose children differed in their responses to the Strange Situation, and Crittenden's categories are 'theory-driven' to a greater degree. This contrasts with the way in which CAT has derived those RRs commonly acknowledged to be of major significance for patients—from clinical practice, both in CAT and in other psychotherapeutic traditions. There is no doubt, however, that there can be considerable similarity between such concepts, as with the Main and Goldwyn Ds_2 attachment state, and the RRs *contemptuous* to *contemptible*, for example. The issue is, rather, whether attachment concepts and research can contribute something to CAT in clinical practice, as I have previously argued (Jellema, 1999).

Using detailed descriptions of differing discourse patterns found in attachment states, it should be possible to understand in more detail how procedures in CAT operate. Building on Bowlby's work (1980, Chap. 4), AAI researchers distinguish between Ds subjects, who use semantic (verbal) memory to answer the 'five adjectives' questions on the AAI, whereas E subjects rely on episodic memory. Thus dismissing subjects have little trouble giving the adjectives, but give few detailed memories to support these; sometimes

they provide examples of memories which actually contradict the adjectives. In contrast, the preoccupied produce detailed memory narratives, but ones in which it is unclear as to who was responsible for what, and they have great difficulty providing generalized verbal descriptions of relationships. Secure (F) subjects, by contrast, typically show good semantic *and* episodic recall (M. Main and R. Goldwyn, unpublished data; P. M. Crittenden, unpublished data). In future, attachment research may suggest to CAT therapists extra 'exits' from patients' procedures (A. Jellema, unpublished data).

Although Crittenden describes how both affect and cognition are affected by insecure attachment, many attachment researchers focus primarily on affect. Kobak and Sceery (1988) in fact see attachment theory as a theory of affect regulation. Affect can be seen as under-modulated in the dismissing, and over-modulated in the preoccupied. Experimental evidence for such differences is now beginning to emerge; see e.g. Mikulincer (1998), on anger regulation in insecure versus secure attachment. The importance of taking such differences into account in therapy, is reinforced by research in developmental neurobiology reviewed by Schore (1996). He describes how early adverse attachment experiences become 'wired in' to the brain and the nervous system, with both structures and physiology being enduringly affected. 'Biasing' of physiological responsiveness develops, so that, for example, insecure–resistant (preoccupied) infants show a predominance of sympathetic over parasympathetic autonomic nervous system activity, and are likely to show a high degree of affectivity (for insecure–avoidant infants (dismissing), the reverse applies). Of particular interest here is a finding that BPD patients show impaired orbitofrontal activity (Goyer *et al.*, 1994, quoted in Schore, 1996). The orbitofrontal cortex of the brain, which connects with the limbic system, mediates the regulation, sequencing and intensity of affective responses. This may help to explain the relative intractability of BPD; it also lends weight to Ryle's emphasis on not colluding with (and thus reinforcing) borderline patients' maladaptive states and extreme emotional responses.

Since the time of Freud, changes have been noted in the population of patients who present themselves for psychotherapy, in both the public and the private sectors. I would suggest that one such change is an increase in the number of patients with preoccupied and mixed attachment patterns, i.e. those with more 'borderline' tendencies, but the implications for therapy of this population are not yet well addressed. Attachment theory highlights the significance of their differences from the more dismissing patients; they have different ways of managing affect and cognition, which will affect the course of therapy. Both groups, however, require the therapist to provide a sufficiently 'secure base' for change.

In CAT, with preoccupied/mixed patients, exits may be found by helping patients to 'cognitively' link core states, much as Ryle (1997a and b) suggests, with particular attention given to level 2 (integrating) and level 3 (self-reflective) procedures; however, the dismissing require 'affective' work to access the core pain. To focus on preoccupation with, and the dismissing of affect, is to refocus CAT on the underlying *aims* of patients' procedures, which may be in danger of getting lost when there is an emphasis on core states.

