

Pathological Attachments and Therapeutic Action

Peter Fonagy,
PhD, FBA

A transgenerational
model of personality disorder

There is some evidence of a specific link between childhood maltreatment and certain personality disorders. As children, such individuals frequently had caregivers who were themselves within the so-called 'borderline spectrum' of severe personality disorder (Barach, 1991; Benjamin & Benjamin, 1994; Shachnow et al., 1997). The social inheritance aspect may be an important clue in our understanding of the disorder.

Studies by our group (Fonagy et al., 1996), as well as others (Patrick, Hobson, Castle, Howard, & Maughan, 1994), have demonstrated considerable distortions of attachment representation in personality disordered, particularly borderline, individuals. In our study, individuals with BPD diagnosis had predominantly preoccupied attachments, associated with unresolved experiences of trauma and a striking reduction in reflective capacity. In a further study we compared our patient group to a matched group of forensic psychiatric referrals. In the latter group dismissing patterns of attachment predominated, unresolved trauma was less evident (although the prevalence of trauma was comparable) and reflective capacity was even lower (Levinson & Fonagy, submitted).

We have proposed that some personality disordered individuals are those victims of childhood abuse who coped by refusing to conceive of their attachment figure's thoughts, and thus avoided having to think about their caregiver's wish to harm them (Fonagy et al., 1996). Continuing to defensively disrupt their capacity to depict mental states in themselves and in others leaves them to operate on inaccurate, schematic impressions of thoughts and feelings. They are then immensely vulnerable in intimate relationships. There are two propositions here:
1) individuals who experience early trauma may defensively inhibit

their capacity to mentalize; and 2) some characteristics of personality disorder may be rooted in this inhibition. I shall attempt to deal with these propositions in turn.

The impact of maltreatment on reflective function

There is accumulating evidence that maltreatment impairs the child's reflective capacities and sense of self. Schneider-Rosen and Cicchetti (Schneider-Rosen & Cicchetti, 1984; Schneider-Rosen & Cicchetti, 1991) noted that abused toddlers showed less positive affect on recognising themselves in the mirror than controls. Beeghly and Cicchetti (Beeghly & Cicchetti, 1994) showed that these toddlers had a specific deficit in use of internal state words and that such language tended to be context-bound. Our Menninger study of maltreated five to eight year olds found specific deficits in tasks requiring mentalisation, particularly amongst those referred for sexual or physical and sexual abuse. These results suggest that maltreatment may cause children to withdraw from the mental world.

We have suggested that this situation can, and probably often does, induce a severe and extremely vicious developmental cycle. The psychological isolation of maltreatment amplifies distress, activating the attachment system. The need for proximity thus persists and perhaps even increases as a consequence of the distress caused by abuse. Mental proximity becomes unbearably painful, and the need for closeness is expressed at a physical level. Thus, the child may paradoxically be driven physically closer to the abuser. Their ability to adapt to, modify or avoid the perpetrator's behavior is likely to be further constrained by limited mentalising skills. The contradiction between proximity seeking at the mental and physical level lies at the root of the disorganized attachment so consistently seen in

abused children.

Why should the family environment of maltreatment undermine reflective function? First, recognition of the mental state of the other can be dangerous to the developing self. The child who recognizes the hatred or murderousness implied by the parent's acts of abuse is forced to see himself as worthless or unlovable. Second, the meaning of intentional states may be denied or distorted. Abusive parents commonly claim beliefs or feelings at odds with their behavior. The child cannot test or modify representations of mental states, which become rigid or inappropriate and may be abandoned. Third, the public world, where reflective function is common, and could generate an alternative model of experiencing himself are rigidly kept separate from the attachment context. Finally, the dysfunction may occur, not because of the maltreatment but of the family atmosphere that surrounds it. Authoritarian parenting, commonly associated with maltreatment, is also known to retard the development of mentalisation (see Astington, 1996). These youngsters and their mothers find it difficult to take a playful stance (Alessandri, 1992), so the social scaffolding for the development of mentalisation we considered this morning may be absent in such families. A mentalising stance is also unlikely to develop in a child who generally feels treated as an uncared-for physical object.

