TWO THERAPISTS FOR ONE PATIENT: THE ATTACHMENT THEORY AS A FRAMEWORK FOR CO-THERAPIES IN BORDERLINE PATIENTS TREATMENTS

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Summary

Treatments in multiple settings are very common in the management of borderline personality disorder (BPD). The potential of multiple setting treatment is such that it is recognised in the American Psychiatric Association's proposed treatment guidelines for BPD.

The general consensus of clinicians on the importance of using different therapists and different settings simultaneously in treating patients with BPD is not supported by a unifying theoretical model explaining the specific effects of multiple therapist-multi-setting approach in treating BPD.

This paper provides an attachment theory-based possible theoretical explanation of why a patient with BPD could benefit from simultaneous relationships with more than one therapist. According to our hypothesis, the complex relational configuration created by the simultaneous presence of therapists working in different settings may constitute an ideal basis to prevent or correct some of the consequences of disorganised attachment which are present in BPD. Such consequences are likely to result in an unstable or unfruitful relationship for both the patient and therapist.

Key Words: Multiple settings treatment – Borderline Personality Disorder – Attachment theory – Disorganised attachment

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Introduction

The treatment of patients with borderline personality disorder (BPD) requires the simultaneous use of more than one therapeutic instrument, i.e., drug treatment, hospitalisation, psychotherapy etc. The use of simultaneous multiple settings is not limited to the case in which the care of the patient is shared by one psychotherapist and one drug-prescribing psychiatrist who periodically controls drug dosing and effects (Soler 2005), but also extends to the simultaneous use of more than one type of psychotherapy (individual, family, group) (Bateman and Fonagy 2004, Bohus et al. 2004, Linehan 1993).

The practice of combining therapeutic settings with BPD patients is widely diffuse and not related to any specific theory, being shared by almost all psychotherapeutic doctrines engaged in BPD care and management (Bateman and Fonagy 2004, Gabbard and Kay 2000, Gunderson 2001, Clarkin et al. 1999, Linehan 1993). Despite the lack of empirically-controlled efficacy trials and the absence of unifying theory supporting its usefulness and co-ordinating its interventions, the practice of multiple setting therapies appears so effective that the American Psychiatric Association recommends this practice in its BPD treatment guidelines (APA 2001). Furthermore the National Institute for Mental Health in England also recommends the development of specialist multi-disciplinary teams for the treatment of borderline patients (Bateman and Fonagy 2004).

To define the simultaneous and integrated use of various treatments in BPD therapy, many expressions are used, such as "integrated multimodal approach" (Tuker et al. 1992), "multiple-treater setting" (Gabbard 1994), "co-therapy" (APA 2001), "combined treatments" (Vaslamatzis et al. 2004, Linehan 1993), "one-team model treatment" (Bateman and Fonagy 2004). Although there is no reason to prefer one term over the other, we will here use the general expression "co-therapy" (CT).

The borderline patient requires more than one treatment

The history of CT in BPD care is a clear example of clinical practice influencing theory and not *vice versa*. It is the clinical reality of the borderline patient, so complex and difficult to manage, that requires more intensified and articulate care, to impose the combination of various treatments independently from doctrine-

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related rules.

In fact, for a long time it was held that splitting and multiplicity of therapeutic figures could harm severely ill patients and borderline patients in particular (APA 2001, Gabbard and Kay 2001, Gunderson 2001).

From the Fifties to the Seventies, especially in the psychoanalytic field, it was considered improper to use other types of therapy with patients already in psychotherapy (Gunderson 2001, Gabbard and Kay 2001). Psychoanalysis has long dictated that the borderline patient was cared for by one single therapeutic figure (Gunderson 2001). According to investigators inspired by object relations theory, the borderline patient tends to defensively split partial and opposite representations of the Self or of external objects. This, conjointly to other psychopathogenetic mechanisms, would provoke intense negative transference reactions and would result in difficulty to construct a stable therapeutic alliance (Gabbard 1990, Kenberg 1975). For these reasons, the use of multiple therapies, each carried-out by a different therapist, was contraindicated, since it would facilitate the tendency to split and project partial and contradictory aspects in the different settings (Clarkin et al. 1999). Furthermore, it is useful to underline that the need for an adjunctive treatment (drugs, hospitalisation, contacts with families) to overlap with the psychoanalytic one, was considered (mostly in the past) to be an interference with the individual setting. Hence, when it appeared that such an add-on was absolutely necessary, it occurred in a regimen of rigid separation of places and therapeutic practices, that is, without any integration.

However, during the late Eighties, Waldinger and Frank (1989) found-out that about 90% of psychoanalysts interviewed admitted to prescribing drugs to their borderline patients.