The mature development of psychotherapy has been inhibited by the 'lure of the panacea'; just as Roth and Fonagy (1996) ask, 'what works for whom?', CAT too should examine what therapeutic processes in CAT work best for which patients.

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REFERENCES

Ainsworth MDS. 1997. Attachments and other affectional bonds across the life cycle. In *Attachment Across the Life Cycle*, Parkes CM, Stevenson-Hinde J, Marris P (eds). Routledge: London; 35–51.

Ainsworth MDS, Blehar M, Waters E, Wall S. 1978. *Patterns of Attachment: A Psychological Study of the Strange Situation*. Erlbaum: Hillsdale, NJ.

Alexander PC. 1992. Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology* **60**: 185–195.

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders*. APA: Washington, DC.

Atkinson L, Zucker KJ. 1997. *Attachment and Psychopathology*. Guilford: London.

Bakermans-Kranenburg MJ, van Ijzendoorn MH. 1993. A psychometric study of the Adult Attachment Inter-

view: reliability and discriminant validity. *Developmental Psychology* **29**: 870–879.

Bartholomew K. 1997. Adult attachment processes: individual and couple perspectives. *British Journal of Medical Psychology* **70**: 249–263.

Bell L. 1996. Cognitive Analytic Therapy: its value in the treatment of people with eating disorders. *Clinical Psychology Forum*, issue 92: 5–10.

Bowlby J. 1969. *Attachment and Loss: 1. Attachment*. Penguin: Harmondsworth.

Bowlby J. 1979. *The Making and Breaking of Affectional Bonds*. Tavistock: London.

Bowlby J. 1980. *Attachment and Loss: 3. Sadness and Depression*. Penguin: Harmondsworth.

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

Brennan KA, Shaver PR. 1998. Attachment styles and personality disorders: their connections to each other and to parental divorce, parental death and perceptions of parental caregiving. *Journal of Personality* **66**: 835–878.

Bretherton I. 1985. Attachment Theory: retrospect and prospect. In *Growing Points of Attachment Theory and Research*, Bretherton I, Waters E (eds). *Monographs of the Society of Research in Child Development*, vol. 50, 3–35, nos 1/2.

Cassidy J, Berlin LJ. 1994. The insecure–ambivalent pattern of attachment: theory and research. *Child Development* **65**: 971–991.

Crittenden PM. 1985a. Maltreated infants: vulnerability and resilience. *Journal of Child Psychology and Psychiatry* **26**: 85–96.

Crittenden PM. 1985b. Social networks, quality of child rearing, and child development. *Child Development* **56**: 1299–1313.

Crittenden PM. 1990. Internal representational models of attachment relationships. *Infant Mental Health Journal* **11**: 259–277.

Crittenden PM. 1995a. Attachment and psychopathology. In *Attachment Theory: Social, Developmental and Clinical Perspectives*, Goldberg S, Muir R, Kerr J (eds). Analytic Press: Hillsdale, NJ.

Crittenden PM. 1995b. Attachment and risk for psychopathology: the early years. *Journal of Developmental Behaviour and Paediatrics* **16**(Suppl.): S12–S16.

Crittenden PM. 1997a. The effect of early relationship experiences on relationships in adulthood. In *Handbook of Personal Relationships* (2nd edn), Duck S (ed). Wiley: Chichester.

Crittenden PM. 1997b. Truth, error, omission, distortion and deception: the application of attachment theory to the assessment and treatment of psychological disorder. In *Assessment and Intervention Across the Lifespan*, Dollinger SMC, Dilalla LF (eds). Erlbaum: Hillsdale, NJ; 35–76.

Crittenden PM. 1998. *Adult Attachment Interview: Coding Manual for the Dynamic–Maturational Method*. Unpublished ms, available from the author.

Crittenden PM, Claussen AH (eds). 2000. *The Organisation of Attachment Relationships: Maturation, Context, and Culture*. Cambridge University Press: New York; in press.