If lack of consideration for the child's intentionality is pervasive, consequences may occur not just at the functional but also at the neurodevelopmental level. The work of Bruce Perry (1997) suggests that Romanian orphans, institutionalized shortly after birth and suffering severe neglect and maltreatment during most of the first year of their lives, show significant loss of cortical function in the fronto-temporal areas. These areas have been independently shown to be involved with inferring mental states (Frith, 1996). At four years, those who had been adopted before four months showed far less frequent disorganized attachment than those adopted later (Fisher, Ames, Chisholm, & Savoie, 1997). It has been independently demonstrated that insecure, particularly disorganized, attachment is associated with a far slower return to baseline of separation-induced cortisol elevation (Spangler & Grossman, 1993). Chronic exposure to raised levels

of cortisol associated with chronically insensitive caregiving may bring about neurodevelopmental anomalies that result in mentalising deficit.

Personality disorder and deficit in mentalising

So, to the second proposition, are some characteristics of personality disorder rooted in a deficit of mentalisation? In several studies, our team (Fonagy et al., 1996; Levinson & Fonagy, submitted) found low reflectiveness in the attachment narratives of individuals with criminal histories or borderline diagnosis. It is tempting to argue that some problems of violence and borderline states can be explained as dismissive and preoccupied forms of non-mentalising self-organisations, respectively. This is over-simplistic. In both instances there are variations across situations or types of relationships. The delinquent adolescent is, for example, aware of the mental states of others in his gang and the borderline individual is at times hypersensitive to the emotional states of mental health professionals and family members.

Following the principles of Kurt Fischer's "dynamic skills theory" of development (Fischer, Kenny, & Pipp, 1990), we may assume that maltreatment is associated with a "fractionation" or splitting of reflective function across tasks and domains. During the earlier stages of development, just as the understanding of conservation of liquid does not as yet generalize to conservation of area, reflective capacity in one domain of inter-personal interaction may not at first generalize to others. In normal development, there would be some degree of integration and generalisation of a mentalising model of behavior, however, in personality disorder, development goes awry -- the normal co-ordination of previously separate skills does not come about, fractionation seems adaptive to the individual and continues to dominate over integration.

Teleological models of behavior persist in all of us, and develop in sophistication, since in many circumstances they provide useful predictions and adequate explanations. For example, if on a wet day I observe my friend crossing the road I might, taking the intentional stance, infer that he does not wish to get wet (desire state) and he thinks there is still a shop on that side which sells umbrellas (belief state) (it actually closed two weeks ago - I snigger with appropriate schadenfreude). However, the same action could be interpreted as rational within the teleological framework as well. One could conclude that my friend has crossed the road in order to be able to walk faster (visible outcome), because there are too many people on this side (visible constraint). Clearly, the application of the teleological stance can become problematic in the context of attachment relationships. Assume that X was a close friend. Adopting the teleological stance may be helpful in avoiding imputing the desire to X that he wanted to avoid me, and the belief state that he thinks I did not see him or he thinks that I think he did not see me.

The mentalising inferences of the intentional stance are no more likely to be correct than the physicalistic ones of the teleological mode. However, in our view, mentalising models are uniquely valuable in complex interpersonal situations, involving for instance conflict, potential deception, or irrationality. Unfortunately, non-reflective internal working models come to dominate the behavior of personality disordered individuals in emotionally charged intimate relationships, and any interpersonal situation which calls forth relationship representations which derive from the primary attachment relationships. These individuals can be disadvantaged because a) their caregivers did not facilitate mentalising capacity within a secure attachment relationship (vulnerability); b) they have subsequently acquired an emotional disincentive for taking the perspective of others who are hostile as well as non-reflective (trauma); c) subsequent relationships are jeopardized by the lack of a mental state attributional model of the original trauma and subsequent experiences (lack of resilience); and d) they may divide mentalising resources unevenly between their external and internal worlds, becoming hypervigilant towards others but uncomprehending of their own states (uneven adaptation).

