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ATTACHMENT AND BORDERLINE PERSONALITY DISORDER

The author outlines his concept of reflective function or mentalization, which is defined as the capacity to think about mental states in oneself and in others. He presents evidence to suggest that the capacity for reflective awareness in a child's caregiver increases the likelihood of the child's secure attachment, which in turn facilitates the development of mentalization in the child. He proposes that a secure attachment relationship offers the child a chance to explore the mind of the caregiver, and in this way to learn about minds; he formulates this model of the birth of the psychological self as a variation on the Cartesian *cogito*: "My caregiver thinks of me as thinking and therefore I exist as a thinker." This model is then applied to provide insight into some personality-disordered individuals who were victims of childhood abuse. The author proposes (1) that individuals who experience early trauma may defensively inhibit their capacity to mentalize to avoid having to think about their caregiver's wish to harm them; and (2) that some characteristics of severe borderline personality disorder may be rooted in developmental pathology associated with this inhibition. He offers evidence for and some qualifications of this model, and argues that the therapeutic effect of psychoanalysis depends on its capacity to activate patients' ability to evolve an awareness of mental states and thus find meaning in their own and other people's behavior.

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This paper is a preliminary report of an ongoing collaboration with friends and colleagues Mary Target, George Gergely, and Efrain Bleiberg. Many of the ideas presented are theirs, but if they should be well received the author will have no hesitation in taking credit for them.

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Mary Main (1991) and Inge Bretherton (1991) independently drew attention to what the philosopher Dennett called the *intentional stance*. Dennett (1987) stressed that human beings try to understand each other in terms of mental states—thoughts and feelings, beliefs and desires—in order to make sense of, and even more importantly, to anticipate, each others' actions. If a child is able to attribute an unresponsive mother's apparently rejecting behavior to her sadness about a loss, rather than simply feeling helpless in the face of it, the child is protected from confusion and a negative view of himself. The hallmark of the intentional stance is the child's recognition at around three to four years that behavior may be based on a mistaken belief. Developmentalists have designed numerous tests of the quality of understanding false beliefs, and tend to refer to this capacity as a *theory of mind*. We prefer the terms *mentalization* or *reflective function*, which denote the understanding of one's own as well as others' behavior in mental state terms.

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Say a three-year-old is shown a tube of M&Ms and is asked what it contains. He says: "Candies." The tube is opened and he is shown a pencil. If he is able to predict accurately that his friend waiting outside will also reply "Candies" to the same question, he is said to have a theory of mind; he attributes a false belief. If he replies that his friend will say: "A pencil," he is inappropriately equating mental state with reality. His friend cannot see what is inside the tube, yet the prementalizing child assumes an isomorphism between what he knows as reality and the mental state that he imputes to his friend. This literature has been carefully considered from a psychoanalytic perspective by Linda Mayes and Donald Cohen (Mayes and Cohen 1993; Mayes, Cohen, and Klin 1991).

In a program of work over the last ten years we have attempted to operationalize individual differences in adults' mentalizing capacities. Our operationalization is relatively simple, based on the presence of unequivocal descriptions of mental states (e.g., false beliefs) in the narrative. The measure is reliable, and correlates only negligibly with IQ and educational background. We were curious to know if the extent of reflective observations about the mental states of self and others in Adult Attachment Interview narratives could predict infant security. Reflectiveness ratings made of parents before the child's birth powerfully predicted the child's attachment security in the second year of life. *Both fathers and mothers who rated high*

in this capacity were three or four times more likely to have secure children than parents whose reflective capacity was poor (Fonagy et al. 1991).

The capacity for understanding false beliefs may be particularly important when the child is exposed to unfavorable experiences—in the extreme, abuse or trauma. We divided our sample into two groups of subjects: those who had reported significant deprivation (overcrowding, parental mental illness) and those who had not. Our prediction was that mothers in the deprived group would be far more likely to have children securely attached to them if their reflective function ratings were high. *All of the mothers in the deprived group with high reflectiveness ratings had children who were secure with them, whereas this was true of only one out of seventeen of the deprived mothers with low ratings.* Reflective function seemed to be a far less important predictor for the nondeprived group. Our findings imply that this cycle of disadvantage may be interrupted if the caregiver has acquired a capacity to reflect productively on mental experience (Fonagy et al. 1994).