Davis D. 1990. Narcissistic Personality Disorder. In *Cognitive Therapy of Personality Disorders*, Beck AT, Freeman A. *et al* (eds). Guilford Press: London; 233–256.

De Haas MA, Bakermans-Kranenburg MJ, Van Ijzendoorn MH. 1994. The Adult Attachment Interview and questionnaires for attachment style, temperament, and memories of parental behaviour. *Journal of Genetic Psychology* **155**: 471–486.

Eagle M. 1995. The developmental perspectives of attachment and psychoanalytic theory. In *Attachment Theory: Social, Developmental and Clinical Perspectives*, Goldberg S, Muir R, Kerr J (eds). Analytic Press: Hillsdale, NJ.

Fairbairn WRD. 1944. Endopsychic structure considered in terms of object-relationships. In *Psychoanalytic Studies of the Personality*, Fairbairn, WRD (ed). Routledge: London.

Fonagy P. 1991. Thinking about thinking: some clinical and theoretical considerations in the treatment of a borderline patient. *International Journal of Psycho-analysis* **72**: 639–656.

Fonagy P, Leigh T, Steele M, Steele H, Kennedy R, Mattoon G, Target M, Gerber A. 1996. The relation of attachment states, psychiatric classification and response to psychotherapy. *Journal of Consulting and Clinical Psychology* **64**: 22–31.

Fonagy P, Steele M, Steele H, Higgitt A, Target M. 1994. The theory and practice of resilience. *Journal of Child Psychology and Psychiatry* **35**: 231–257.

Fonagy P, Steele M, Steele H, Target M. 1997. *Reflective–Functioning Manual (version 4.1) for Application to Adult Attachment Interviews*, Unpublished, University College, London.

Fonagy P, Target M, Steele M, Steele H, Leigh T, Levinson A, Kennedy R. 1997. Morality, disruptive behaviour, borderline personality disorder, crime, and their relationships to security of attachment. In *Attachment and Psychopathology*, Atkinson L, Zucker KJ (eds). Guilford: London.

George C, Kaplan N, Main M. 1985. *An Adult Attachment Interview*. Unpublished, University of California, Berkeley.

George C, West M. 1999. Developmental vs. social personality models of adult attachment and mental ill health. *British Journal of Medical Psychology* **72**: 285–303.

Goldberg S, Muir R, Kerr J. 1995. *Attachment Theory: Social, Developmental and Clinical Perspectives*. Analytic Press: Hillsdale, NJ.

Greene LR. 1996. Primitive defences, object relations and symptom clusters in borderline psychopathology. *Journal of Personality Assessment* **67**: 294–304.

Herman JL. 1992. *Trauma and Recovery*. Basic Books: London.

Herman JL, Perry JC, Van der Kolk BA. 1989. Childhood trauma in borderline personality disorder. *American Journal of Psychiatry* **146**: 490–495.

Hesse E. 1996. Discourse, memory and the A.A.I.: a note with emphasis on the emerging Cannot Classify category. *Infant Mental Health Journal* **17**: 4–11.

Higgitt A, Fonagy P. 1993. Psychotherapy in borderline and narcissistic personality disorder. In *Personality Disorder Reviewed*, Tyrer P, Stein G (eds). Gaskell/Royal College of Psychiatrists: London.

Holmes J. 1993. *John Bowlby and Attachment Theory*. Routledge: London.

Jellema A. 1999. Cognitive Analytic Therapy: developing its theory and practice via attachment theory. *Clinical Psychology and Psychotherapy* **6**: 16–28.

Kennerley H. 1996. Cognitive therapy of dissociative symptoms associated with trauma. *British Journal of Clinical Psychology* **35**: 325–340.

Kernberg O. 1967. Borderline Personality Organisation. *Journal of the American Psychoanalytical Association* **15**: 641–685.

Kernberg O. 1975. *Borderline Conditions and Pathological Narcissism*. Jason Aronson: New York.