Recent epidemiological studies on the treatment of personality disorders confirmed the data of Waldinger e Frank's naturalistic investigation. Mary Zanarini and her collaborators studied about 360 individuals with personality disorders; 75% of patients were undergoing at least two types of treatment at the same time (individual psychotherapy and drug treatment, but also different forms of psychotherapy). This occurred significantly more often among borderline patients than among those with other personality disorders (Zanarini et al. 2004).

The efficacy of multiple treatments in BPD has been long known. From a meta-analysis conducted on studies appearing in literature during the Seventies, it emerged that the outcomes of combined therapies were better than those of any form of therapy carried-out alone (Luborsky et al. 1975).

Modern psychiatry is increasingly oriented towards combining forms of treatment differing from one another. The most frequent tendency is to combine biological and psychological therapies, thanks to a rediscovered bio-psycho-social integration that is overcoming the Cartesian mind-body and brain-psyche fractures (Farina et al. 2005, Gabbard 2000b, Kandel 1998). As a consequence of the establishment of this new conceptual reference frame, the number of both severely and moderately ill patients who follow treatments in different settings is increasing, It is estimated that in the USA, about 55% of patients are concomitantly treated with both pharmacological and psychological therapies (Pincus et al. 1999).

Even though there is much preoccupation among psychoanalysts over the use of multiple settings with the borderline patients, the banning of using simultaneous therapies has relaxed since the Eighties (Vaslamatzis et al. 2004, Clarkin et al. 1999, Gabbard and Kay 2001, Gunderson 2001). For example, the Kleinian-oriented American psychoanalyst John Gunderson recently reversed the preceding worries, supporting that despite the danger of a split, the therapeutic designs for borderline patients should involve at least two clinicians. Gunderson further supports that: "… despite the danger of splitting, treatment plans for borderline patients should routinely involve at least two treaters, two modalities, or any two components. When coordinated, two components in a treatment can provide a container for splits and projections that keep the borderline patient in treatment" (Gunderson 2001). The modern English psychoanalytical school also recommends the activation of a "fully integrated team" of therapists for the treatment of severe borderline patients, as the presence of multiple therapeutic figures integrated with one another is considered the ideal setting to overcome the difficult relational problems residing in the care of these patients (Bateman and Fonagy 2004).

The integration of treatments as a key factor for therapy of borderline patients

The general consensus on the use of multiple treatments for BPD is such to determine among clinicians of different theoretical inspirations an overall agreement also on the general principles that should regulate such therapeutic strategies. These general principles may be summarised as follows: a) the two therapists must be in constant contact and this should be known by the patient; b) the patient must understand the distinct limits and objectives of the two settings, though being able to exchange information with the individual therapists on what takes place in the other settings; c) the relationship between the therapists must be open and co-operative; any crisis in the relationship between the therapists is often an element related to the therapeutic process and must be dealt with as if they were the patient's symptoms; d) these three principles, along with the confidence in the very efficacy of the co-therapy, must be shared by the two therapists involved in the treatment, independently from divergences linked to the theoretic frame of each therapist: "it is important for all aspects of treatment to be integrated" (Bateman and Fonagy 2004). Those rules are valid even if the different therapies combined are family or group therapy where there is the important role of family members and peers.

Kernberg and his collaborators, for example, remark that in the case of an integrated treatment between psychotherapy and drug treatment of borderline patients the physician responsible for the management of drugs has to be familiar with the psychodynamic treatment model and the two therapist in charge should communicate after every session (Clarkin et al. 1999).

The BPD treatment guidelines of the American

Psychiatric Association prescribe that "Providing optimal treatment for patients with borderline personality disorder who may be dangerously self-destructive frequently requires a treatment team that involves several clinicians. If the team members work collaboratively, the overall treatment will usually be enhanced by being better able to help patients contain their acting out (via fight or flight) and their projections onto others. It is essential that ongoing coordination of the overall treatment plan is assured by clear role definitions, plans for management of crises, and regular communication among the clinicians" (APA 2001).

All reflections on multiple treatments in severe patients, therefore, agree on the need to coordinate the different therapeutic relations and to use this coordination to repair those inevitable errors of interpersonal fine tuning that are so often at the basis of devastating crises of the curing relationship, of patient drop-out and therapist burn-out.

It is this unrelenting repair process of therapeutic relations that unifies the clinical work of all psychotherapists, of any theoretical approach, involved with this type of patients (Kernberg 2003).

For example, Gunderson wrote: "Whatever the components […] the governing principle is that having two relatively independent, but complementary therapies allows the inevitable frustrations with any particular treatment to be contained without necessitating fight […] Borderline patients' inability to experience frustrations without assigning malevolence and taking angry or fearful flight is the reason why they so frequently drop-out of therapies […]. When they have a second component to discuss their frustrations with, they retain a "good object" who will urge them to voice their complaints to the frustrating therapist (psychopharmacologist, group leader, etc.) rather then leave" (Gunderson 2001).