Why should emotionally charged interactions trigger a "regression" to non-mentalistic thinking? Schuengel and colleagues (Schuengel, 1997) have recently provided evidence for Main and Hesse's hypothesis that caregivers of disorganized infants frequently respond to the infant's distress by frightened or frightening behavior. It is as if the infant's emotional expression triggered a temporary failure on the part of the caretaker to perceive the child as an intentional person. The child comes to experience his own arousal as a danger signal for abandonment. It should not surprise us then that emotional arousal in such children can become a trigger for teleological non-mentalising functioning; it brings forth an image of the parent who withdraws from the child in a state of anxiety or rage to which the child reacts with a complimentary dissociative response.

Disorganized attachment and personality disorder

Thus far we have skirted around the central implication of this model. We have suggested that reflective function and its attachment context are at the root of self organisation. The internalisation of the caregiver's image of the child as an intentional being is central. The child's emerging self representation will map on to what could be called a primary or "constitutional self" (the child's experience of an actual state of being, the self as it is). The representation will not be true to the child's primary experience in the case of maltreatment. The caregiver's hostile intent precludes such an organic self image. Internal experience is not met by external understanding, it remains unlabelled, confusing and the uncontained affect generates further dysregulation.

There is overwhelming pressure on the child to develop a representation for internal states. As we have seen, within the bio-psycho-social attachment system the child seeks out

aspects of the environment contingently related to his self-expressions. Winnicott (1967, p.33) warned us that failing to find his or her current state mirrored, the child is likely to internalize the mother's actual state as part of his or her own self structure. The child incorporates into his or her nascent self-structure a representation of the other (Fonagy & Target, 1995). When confronted with a frightened or frightening caregiver, the infant takes in as part of himself the mother's feeling of rage, hatred, or fear, and her image of him as frightening or unmanageable. This painful image must then be externalized for the child to achieve a bearable and coherent self-representation. The disorganized attachment behavior of the infant, and its sequelae, bossy and controlling interactions with the parent, may be understood as a rudimentary attempt to blot out the unacceptable aspects of the self-representation. Later attempts at manipulating the behavior of the other permits the externalisation of parts of the self and limits further intrusion into the self-representation. This dissociated core of the self is an absence, rather than genuine psychic content. It reflects a breach in the boundaries of the self, creating an openness to colonisation by the mental states of other important attachment figures. Disastrously, in the case of some children maltreated later in development, this will not be a neutral other but rather a torturing one. Once internalized and lodged within the self-representation, this "alien" representation will have to be expelled not only because it does not match the constitutional self, but also because it is persecutory. The consequences for interpersonal relationships and for affect regulation are then disastrous (Carlsson & Sroufe, 1995).

This, we believe, is the essence of disorganized attachment. Research shows that the disoriented disorganized behavior of the infant is gradually replaced, over the first five years of life, by brittle behavioral strategies that seek to control the parent, through either punitive acts or age-inappropriate care-giving behavior (Cassidy & Marvin, 1992; Main & Cassidy, 1988). There is independent evidence that the parents of such children experience the child as taking control of the relationship and, consequently, themselves as increasingly immobilized and helpless and failing to provide care-giving (George & Solomon, 1996; Solomon & George, 1996). The descriptions by mothers of disorganized children are often quite remarkable; they see the child as a replica

of themselves and experience themselves as merging with the child. We assume that these experiences are explained by the child externalizing aspects of their self-representation which relate, not to the internalization of the mother's representation of the self, but the representation of the mother within the self. The tendency for such children to show precocious care-giving behavior (West & George, in press) is also consistent with the idea that the representation of the mother is internalized into the self.

The externalization of the image of the mother from within the self-representation serves the function of achieving a coherent self-representation. Such externalization can only be successfully achieved if the mother is controlled sufficiently to become an adequate vehicle for the alien self-representation to be experienced as external. This strategy may be reinforced, in childhood, insofar as offensive or threatening behavior often compels the adult to resume a position of authority and thus reactivate the parent's own care-giving system which the parent had temporarily abandoned (West & George, in press).