Kernberg O. 1984. *Severe Personality Disorders*. Yale University Press: New Haven.

Kobak RR, Sceery A. 1988. Attachment in late adolescence: working models, affect regulation and representations of self and others. *Child Development* **59**: 135–146.

Kohut H. 1971. *The Analysis of the Self.* International Universities Press: New York.

Leighton T. 1997. Borderline personality and substance abuse problems. In *Cognitive Analytic Therapy and Borderline Personality Disorder*, Ryle A (ed.). Wiley: Chichester.

Leiman M. 1997. Procedures as dialogical sequences: a revised version of the fundamental concept in Cognitive Analytic Therapy. *British Journal of Medical Psychology* **70**: 193–207.

Liotti G. 1992. Disorganised/disoriented attachment in the etiology of the dissociative disorders. *Dissociation* **5**: 196–204.

Livingstone Smith D. 1995. A brief history of narcissism. In *Narcissistic Wounds*, Cooper J, Maxwell N (eds). Jason Aronson: London; 3–15.

Main M. 1990. Cross-cultural studies of attachment organisation: recent studies, changing methodologies and the concept of conditional strategies. *Human Development* **33**: 48–61.

Main M. 1991. Metacognitive knowledge, metacognitive monitoring and singular (coherent) vs. multiple (incoherent) model of attachment. In *Attachment Across the Life Cycle*, Parkes CM, Stevenson-Hinde J, Marris P. (eds.), Routledge: London; 127–159.

Main M. 1995. Recent studies in attachment: overview with selected implications for clinical work. In *Attachment Theory: Social, Development and Clinical Perspectives*, Goldberg S, Muir R, Kerr J (eds). Analytic Press: Hillsdale, NJ.

Main M. 1996. Introduction to the special section on attachment and psychopathology: 2. Overview of the field of attachment. *Journal of Consulting and Clinical Psychology* **64**: 237–243.

Main M, Hesse E. 1990. Parents' unresolved traumatic experiences are related to infant disorganised attachment status: is frightened and/or frightening parental behaviour the linking mechanism? In *Attachment in the Pre-school Years: Theory, Research and Intervention*, Greenberg MT, Cicchetti D, Cummings EM (eds). University of Chicago Press: Chicago.

Main M, Solomon J. 1986. Discovery of an insecure–disorganised/disoriented attachment pattern. In *Affective Development in Infancy*, Brazelton TB, Yogman MW (eds). Ablex: Norwood, NJ.

Main M, Weston DR. 1981. The quality of the toddler's relationship to mother and to father: related to conflict behaviour and the readiness to establish new relationships. *Child Development* **52**: 932–940.

Main M, Goldwyn R. 1994. *Adult Attachment Scoring and Classification Systems, Version 6.0,* Unpublished, University College, London.

Main M, Kaplan N, Cassidy J. 1985. Security in infancy, childhood and adulthood: a move to the level of representation. In *Growing Points in Attachment Theory and Research*, Bretherton I, Waters E (eds). *Monographs of the Society for Research in Child Development 50*, 67–104, nos 1/2.

Malan DH. 1979. *Individual Psychotherapy and the Science of Psychodynamics*. Butterworths: London.

Marrone M. 1998. *Attachment and Interaction*. Kingsley: London.

Melges FT, Swartz MS. 1989. Oscillations of attachment in borderline personality disorder. *American Journal of Psychiatry* **164**: 1115–1170.

Mikulincer M. 1998. Adult attachment style and individual differences in functional vs. dysfunctional experiences of anger. *Journal of Personality and Social Psychology* **74**: 513–524.

Mollon P. 1993. *The Fragile Self: The Structure of Narcissistic Disturbance*. Whurr: London.

Ogawa JR, Sroufe LA, Weinfield NS, Carlson EA, Egeland B. 1997. Development and the fragmented self: a longitudinal study of dissociative symptomatology in a non-clinical sample. *Development and Psychopathology* **9**: 885–889.