Furthermore, Bateman and Fonagy support that the integration of therapeutic projects, by allowing the patient to be confronted with two therapists who provide him a unified and consistent version of his own self-representation, "thought of as a thinking subject" and endowed with his personal theory of mind, enhances the metacognitive abilities of patients and is *per se* therapeutic (Bateman and Fonagy 1999, 2001).

Attachment theory and the disorganization of attachment

In the last decades, Bowlby's attachment theory (AT) has become one of the most important conceptual frameworks for understanding the process of affect regulation (Bowlby 1969/1982, 1979, 1980, 1988; Cassidy e Shaver 1999; Schore 2001). In AT, early attachment appears as a major organising principle that may explain important aspects of normal and pathological interpersonal relations (including the therapeutic relationship: Bowlby 1979, 1988). The AT, and in particular the concept of *attachment disorganization* could offer an original perspective to understand the efficacy of multiple and integrated therapeutic relationships in the treatment of BPD (Liotti 2000).

According to AT mammalian infants (especially primates) are born with the innate disposition to search for closeness to conspecifics when distressed or frightened. This care-seeking behaviour is particularly evident in the offspring's early relationships with parents, but it emerges also in adults individual when they are distressed or in danger (Bowlby 1969/1982). Usually, the propensity to seek for protection and comfort is met with positive responses from significant others (perceived as "stronger and/or wiser" than the suffering self: Bowlby 1979). The inborn disposition to care for one's kin (George & Solomon 1999), that matches the equally inborn tendency to ask for help, provides the basis for a relatively smooth functioning of caregiving-careseeking interactions. Ethological observations and affective neuroscience (Panksepp 1998) provide abundant evidence of the evolutionary processes that build up, in homologous parts of any mammal species' brain, distinct emotional/motivational systems able to organize, respectively, care-seeking (i.e., attachment) and care-giving behavior.

Attachment behaviour could be direct to more than one caregiver and organises attachment figures in a hierarchical fashion on the basis of their availability (Bowlby 1969/1982). According to this "hierarchy of attachment figures" (Bowlby 1969/1982) infants have a strong tendency to prefer the main attachment figure (usually the mother) in their seeking for comfort and security but they can also resort to one or more subsidiary figures if the primary one is absent. The hierarchy of attachment figures could change throughout the lifespan in order of changing their accessibility and availability (Bowlby 1969/1982, Mikulincer et al. 2003).

Bowlby also specified that the inborn, evolved mechanisms of attachment strongly contribute to the organisation of interpersonal behaviour, emotional experience and social cognition (Bowlby 1979, 1988). AT states that infants construct structures of implicit memory concerning the self and the attachment figure (internal working models, IWMs) on the basis of their actual experience with the caregiver. The IWM provides expectations as to the caregiver's future responses to the individual's attachment needs (Bowlby 1969/1982, 1988; Bretherton 1990; Amini et al. 1996). When activated, an IWM can co-opt all the typical emotions of the attachment motivational system (fear of separation, anger-protest at expected separations, sadness, joy at reunion, felt security, etc.).

Research on early attachment (Ainsworth et al. 1978, Main 1995, Cassidy e Shaver 1999) shows that, during the second year of life, most infants are able to organise their attachment behaviour according to three patterns: *secure* (the infant cries at separation and is quickly comforted at reunion), *insecure-avoidant* (the infant does not cry at separation and actively avoids the caregiver on reunion), and *insecure-ambivalent* (the infant cries at separation, but is not easily comforted on reunion). Some infants are not able to organize their attachment behavior according to any unitary or coherent pattern. They are classified as *disorganized* in their attachments style (Main 1995, Main and Solomon 1990).

In the Strange Situation (the experimental procedure for the assessment of attachment behaviour during the first two years of life: Ainsworth et al. 1978), disorganised attachment (DA) shows up as incompat-

ible responses emitted simultaneously or in quick sequence, or else as lack of orientation during attachment interactions (Main and Solomon 1990). For instance, attachment behaviour is labelled disorganised when the infant calls loudly for the parent during the phase of separation (approach behaviour similar to that emitted in the secure and the resistant patterns), but then, two-three minutes later, actively avoids contact with the parent at reunion (avoidance behaviour akin to that shown in the avoidant pattern). DA may be also manifested in lack of orientation, in frightened expression or in freezing behaviour. Children who, at reunion, approach the caregiver with head or gaze averted, or who cling to the caregiver while arching the body away (two examples of simultaneous display of contradictory patterns), are also considered disorganised in their attachment behaviour (Main and Solomon 1990).