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MENTALIZING AND THE DEVELOPMENT OF THE SELF

Not only are parents high in reflective capacity more likely to promote secure attachment in the child, particularly if their own childhood experiences were adverse, but secure attachment itself may be a key precursor of robust reflective capacity (Fonagy et al. 1995). In our longitudinal study of ninety-two children with Miriam and Howard Steele, the proportion of secure children was twice as high in the group that passed a false belief task, compared to the group that failed. The mother's reflective function was also associated with the child's success. Eighty percent of children whose mothers were above the median in reflective function passed, whereas only fifty-six percent of those whose mothers were below did so.

These results suggest that the parents' capacity to observe the child's mind facilitates the child's general understanding of minds through the mediation of secure attachment. A reflective caregiver increases the likelihood of the child's secure attachment, which in turn facilitates the development of mentalization. We assume that a secure attachment relationship provides a congenial context in which the

child can explore the mind of the caregiver, and in this way learn about minds. The philosopher Hegel (1807) taught us that it is *only through getting to know the mind of the other that the child develops full appreciation of the nature of mental states. Reflectiveness depends upon attachment*. The process is intersubjective: the child gets to know the caregiver's mind as the caregiver endeavors to understand and contain the mental state of the child.

The securely attached child perceives in the caregiver's reflective stance an image of himself as desiring and believing. He sees that the caregiver represents him as an *intentional being*, and this representation is internalized to form the self. "I think, therefore I am" will not do as a psychological model of the birth of the self; "She thinks of me as thinking and therefore I exist as a thinker" perhaps comes closer to the truth. If the caregiver's reflective capacity has enabled her accurately to picture the child's intentional stance, then he will have the opportunity to "find himself in the other" as a mentalizing individual. The development of awareness of mental states in oneself can then be generalized to the caregiver. *Thus a "theory of mind" is first of all a theory of self.*

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A TRANSGENERATIONAL MODEL OF PERSONALITY DISORDER

There is some evidence of a specific link between childhood maltreatment and certain personality disorders. As children, such maltreated individuals frequently had caretakers who were themselves within the so-called "borderline spectrum" of severe personality disorder (Barach 1991; Benjamin and Benjamin 1994). 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 et al. 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, which are 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 further reduced (Levinson and Fonagy in preparation).

We have hypothesized that some personality-disordered individuals are 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). The continuing defensive disruption of their capacity to depict mental states in themselves and in others leaves them operating 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 developmental pathology associated with 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 (1984, 1991) noted that abused toddlers showed less positive affect on recognizing themselves in the mirror than did controls. Beeghly and 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; that is, while the children had picked up various idioms the use of which might seem to imply the ability to mentalize, they used them without real understanding. Our study of maltreated five- to eight-year-olds found specific deficits in tasks requiring mentalization, particularly among those referred for sexual or physical abuse. They could not solve puzzles that required them to conceive of one person's false beliefs concerning a second person's false beliefs. These results suggest that maltreatment may cause children to withdraw from the mental world.

The need for proximity, however, 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. The ability to adapt to, modify, or avoid the perpetrator's behavior is likely to be further constrained by limited mentalizing skills. The contradiction between

proximity-seeking at the physical level and proximity-avoidance at the mental level lies at the root of the disorganized attachment so consistently seen in abused children.

Why should a 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, may give rise to alternative models of experiencing himself that are rigidly kept separate from the attachment context. Finally, the dysfunction may occur not because of the maltreatment but because of the family atmosphere that surrounds it. For example, authoritarian parenting, commonly associated with maltreatment, is also known to retard the development of mentalization (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 mentalization may be absent in such families. A mentalizing stance is also unlikely to develop in a child who generally feels treated as an uncared-for physical object.

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If lack of consideration for the child's intentionality is pervasive, consequences may occur not only at the functional but also at the neurodevelopmental level. The work of Bruce Perry (1997) suggests that the Romanian orphans who were institutionalized shortly after birth and suffered 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 the inference of 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 et al. 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 and Grossman 1993). Chronic exposure to the raised levels of cortisol associated with chronically insensitive caregiving may bring about neurodevelopmental anomalies that result in mentalizing deficit.

Personality Disorder and Deficit in Mentalizing

Turning now to the second proposition: are some characteristics of personality disorder rooted in a deficit of mentalization? In several studies, our team (Fonagy et al. 1996; Levinson and Fonagy in preparation) found low reflectiveness in the attachment narratives of individuals with criminal histories or borderline diagnosis. It is tempting to argue that some borderline states and problems of violence can be explained as *preoccupied* and *dismissive* forms of nonmentalizing self organizations, respectively. This is an oversimplification. 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, and Pipp 1990), we may assume that maltreatment is associated with a *fractionation* or splitting of reflective function across tasks and domains. Just as the understanding of conservation of liquid does not generalize to conservation of area, reflective capacity in one domain of interpersonal interaction may not generalize to others. In personality disorder, development goes awry—the normal coordination of previously separate skills does not come about, fractionation seems adaptive to the individual, and it comes to dominate over integration.