Patrick M, Hobson RP, Castle D, Howard R, Maughan B. 1994. Personality disorder and the mental representation of early social experience. *Developmental Psychopathology* **6**: 375–388.

Perris C. 2000. A conceptualisation of personality-related disorders of interpersonal behaviour with implications for treatment. *Clinical Psychology and Psychotherapy*, in press.

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

Ross-Gower J, Waller G, Tyson M, Elliott P. 1998. Reported sexual abuse and subsequent psychopathology among women attending psychology clinics: the mediating role of dissociation. *British Journal of Clinical Psychology* **37**: 313–326.

Roth A, Fonagy P. 1996. *What Works for Whom? A Critical Review of Psychotherapy Research*. Guilford Press: London.

Russell G. 1985. Narcissism and the narcissistic personality disorder: a comparison of the theories of Kernberg and Kohut. *British Journal of Medical Psychology* **58**: 169–178.

Rutter M. 1995. Clinical implications of attachment concepts—retrospect and prospect. *Journal of Child Psychology and Psychiatry and Allied Disciplines* **36**: 546–571.

Rycroft C. 1968. *A Critical Dictionary of Psychoanalysis*. Penguin: Harmondsworth.

Ryle A. 1984. How can we compare different psychotherapies? Why are they all effective? *British Journal of Medical Psychology* **57**: 261–264.

Ryle A. 1985. Cognitive theory, object relations and the self. *British Journal of Medical Psychology* **58**: 1–7.

Ryle A. 1990. *Cognitive Analytic Therapy: Active Participation in Change*. Wiley: Chichester.

Ryle A. 1995a. *Cognitive Analytic Therapy: Developments in Theory and Practice*. Wiley: Chichester.

Ryle A. 1995b. The 'special needs project' (CAT for borderline patients). *ACAT Newsletter*, No. 4: 4–8.

Ryle A. 1997a. The structure and development of borderline personality disorder: a proposed model. *British Journal of Psychiatry* **170**: 82–87.

Ryle A. 1997b. *Cognitive Analytic Therapy and Borderline Personality Disorder*. Wiley: Chichester.

Ryle A. 1998. Transferences and counter-transferences: The Cognitive Analytic Therapy perspective. *British Journal of Psychotherapy* **14**: 303–309.

Schore AN. 1996. The experience-dependent maturation of a regulatory system in the orbital prefrontal contex and the origin of developmental psychopathology. *Development and Psychopathology* **8**: 59–87.

Sroufe LA, Carlson EA, Levy AK, Egeland B. 1999. Implications of attachment theory for developmental psychopathology. *Development and Psychopathology* **11**: 1–13.

Svanberg POG. 1998. Attachment, resilience and prevention. *Journal of Mental Health* **7**: 543–578.

Symington N. 1993. *Narcissism: a New Theory*. Karnac: London.

Treasure J, Ward A. 1997. Cognitive Analytic Therapy in the treatment of anorexia nervosa. *Clinical Psychology and Psychotherapy* **4**: 62–71.

Van Ijzendoorn MH. 1995. Adult attachment representations, parental responsiveness and infant attachment: a meta-analysis on the predictive validity of the A.A.I. *Psychological Bulletin* **17**: 387–403.

West M, Keller A, Links P, Patrick J. 1993. Borderline disorder and attachment pathology. *Canadian Journal of Psychiatry* **38**(Suppl. 1): 516–522.

Widiger TA, Frances A. 1985. The DSM-III personality disorders: perspectives from psychology. *Archives of General Psychiatry* **42**: 615–623.

Winnicott DW. 1949. Mind and its relation to the psyche-soma. Reprinted in *Through Paediatrics to Psychoanalysis*, DW. Winnicott 1992. Karnac: London.

Winnicott DW. 1960. Ego distortion in terms of true and false self. In *The Maturational Processes and the Facilitating Environment*, Winnicott DW (ed.). Karnac: London; 140–152.