The mechanism described here may be a prototypical example of the psychoanalytic notion of projective identification (Klein, 1946) or, more specifically, what Elizabeth Spillius (Spillius, 1994) has termed 'evocatory projective identification'. To state it simply: disorganized attachment is rooted in a disorganized self. The individual, when alone, feels unsafe and vulnerable because of the proximity of a torturing and destructive representation from which he cannot escape because it is experienced from within rather than from without the self. Unless his relationship permits externalization, he feels almost literally at risk of disappearance, psychological merging and the dissolution of all relationship boundaries.

Symptomatology
of borderline personality disorder

Let us briefly review some common symptomatology of borderline states from the point of view of this model.

1. The unstable sense of self of many such patients is a consequence of the absence of reflective capacity. A stable sense of self can only be illusory when the alien self is externalized onto the other and controlled therein. The individual then is an active agent who is in control, despite the fragility of the self. The heavy price paid is that by forcing the other to behave as if they were part of his internal representation, the potential of a "real" relationship has been lost and the patient is preparing the way for abandonment.

2. The impulsivity of such patients may also be due to: a) lack of awareness of his own emotional states associated with the absence of symbolic representations of them, and b) the dominance of pre-mentalistic physical action-centred strategies, particularly in threatening relationships. In the non-mentalistic teleological mode, behavior of the other is interpreted in terms of its observable consequences, rather than as being driven by desire. It is only when behavior is construed as intentional, however, that one can conceive of influencing it through changing the other's state of mind. Talking about it only makes sense if the behavior of the other has been explained in terms of wishes and beliefs. If, on the other hand, it is interpreted solely in terms of its observable consequence, a kind of "mentalistic learned helplessness" sets in. The obvious way then to intervene will be through physical action. This may include words, which sound like an attempt at changing the other person's intentions, but are in fact intimidation, efforts to force the other person into a different course of action. Only a physical end-state is seen. This may be represented in terms of that person's body. The patient may physically threaten, hit, damage or even kill; alternatively they may tease, excite, even seduce.

Such patients bring many

memories of having been treated in such ways. A young man confessed to his father that he had accidentally broken a lamp. The father reassured him that it was OK since he didn't do it on purpose. The father later saw that the lamp the child broke was his favourite and beat his son so hard that he fractured his arm as the child raised it to protect himself. The father's mind is working in a non-mentalising (teleological) mode in these examples. What the child has done (visible outcome), rather than his intention (mental state), drives the father's action.

3. Emotional instability and irritability require us to think about the representation of reality in borderline patients. The absence of mentalisation reduces the complexity of this representation; only one version of reality is possible, there can be no false belief (Fonagy & Target, 1996). If the behavior of the other and knowledge of reality do not fit, we normally try to understand the behavior in mentalising terms. For example, "He mistook my \$20 for a \$10 bill (false belief). That is why he only gave me \$5 change". If this and other possibilities do not readily occur to one, and alternatives cannot easily be compared, an oversimplified construction is uncritically accepted: "He was cheating me!" This frequently, especially for individuals who had non-reflective, coercive caregiving, leads to paranoid constructions of the other's desire state.

Mentalisation acts as a buffer: when actions of others are unexpected, this buffer function allows one to create auxiliary hypotheses about beliefs, which forestall automatic conclusions about malicious intentions. Once again, we see the traumatized individual doubly disadvantaged. Internal working models constructed on the basis of abuse assume that malevolence is not improbable. Independently, being unable to generate auxiliary hypotheses, particularly under stress, makes the experience of danger even more compelling. Normally, access to the mentalisation buffer allows one to play with reality (Target & Fonagy, 1996). Understanding is known to be fallible. But if there is only one way of seeing things, an attempt by a third party, such as a therapist, to persuade the patient that they are wrong might be perceived as an attempt to drive them crazy.

Interpersonal schemata are notably rigid in borderline patients because they cannot imagine that the other could have a construction of reality different from the one they experience as compelling. In the teleological stance, life is simple. The individual sees the result of an action, and this is seen as its explanation. A deeper understanding would require recognising alternative underlying motivations and beliefs, to account for the observed behavior.