It is noteworthy that in samples at high risk for emotional disorders (e.g., mother-child dyads where the mother suffers from depression, mother-child dyads living in chaotic or maltreating families, or mother-child dyads characterised by prenatal alcohol abuse) disorganisation of infant attachment is the rule: up to about 80% of the children in these samples proved unable to organise attachment behaviour along any identifiable pattern (Carlson et al. 1989, Lyons-Ruth et al. 1991, O'Connor et al. 1987, Radke-Yarrow et al. 1995). DA has been empirically linked to unresolved memories of losses, abuses and other traumas in the caregiver (Main and Hesse 1990). The link between DA in the child and unresolved traumatic memories in the caregiver is a statistically robust finding, that has been replicated repeatedly (Ainsworth and Eichberg 1991, Benoit and Parker 1994, Lyons-Ruth and Block 1996, Ward and Carlson 1995, for a meta-analysis, see Van Ijzendoorn 1997).

Infants whose attachment behavior toward a given, "unresolved" parent is disorganized may develop coherent, organized patterns of attachment behavior toward another caregiver, provided that the latter's state of mind concerning attachment is coherent (e.g., the same infant may be disorganized in the attachment behavior toward the "unresolved" mother, organized-avoidant in the attachment toward the "dismissing" father, and organized secure toward a third, "free" attachment figure). Disorganization of early attachment, therefore, seems to reflect an intersubjective reality rather than being a property of the individual child's mind.

While in organized attachments the children's request for help and comfort activates the parents' (or other caregivers) propensity to give care in a linear way, in DA this activation is complicated or distorted by unresolved traumatic memories that surface in the mind of parents while they are responding to the attachment requests of their children. The mental suffering linked to these memories activates the parents' attachment system together with their care-giving system (that the attachment system is normally activated not only in children, but also in adults by any type of suffering is, as has been noted above, a central tenet of attachment theory). In the absence of soothing responses from significant others, the activation of the attachment system arouses in the "unresolved" parent strong emotions of fear and/or anger. Thus, while infants are crying, unresolved parents may interrupt their attempts to soothe them (attempts stemming from the parent's care-giving system) with unwitting, abrupt manifestations of alarm and/or of anger (stemming from the parent's attachment system). Caregivers' abrupt manifestation of both anger and fear are always frightening to infants. The innate defensive reaction of escaping from the signal of threat (e.g., by distracting attention or avoidance of gaze) ensues in the infant.

The increased relational distance, however, further activates the (equally inborn) infant's attachment system, because increased distance from the attachment figure innately strengthens the need for protective proximity, *whatever the behavior of the attachment figure may be*. The attachment figure, in interactions leading to attachment disorganization, is "at once the source and the solution" (Main and Hesse 1990) of the infant's alarm, and this leads to *fright without solution*. That is, the infant has no way out of this paradox. There is no single, coherent behavioral or attentional strategy able to interrupt the loop of increasing fear and contradictory intentions (approach and avoidance) in the infant's experience.

Usually, once established, the IWM guides both attachment behavior and the appraisal of attachment emotions in self and others. If the attachment figure has been accessible to the infant in real-life situations, the IWM conveys to the developing child an inner sense of legitimacy of the attachment emotions and of potential accessibility of help and comfort even when the attachment figure is not actually present during distressing experiences. This is the IWM of secure attachments. On the contrary, the IWMs of insecure attachments (avoidant, ambivalent or disorganized) convey expectations that the attachment figure will not be available or will respond negatively to requests of help and comfort. The IWM of disorganized attachment differs from that of avoidant and ambivalent attachments because it not only prefigures negative consequences of asking for help and comfort, it also brings on a dissociated (non-integrated) multiplicity of dramatic and contradictory expectations (Hesse et al. 2003; Hesse and Main 2000; Liotti 1991, 1995, 2000, 2002, 2004, 2005; Main 1995; Main & Morgan 1996).

Disorganization of Attachment and Developmental Psychopathology

The effects of early DA may extend into childhood and adolescence and may become a risk factor for psychopathological developments. Research on attachment yields evidence that the development of the integrative functions of consciousness during childhood and adolescence is hindered if the attachment relationship to the caregivers remains disorganised (Liotti 2000, 2005). The development of this capacity manifests itself, during childhood and adolescence, with the growing abilities: [1] to distinguish between appearance and reality (Flavell et al. 1983, Wimmer and Penner 1983); [2] to construct a theory of mind (Baron-Cohen 1995); [3] to reflect on mental states (Fonagy et al. 1995); [4] to monitor thoughts, feelings and language (metacognitive monitoring: Flavell 1979, Main 1991); [5] to perform formal operations of thought (Flavell 1963),

and [6] to pay attention to external stimuli without being unwittingly absorbed in daydreams.

In a longitudinal study, children whose attachment behaviour in infancy had been disorganised, were judged by their teachers as significantly more confused and "absent minded" than their peers with a different attachment history (Carlson 1998, Ogawa et al. 1997). Children 5- 8 year old, judged disorganised in their response to the Manchester Child Attachment Story Task (Green et al. 2000), show marked impairment of metacognitive capacities in comparison to securely attached peers. Adolescents who had been fearful/disorganised children showed marked difficulties in tests of formal reasoning, when compared with peers who had different attachment experiences (Jacobsen et al. 1994).