4. A brief word about suicidality. Clinicians are familiar with the enormous fear of physical abandonment in borderline patients. This, perhaps more than any other aspect, alerts clinicians to the disorganized attachment models which such patients are forced to live with. When the other is needed for self-coherence, abandonment means the reinternalisation of the intolerable, alien self-image, and consequent destruction of the self. Suicide represents the fantasized destruction of this alien other within the self. Suicide attempts are often aimed at forestalling the possibility of abandonment; they seem a last ditch attempt at re-establishing a relationship. The child's experience may have been that only something extreme would bring about changes in the adult's behavior, and that their caregivers used similarly coercive measures to influence their own behavior.

While suicide and self-harm are common manifestations of disorganized attachment in women, in men with similar pathology violence against the other is more common. Such a person can only maintain a relationship if this enables him to externalize alien parts of the self. The relationship violent men are forced to establish is one where their significant other can act as a vehicle for intolerable self-states. They control their relationship through crude manipulation in order to engender the self-image which they feel desperate to disown. They resort to violence at times when the independent mental existence of the other threatens

this process of externalization. At these times, dramatic and radical action is taken because the individual is terrorized by the possibility that the coherence of self achieved through control and manipulation will be destroyed by the return of what has been externalized.

The act of violence at these moments performs a dual function. First, to recreate and re-experience the alien self within the other and second to destroy it in the unconscious hope that it will then be destroyed forever. Perceiving the terror in the eyes of their victim, they are once again reassured and the relationship regains its paramount importance in their psychic organisation. Thus their pleas for forgiveness and unreserved contrition are genuine in the sense that their need for a relationship where this externalisation is possible is undoubtedly absolute. Let me conclude by considering in some detail the clinical presentation of men involved in partner abuse, based both on available clinical descriptions and our own interviews with men whose violence was sufficiently extreme to merit incarceration in terms of the theoretical framework proposed.

5. Splitting, the partial representation of the other (or the self) is a common obstacle to adequate communication with such patients. Understanding the other in mental terms initially requires integrating assumed intentions in a coherent manner. The hopelessness of this task in the face of the contradictory attitudes of an abuser is one of the causes of the mentalising deficit. The emergent solution for the child, given the imperative to arrive at coherent representations, is to split the representation of the other into several coherent subsets of intentions (Gergely, 1997), primarily an idealized and a persecutory identity. The individual finds it impossible to use both representations simultaneously. Splitting enables the individual to create mentalized images of others but these are inaccurate, over-simplified and allow for only an illusion of mentalized inter-personal interchange.

6. A further

common experience of such patients is the feeling of emptiness which accompanies much of their lives. The emptiness is a direct consequence of the absence of secondary representations of self-states, certainly at the conscious level, and of the shallowness with which other people and relationships are experienced. The abandonment of mentalisation creates a deep sense of isolation. To experience being with another the person has to be there as a mind; to feel the continuity between past and present it is mental states that provide the link; emptiness and, at an extreme, dissociation is the best description such individuals can give of the absence of meaning which the failure of mentalisation creates.

Some qualifications of the model proposed

Perhaps at this stage a number of qualifications are in order. First, abnormalities of parenting represent but one route to difficulties with mentalisation. Biological vulnerabilities, such as attention deficits, are also likely to limit the child's opportunities for evolving reflective capacity. We should be aware that, as in most aspects of development, there is a subtle bi-directional causal process inherent to such biological vulnerabilities. Vulnerabilities provoke situations of interpersonal conflict as well as placing limitations on the child's capacities. Thus biological factors can limit mentalising potential but may also act through generating environments where mentalisation is unlikely to be fully established.

Second, many of us working with borderline patients willingly attest to their at times apparent acute sensitivity to mind states, certainly for the purposes of manipulation and control. Does this imply that mentalisation is not a core dysfunction? The likely solution to this puzzle is that patients with severe personality disorders do develop a certain level of non-conscious

mind-reading skills. Clements and Perner (Clements & Perner, 1994) show that children just before the age of three have an intuitive understanding of false belief which they are unable to communicate verbally but can demonstrate in their non-verbal reactions, such as eye movements. It is conceivable that, at a stage when such non-conscious mind reading skills begin to evolve, the implications of the child trying to infer the intentions behind their caregivers' reactions are so negative that they are forced to fall back on the strategy of influencing the other by action rather than by words. However, they retain access, at a non-conscious level, to mental states but repudiate consciousness of it. The borderline patient is not "mind blind", rather she or he is not "mind conscious". They pick up on cues which influence the behavioral system but this does not surface in terms of conscious inferences.