Metacognitive and mentalising (i.e., theory of mind) deficits during development bring over concurrent difficulties in understanding, naming, discriminating and therefore controlling mental states in general and emotions in particular (Bateman and Fonagy 2004; Fonagy et al. 2003, 1995). In accordance with this hypothesis, a number of studies provide evidence that disorganised infants tend to grow into children with difficulties in the control of anxiety (Hesse & Main 2000) and aggression (Lyons-Ruth 1996, Van Ijzendoorn 1997). Finally, a metacognitive deficit implies a poor capacity to reflect on one's own mental representations, yielding negative and disorganised self-representations more often than controls (Cassidy 1988, Hesse and Main 2000, Main 1995, Solomon et al. 1995). All these findings suggest that the effects of early DA may extend into childhood and adolescence and may become a risk factor for psychopathological developmentsAs to the nature of these developments, the dissociative disorders and the borderline personality disorder (BPD) seem likely candidates.

Disorganization of Attachment and Psychopathology of Borderline Personality Disorder

Disorganisation of attachment is becoming a widely accepted model for understanding the developmental psychopathology of BPD (Clarkin and Posner 2005; Levy et al. 2005: Holmes 2004, 2003; Liotti 2000, 2004; Fonagy et al. 2003), although a multifactorial etiology with interacting genetic and environmental substrates it should be considered in the BPD (Siever et al. 2002). Models of BPD based on DA are compatible with some basic tenets of other theories of borderline pathogenesis like Kernberg's (1975, 2003) psychoanalytic theory and Linehan's (1993) cognitive-behavioural theory (Liotti 2004). For instance, the central theme of Kernberg's model of borderline, in which the patient's disturbances are linked to the existence of split representations of positive and negative features of self and others, can be matched (with some important differences) with the multiple and incompatible representations of self and the attachment figure postulated by AT researchers (Liotti 2000).

Clinical and empirical studies support the hypothesis that DA is a risk factor for the development both of dissociative disorders and of BPD (Carlson 1998, Fonagy et al. 2003, Liotti et al. 2000, Ogawa et al. 1997, Pasquini et al. 2002, Holmes 2004). Both unresolved traumas or losses in the life of a parent and abuses that a child suffers at the hand of a parent are linked to DA, and both are risk factors in the development of dissociative and borderline disorders. There is evidence that the presence of traumas (neglect, sexual or physical abuses, etc.), losses or mental disorders in the life of the patients' mother around the time of the birth of the patient, an antecedent of DA, is also a risk factor for BDP (Liotti et al. 2000) and for dissociative disorders (Pasquini et al. 2002). The *Practice guideline for the treatment of patients with borderline personality disorder* of the American Psychiatric Association (2001) emphasizes that among the environmental contributions to the etiology of BPD, the role of childhood abuse is prominent, particularly severe abuse and sustained abuse (Oldham 2005). Sustained abuse, it may be remarked, is likely to happen when family members are the abusers. Sustained abuse suffered at the hand of a member of the family is likely to cause disorganization of the abused child's attachment to that family member.

The DA model of BPD explains particularly well the cognitive, metacognitive, affective, relational and behavioral alterations of the borderline symptomatology (Clarkin and Posner 2005, Bateman and Fonagy 2004, Liotti 2004). For instance, the deficit in the system of emotional regulation that is so typical of BPD could be linked to the failure of the integrative and reflective functions of mind caused by severely disturbed attachments (Bateman and Fonagy 2004, Linehan 1993, Liotti 2004). The functions of this system imply reflecting on the emotions as discrete mental states, naming them properly, and acknowledging their origin, function and value both in the inner and in the interpersonal life (Linehan 1993). A proper functioning of the system that regulates emotions, therefore, is linked to the development of metacognitive monitoring and of an adequate theory of one's own and of others' minds (Bateman and Fonagy 2004). Metacognitive deficits have been assessed in samples of BPD patients together with indicators of DA (Fonagy et.al. 1995, Fonagy et al. 2003). The metacognitive deficit adds to the rigid interpersonal schemata of BPD, causing frequent misinterpretations of others' intentions and behaviours, in provoking intense emotional responses (Bateman and Fonagy 2004).