Third, not all parents of individuals with problems related to mentalisation are borderline. Some, in our experience at least, are highly reflective individuals who have, however, significant problems related to their children and sometimes to a specific child. Lack of sensitivity to intentional states is not a global variable affecting all situations. It must be assessed in relation to a specific child-caregiver relationship. In other words, it concerns the caregiver's representation of the specific child's mentalisation (Slade, Belsky, Aber, & Phelps, in press).

Psychotherapy
and
mentalising

Psychotherapy, in all its incarnations, is about the rekindling of mentalisation. Whether we look at Marcia Linehan's dialectic behavior therapy protocol (Linehan, 1993), John Clarkin's and Otto Kernberg's recommendations for psychoanalytic psychotherapy (Kernberg & Clarkin, 1993), or Anthony Ryle's cognitive analytic therapy (Ryle, 1997) they all:

- (1) Aim to establish an attachment relationship with the patient,

(2) Aim to use this to create an interpersonal context where understanding of mental states becomes a focus; (3) Attempt (mostly implicitly) to recreate a situation where the self is recognized as intentional and real by the therapist and this recognition is clearly perceived by the patient.

Permit me to expand on this model. I believe at the core of psychological therapy with individuals with severe personality disorder is the enhancing of reflective processes. The therapist must help the patient understand and label emotional states with a view to strengthening the secondary representational system. Often this is achieved not just by interpretations of moment-to-moment changes in the patient's emotional stance but by focusing the patient's attention on the therapist's experience. The patient comes in looking somewhat timid. The therapist says: "You see me as frightening". The therapist avoids describing complex mental states, rarely refers to the patient's conflicts, ambivalence (conscious or unconscious). I vividly remember my first analytic experience with a borderline patient. Early in his analysis, following a discussion of his anxieties about competitiveness, I suggested that these might be related to unresolved conflicts about his sexual competition with his father as a little boy (I am still ashamed of the degree of my naiveté). He seemed thoughtful about my interpretation and returned proudly the next day with an account of a dream where he and his father were fighting; he had a knife and after a struggle managed to cut his father's penis off which he held up victoriously, reminding himself of the Statue of Liberty. By then I had the presence of mind to make the more appropriate interpretation that his anxiety the day before concerned his feeling of being in competition with me, and now (feeling that I had failed to see this) he could indeed afford to feel triumphant. While reducing his anxiety momentarily, these and other interpretations had little impact on his ways of seeing things. Change is generated in these patients by brief, specific interpretation. The inevitable destructiveness of these patients in relation to the therapeutic enterprise are rarely adequately dealt with by confrontation or interpretations of their aggressive intent. If such attacks are seen as self-protective the helpful interpretation is often aimed at the emotional antecedents of enactments, emotions which cause confusion and

disorganisation.

As we have seen, gaps in mentalisation engender impulsivity and the intensification of the therapeutic relationship frequently highlights the patient's difficulties in creating a distance between internal and external reality. The therapist's task is in some way analogous to that of the parents who create a frame for pretend play – except in this case it is thoughts and feelings that need to become accessible through the creation of such a transitional area.

The therapist must get used to working with precursors of mentalisation. The task is the elaboration of teleological models into intentional ones. Integrating or trying to bridge the pretend dissociated mode of the patient's functioning where nothing feels real (certainly not words or ideas) with moments when words and ideas carry unbelievable potency and destructiveness can seem an awesome task. Yet only by being able to become part of the patient's pretend world, trying to make it real, while at the same time avoiding entanglement with the equation of thoughts and reality, that progress becomes conceivable.