Besides explaining the deficits in emotional regulation and metacognitive monitoring, the DA model provides an explanation for the severe relational problems of BDP patients (Liotti 2000, 2004; Holmes 2003). According to the DA model, the activation of the attachment system in borderline patients gives rise to multiples, fragmented and contradictory representations of self and others, which in turn yields maladaptive relational behaviours (see next paragraph). Moreover, the activation of the attachment system in these patients causes the re-experiencing of threatening emotions and a vicious cycle of helplessness, fear of abandonment and desperate efforts to avoid it. At the same time the multiple, shifting representations of the IWM are responsible for an uncertain sense of self, dramatically changing attitudes toward significant others, and self-damaging behaviours (sometimes linked to a representation of the self as evil and deserving punishment). Dissociative experiences, that quite often, rather than

constituting a defence against mental pain, plague further the already painful life of borderline patients, may also be explained as the outcome of the activation of the attachment system: these experiences reflect the disordered state of a consciousness that must deal with multiple and incompatible simultaneous self-representations (Liotti 2000, 2004), particularly likely to be evoked in complex or confusing interpersonal contexts implying caregiving-careseeking (attachment) exchanges.

Disorganization of Attachment and the Drama Triangle

DA yields the experience of oscillation between multiple, incompatible, dissociated, dramatic representations of self and the caregivers. The concept of *Drama Triangle*, originally formulated by a transactional analyst (Karpman 1968), describes vividly such an oscillation of the representational processes induced by the disorganized IWM: both the representations of the self and those of the attachment figure shift quickly among the three dramatic stereotypes of the Victim, the Rescuer and the Persecutor (Liotti 2000, 2004; Gabbard and Wilkinson 1994). The attachment figure is represented negatively, as the cause of the ever-growing fear experienced by the self (self as victim of a persecutor), but also positively, as a rescuer (a parent frightened by unresolved traumatic memories may be willing to offer comfort to the child, and may be unaware of the facial expression and of its effect on the infant; the child may feel such comforting availability together with the fear). Together with these two opposed representations of the attachment figure (persecutor and rescuer) meeting a vulnerable and helpless (victim) self, the IWM of DA conveys also a negative representation of a powerful, evil self meeting a fragile or even devitalised attachment figure (persecutor self, held responsible for the fear expressed by the attachment figure). Moreover, there is the possibility, for the child, to represent both the self and the attachment figure as the helpless victims of a mysterious, invisible source of danger. Finally, since the frightened attachment figure may be comforted by the tender feelings evoked by contact with the infant, the implicit memories of DA may also convey the possibility of construing the self as the powerful rescuer of a fragile attachment figure (the little child perceives the self as able to comfort a frightened adult). Descriptions of the shifts of a patient's self-representations between the poles of the victim, the persecutor and even the rescuer (while the therapists is represented, in sometimes very quick succession, as rescuer, persecutor and victim) may be easily found in the literature on the treatment of borderline and dissociative patients (Davies and Frowley 1994; Gabbard and Wilkinson 1994; Liotti 1995, 2000, 2004).

The activation of the attachment system as a mediator of BPD symptoms has important consequences on the therapeutic strategy, particularly on the understanding of the typical difficulties of the therapeutic relationship with borderline patients.

Multiple and Integrated Therapeutic Relationships in the Treatment of BPD

Early discontinuation of treatment is an important clinical feature of BPD (Bender 2005; Chiesa et al. 2000, 2003; Gunderson et al. 1989). Interpersonal disturbances in BPD, especially those involved in the relationship with caregivers, are considered the grounds of treatment discontinuations and of horny dilemmas in the therapeutic relationship (Liotti 2000, 2004; Bateman & Fonagy 2004; Holmes 2003, 2004; Gunderson 2001). The fact that borderline patients have difficulty developing and sustaining trusting relationships suggest that such a difficulty should be regarded as a focus of treatment (APA 2001).

The DA model of BPD not only offers satisfactory explanations of the interpersonal relationships disturbances (Holmes 2003): it also suggests how to best deal with them. In particular, the DA model invites to focus on multi-setting integrated treatments as the main strategy for repairing the strains and ruptures in the therapeutic alliance and for preventing premature termination of treatment (Liotti 2000).

The DA explanation of interpersonal difficulties in BPD patients traces them back to the activation of the attachment motivational system. Such an activation is accompanied by disorientation, altered states of consciousness, a loop of increasing fear whether one approaches or avoids the attachment figure, dramatic shifts between the representation of self and the attachment figure as an almost omnipotent rescuer, a persecutor/abuser and a helpless victim. When these unpleasant states of mind, related to the dramatic and multiple IWM of DA, are experienced in the psychotherapy setting, they could make therapeutic relationship unbearable to both partners, and force one or the other to interrupt the treatment prematurely.

Likewise, the strains and ruptures in the therapeutic alliance could be provoked by the attempts of patient to avoid the unpleasant experiences that accompany activation of the attachment system. Such an avoidance of attachment emotions may be obtained by shifting to another inborn motivational system, whose operations manifest themselves with partially similar emotions. For instance, borderline patients quickly shift from attachment anger (i.e., the type of anger characterizing the secure child's protest during separation from the mother) to competitive anger (e.g., ritualised aggression aimed at defining the social rank: Gilbert 1989, 1992), thereby facilitating the activation of the agonistic rather than the care-giving system in the other person and cutting off the interpersonal cycle of attachment system (Liotti 2000, 2004). These may be the underpinnings of the affective instability and of the inappropriate, intense anger that are listed among the diagnostic criteria for BPD (American Psychiatric Association 1994). Bateman and Fonagy emphasize that "the most complicated challenge arising in the treatment of borderline patients" concerns how to deal with "their tendency to externalize unbearable self-states, and the strong countertransference responses which this can produce" (Bateman and Fonagy 2004).