Should the psychoanalytic therapist work in the transference with borderline patients? The answer is No and Yes. No – in the sense that the transference of early relationship patterns onto current relationships, while ever present, is rarely helpful to highlight. Without mentalisation transference is not displacement but is experienced as real. The therapist is the abuser – no as-if about it. When such transference interpretations are made the patient is often thrown into a pretend mode and gradually patient and therapist may elaborate a world, which however detailed and complex, has little experiential contact with reality. Thus a more productive line is the simple acknowledgement of affect in the here and now, while conveying in words, tone and posture that the therapist is able to cope with the patient's emotional state. Yes - in that the transference, using the term in its broadest sense, is helpful as a concrete demonstration of alternative perspectives. The contrast between the patient's perception of the therapist as she or he is imagined and as she or he is may help to place quotation marks around the transference experience.

The most complicated challenge arising out of treating such patients relates to externalisations of unbearable self-states. Some therapists split the transference by creating alternative foci for the patient's feelings — a pharmacotherapist and a psychotherapist, individual and group treatments. Others attempt to control enactments by making therapy contractually dependent. Sometimes neither of these is possible, at other times neither is sufficient. I find being modest in my aims the most helpful device. I do not hope that insight will prevent enactment, my aim is simply the gradual encouragement of mentalisation. I consequently rarely interpret enactments but try and deal with their antecedents and consequences. I am equally permissive about my own tendency to enact in the counter-transference. Within the model I am working with, I have to accept that in order for the patient to stay in mental proximity have occasionally to become the vehicle for the alien part within his self. If I am to be any use to him, I have to become what he needs me to be. Yet I know that if I become that person, I can be of no help to him. What I aim to achieve is a state of equipoise between the two - allowing myself to do as required yet trying to retain in my mind as clear and coherent an image of the state of his mind as I am able to achieve.

So, what are the hallmarks of a successful therapy with an individual with severe borderline features? While I do not believe that any theory, including the present one, gets anywhere close to explaining the patient's problems, I do believe that having a theoretically coherent approach is important. Such patients require that we are predictable and our models of them can then come to form the core of their self-representations. A stable, coherent image is hard to maintain should the therapist swap theoretical approaches at an alarming rate. Mentalisation can only be acquired in the context of an attachment relationship. And this means that the therapy must embody a secure base. In my view attachment is inseparable from a focus on the mental state of the other. There can be no bond without understanding even if understanding is possible without a bond. In my experience these treatments always take considerable time and consistency over such prolonged periods is often hard to

maintain. The patient is terrified of and actively fights mental closeness, even when physical proximity appears to be his overarching goal. Retaining such proximity while under persistent attack is neither comfortable nor likely to be achieved unless one leaves one's narcissism at the door. And a final word of advice – never under-estimate the extent of the patient's incapacity. It is so easy and so relatively comforting to engage with the representational world of these patients at a level of complexity that they in reality have little appreciation of. They are readily seduced into such relationships and accept such complexities within a pretend mode, dramatically removed from anything which feels to them real. Such therapies tend to be, in Freud's terms, durable but they are sadly unhelpful in the long run.

Clinical illustration

Mr S. was a violent 27-year-old borderline man. He frequently shouted and screamed at me and I felt frightened and frustrated as well as bewildered in his presence. He had been severely maltreated as a child. His associations at first lacked depth, resonance and evocativeness, and his utterances left me with a sense of emptiness which I gradually recognized was something that he experienced.

Two months into his analysis he brought his first dream. He started the session describing in painful detail his journey from the underground station including commenting on the houses, the railings, the cracks in the pavement. I noted that he made no mention of the people he must have encountered. I said: "I think you would like me to know how hard it is for you to come and see me". He replied that no effort was involved but that he was tired because he had had a bad dream. The dream was of a bureau with many drawers. He spent a long time finding the key. He knew that the drawers should be full but when he opened each in turn they were empty. He was silent for a while then started talking about aspects of the building we were in which impressed him: its size, its grandeur, its many rooms.

I said: 'I think you are very frightened of having to look for your ideas and feelings in here because you feel that you will only find emptiness'. He replied that there were so many people trying to get out of the station that evening that he was frightened that he might never get to his session. I said that he also seemed frightened of closeness to me because it might replace his emptiness in a way that might make him feel confused, suffocated and trapped. He did not respond. I felt that he truly did not understand what I had in mind.

I now tend to think of dreams of borderline patients as rudimentary attempts at reflection in individuals who have partly disavowed this capacity, thus a unique window on their mental world. This dream makes clear that Mr S was depicting his desperation about the emptiness which he experienced as his mind. He felt the drawers should have been full; he felt pressure from me to bring ideas, depicted in the pressure of people emerging from the station, but was unable to pull them out from his mind. He was missing the key to understanding. He was impressed with all the ideas I was putting to him but they had a sham grandeur: he was impressed merely by their number or their appearance, not by their content. My statements felt empty to him.

A further dream from this analysis might help illustrate the progress that it is possible to achieve even with someone as severely incapacitated as Mr S. For two years I worked hard with Mr S, not at uncovering deep-seated conflicts, not at providing subtle insights but more simply at exploring triggers for feelings, identifying small changes in his mental states, highlighting our differences in perceptions of the same events, and placing affect into a causal chain of concurrent mental experience. I also pushed Mr S to focus on my mental state as I struggled to reflect and understand the oftentimes dramatic shifts and swings of his perceptions and emotions.

In one session he talked of his parents peering at him from the past, which he linked to an image of two sets of red eyes staring

at him from the darkness. At the end of that session I had to ask him to make a couple of small changes in the times of his sessions two weeks hence. In the next session, he refused to lie down on the couch. After a silence, he recalled two dream fragments. One was about a lion which, to his surprise, he kept at home. The other, more disturbing, was about a man who was apparently being executed by someone who took two small red balls out of his pocket, as if he was going to give change to someone, and hammered them into the other's head. The executioner reminded him of his father and the lion of a toy he had had as a child and which he had subjected to 'terrible abuse'. He remembered that its mane had completely disappeared. I said that he wished me to know that the changes that I had called small had felt devastating to him and that if I, as the lion, were to suffer terrible abuse then I would learn how he felt. This would help him cope with his sense of not mattering.

I sensed his shame and his anger. Eventually he volunteered that the lion had been a present from his father and that its eyes had been red but were missing in the dream. Referring to the red eyes of the previous session, I suggested that he felt one or other of us might be killed if we were forced to see things from the other's standpoint. Through tears he recounted that his father, having been away, saw that the lion he had given him was dirty and damaged and severely beat the six year old Mr S. He remembered his father screaming at him: 'I'll beat some sense into your head. Now you can see how it feels.' I said: 'I think you are terrified of me hammering my crazy ideas into you. If you try to see things from my point of view you would be driven crazy.' He suddenly got up and lay down on the couch. There was silence but also a mutual experience of communication. [Eventually he said that he did not imagine that coming to analysis would ever make him feel happy, but he did feel that he had more space.]

Conclusion

In conclusion, what is the

nature of cure with such patients? The therapist's mentalistic, elaborative stance ultimately enables the patient to find himself in the therapist's mind as a thinking feeling being and integrate this image as part of his sense of himself. There is a gradual transformation of a non-reflective mode of experiencing the internal world which forces the equation of the internal and external to one where the internal world is treated with more circumspection and respect, separate and qualitatively different from physical reality. Even if work were to stop here, much would have been achieved in terms of making behavior understandable, meaningful and predictable. The internalisation of the therapist's concern with mental states enhances the patient's capacity for similar concern towards his own experience. Respect for minds generates respect for self, respect for other and ultimately respect for the human community. It is this respect which drives and organizes the therapeutic endeavour and speaks with greatest clarity to our psychological heritage.

Go
to Reference Page

Peter Fonagy, PhD,
FBA

Freud Memorial Professor of Psychoanalysis, UCL

Director of Research, The Anna Freud Centre

Co-ordinating Director, Child and Family Center and Center for
Outcomes Research and
Effectiveness, Menninger Foundation

Address for
correspondence:

Sub-Department
of Clinical
Health Psychology

University College London

Gower Street

London WC1E 6BT

E-mail: p.fonagy@ucl.ac.uk