Parallel, integrated treatments may be instrumental in overcoming these difficulties. Whatever types of treatment are simultaneously provided (individual psy-

chotherapy and pharmachotherapy, individual psychotherapy and family therapy, individual and group psychotherapy) the coordination of two (or more) settings according to the guidelines outlined above (theoretical agreement, cooperation on equal grounds and frequent communications between the clinicians) may often prove superior to any single setting in coping successfully with these relational strains (Gunderson 2001, APA 2001, Liotti 2000, Linehan 1993).

The rationale for this assertion may be explained as follows.

If the activation of the patient's attachment system within an individual psychotherapy brings over an increased propensity to painful dissociative experiences, and to dramatic shifts in the way of construing self and therapist, both patient and therapist are likely to find the therapeutic relationship too difficult to be either tolerated (on the patient's side) or dealt with successfully (on the therapist's side). What happens in these circumstances, according to attachment theory, is a repetition of the situation leading to DA: to relinquish a relationship that alone appears capable of affording comfort from unbearable emotional pain is frightening, but to approach the attachment figure is equally frightening. Each pole of this approach-avoidance dilemma increases the intensity of the painful emotions implied by the other. One of the likely consequences of this state of affairs is the patient's dropping out from treatment; another is a therapeutic stalemate (both are unfortunately common occurrences in the treatment of borderline patients: Gunderson & Sabo 1993). If, however, a second therapist is engaged in the therapeutic program (e.g., the group therapist in Linehan's model), the patient may feel that there is another source of help available, and this perception may reduce the emotional strain on the first therapeutic relationship (e.g, with the individual psychotherapist).

The presence of a second therapist operating in a parallel setting could also foster the mentalising abilities of the patient. Fonagy and his collaborators have repeatedly and convincingly argued that attachment-related traumatic experiences and their rehearsal within the therapeutic relationship seriously impede the capacity to reflect on one's own and the other's state of mind (Foagy et al. 2003, Bateman & Fonagy 2004). This happens because of automatic construing the mind of the other as containing destructive intentions against one's own mind (such deeply negative interpersonal schemata are rather easily activated by the IWM of DA). While the relational strain within the primary therapeutic relationship hinders the patient's metacognitive functions, the second therapist may assist the patient in construing alternative hypotheses about the primary therapist's beliefs and intentions. Perceiving the same interpersonal episode from simultaneous different perspectives improves both the complexity of internal representation of self and others and the capacity of reflecting upon them (mentalization or metacognitive capacity). The less threatening interpersonal context the patient may perceive within the second therapeutic setting may facilitate a better understanding of mental states. In turn, this could have a positive feed-back effect on the capacity to tolerate and modulate unpleasant emotions. This widened capacity for considering alternative hypotheses on the first therapist's mental state and for modulating-tolerating unpleasant emotions may protect the primary therapeutic relationship from premature interruption and therapeutic stalemates.

Another therapeutic effect of multi-setting integrated treatments (CT) on metacognitive functioning is linked to the possibility of presenting to the patient, within different relationships, coherent representations of self and others. Psychoanalytic oriented therapists suggest that the possibility of two therapists offering to the patient a coherent view of self-with-other may have a corrective effect on the splitting defence mechanism, quite typical of BPD: the partial, split representation that may appear in each of the two settings may become more easily integrated when the comments or interpretations of the two therapist converge toward the same view of what is happening (Bateman and Fonagy 2004, Vaslamatzis et al. 2004, Gunderson 2001).

Finally, another important positive effect of CT is the increased sense of security of the therapist. BDP patients, especially those with aggressive impulsive behaviours, quite often evoke negative feelings in their therapists. Fear, anger, a sense of deep impotence and a wish to interrupt the therapy are therapists' responses not uncommon experienced during the treatment of severe BDP. Of course, these countertransferential reactions, if expressed (however subtly) re-traumatize the patent by confirming the drama triangle and reproducing the interpersonal situation that originally yielded disorganization of attachment: a fragile, fragmented self meeting a frightened and frightening attachment figure (Liotti 2004). The involvement of a second, cooperating clinician in the therapy of these severely disturbed patients can reduce the emotional strain on the first therapist insofar as it allows for the sharing of difficulties, worries and responsibilities. In this perspective, the presence of the second therapist is instrumental in avoiding re-traumatization of the patient (Vaslamatzis et al. 2004; Gunderson 2001; Liotti 2000, 2004).

If the key reason for the usefulness of two simultaneous settings in the treatment of borderline patients is the distribution of the patients' attachment needs on more than a single therapist, then such usefulness should appear also with parallel interventions other than individual and group. Combined individual psychotherapy and family therapy, or even individual psychotherapy and pharmacological therapy (if the drugs are prescribed by a psychiatrist who is well grounded in psychological treatments), could protect the individual psychotherapy from drop-outs as well as individual and group interventions do (Gunderson 2001).

In summary, the simultaneous existence of two (or more) therapeutic relationships in the treatment of BPD may provide important opportunities for:

a) modulating and diluting the activation of the patients' attachment system (i.e. the availability of another therapist may reduce the fear of abandonment and may help resolving the approach-avoidance dilemma typical of attachment disorganization: Liotti 2000);

b) improving the metacognitive functions (by mirroring the representations self- with- others in more than one relationship: Bateman & Fonagy 2004);

c) increasing the sense of security of the therapist while dealing with difficult and sometimes assaultive BPD patients (countertransferential responses to the

patient's aggressive, helplessly frightened or self-destructive behaviours may be better controlled when the first therapist feels assisted by the second one: Vaslamatzis et al. 2004; Liotti 2000, 2004).

Difficulties and Limits of Multi-Setting Integrated Treatments in BPD

One problematic aspect that limit the administration of CT and its efficacy is the simultaneous intervention of two or more therapists, and the need for supervision joint sessions to integrate them, make the CT a fatiguing, laborious and expensive therapeutic technique.

Supervision session to which both therapists participate cannot be avoided (there is wide agreement on the importance of constant and collaborative contacts between the clinicians involved in the treatment: Vaslamatzis et al. 2004, APA 2001, Gunderson 2001, Linehan 1993) which makes CT particularly expensive in time and money involved. This could be a serious problem both in public health services (where the human therapeutic resources are often limited) and in the private setting where the therapists (especially if they work in different places) have to take additional time to interact regularly. Furthermore "because communication between the two of them is rarely reimbursed by third parties, there may be little or no contact, resulting in fragmentation of the treatment" (Gabbard and Kay 2001).

It should be remarked that mistrust, lack of confidence or competition between therapists, whether conscious or not, undermines each other's work or leads to working at cross purposes: both these possibilities are a recipe for encouraging dangerous splitting in the patient (Bateman & Fonagy 2004, Dewan 2002). For this reasons the optimal conditions to implement CT are where a permanent clinical staff may guarantees the sharing of theoretical framework, a good collaboration style and constant contacts between its members (Bateman and Fonagy 2004, Vaslamatzis et al. 2004, APA 2001, Linehan 1993).

The economic worth of CT is, however, controversial. A few emerging data suggest that in the management of BPD even expensive treatments as the CT are cost-effective insofar as they reduce days of hospitalization, medications consumption, functional and work impairment (Zanarini et al 2004, Gabbard et al. 1997).

The most important limit of CT for BPD, therefore, may not be its cost, but the still lacking unequivocal scientific validation of its efficacy. The general agreement about the usefulness of CT in the therapy of BPD notwithstanding (Bateman and Fonagy 2004, Vaslamatzis et al. 2004, APA 2001, Gunderson 2001, Liotti 2000), very few empirical studies are available in literature that provide controlled evidence of their efficacy.

The Dialectical Behaviour Therapy (DBT: a cognitive-behavioural treatment combining individual and group psychotherapy) is a partial exception to the above assertion. Several studies show that DBT: (1) has a sustained positive effect on some of the core symptoms of BPD (parasuicidal behaviour and impulsivity), (2) improves interpersonal functioning and anger management, and (3) lowers dropout rates (van den Bosch et al. 2005, Soler et al. 2005, Bohus et al. 2004, Linehan et al. 1993, Lieb et al. 2004, Robins and Chapman 2004). A psychoanalytically oriented residential treatment of BPD, combining individual and group psychotherapy, has also been successfully tested with empirical controlled studies (Chiesa et al. 2003; Bateman and Fonagy 1999, 2001).

Further studies are needed not only to confirm the general effectiveness of CT, but also to measure the power of the single specific therapeutic ingredients involved in them and the role played in family and group therapy by family members and peers in the treatment process. Furthermore, it is mandatory to explore the efficacy of CT in different subtypes of borderline patients. Finally, validation studies are necessary to establish which types of therapeutic settings should preferably be integrated in each single cases of BPD (i.e., individual, family, group, medication). The possibility that attachment theory and research allows for a detailed explanation of the basic mechanism of CT therapeutic power adds to the promising hints at their efficacy that emerge from the now rather widespread clinical practice of CT, and to the results of the above quoted controlled outcome studies, in encouraging more researchers to engage themselves in such an ambitious research program.

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