In certain contexts, then, the understanding of mental states in maltreated individuals is developmentally retarded. It is *teleological* rather than intentional (Gergely and Csibra 1997). Within this simpler model, which has been demonstrated in nine-month-old infants (Gergely et al. 1995) the behavior of physical as well as human objects is interpreted in terms of visible outcomes rather than desires, and in terms of constraints of *physical* reality rather than beliefs. 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 that he thinks there is still a shop on that side that sells umbrellas (belief state). (It actually closed two weeks ago; I snigger with appropriate *schadenfreude*). A small child would have interpreted the same action as a rational act given the observed physical constraints: say that he is able to walk faster (visible outcome), because there are too many people on this side of the

street (visible constraint). The mentalizing inferences of the intentional stance are no more likely to be correct than the physicalistic ones of the teleological mode. However, they are essential in intimate relationships.

Clearly, the application of the teleological stance becomes problematic in the context of attachment relationships. Assume that X was a close friend. Adopting the teleological stance may help me avoid upsetting myself by 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.

In our view, nonreflective internal working models come to dominate the behavior of personality-disordered individuals *only* in emotionally charged complex attachment relationships. Traumatized individuals can be disadvantaged because (1) their caregivers did not facilitate mentalizing capacity within a secure attachment relationship (vulnerability); (2) they have an emotional disincentive for taking the perspective of others who are hostile as well as non-reflective (trauma); (3) subsequent relationships are jeopardized by the lack of a model for attribution of mental state with regard to the original trauma and subsequent experiences (lack of resilience); and (4) they may divide mentalizing resources unevenly between their external and internal worlds, becoming at the same time *hyper-vigilant* towards others and *incomprehending* of their own states (uneven adaptation).

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Why should emotionally charged interactions trigger a “regression” to nonmentalistic thinking? Karlen Lyons-Ruth (Lyons-Ruth, Bronfman, and Parsons in press) has recently provided evidence for Main and Hesse’s (1991) 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 caregiver 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 nonmentalizing 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.

Thus far we have skirted around the central implication of this model. Reflective function and its attachment context are at the root

of self organization. The internalization of the caregiver's image of the child as an intentional being is central. If this is accurate, 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). When the child feels anxious, the caregiver's contingent reflection of this anxiety will be internalized, and will eventually serve as a symbol for the internal state (Gergely and Watson 1996). The representation will be true to the child's primary experience. Maltreatment and difficulty in mentalizing preclude such an organic self-image. Internal experience is not met by external understanding; it remains unlabeled and 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 biosocial attachment system the child seeks out aspects of the environment contingently related to his self-expressions. Whether or not these truly reflect the primary representation, they will tend to form the basis for secondary representation of self experience. Therefore, representation in the case of unresponsive parenting will be less meaningfully integrated and less symbolically bound. In place of an image corresponding to the constitutional self, the self-representation will be the representation of another. In the case of some maltreated children, this is not a neutral other but rather a torturing one. Once internalized and lodged within the self-representation, this alien representation has to be expelled, not only because it does not match the constitutional self, but also because it is persecutory. The consequences for affect regulation are then disastrous (Carlson and Sroufe 1995).

This state of affairs places a massive burden on those with borderline personality structure. In order for the self to be coherent, the alien and unassimilable parts require externalization; they need to be seen as part of the other where they can be hated, denigrated, and often destroyed. The physical other who performs this function must remain present if this complex process is to operate. The borderline child or adult cannot feel that he is a self unless he has the other (often the therapist) present to frighten and intimidate, to seduce and excite, to humiliate and reduce to helplessness. The other's departure signals the return of his "extrojects," and the destruction of the coherence the child achieves by projecting them.

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 thereby. Although the individual is then is an active agent and in control, despite the fragility of the self, a heavy price is paid. By forcing others to behave as if they were part of his internal representation, the potential of a “real” relationship is 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 their own emotional states, associated with the absence of symbolic representations of them, and (b) the dominance of prementalistic physical-action-centered strategies, particularly in threatening relationships. In the nonmentalistic teleological mode, behavior of the other is interpreted in terms of its observable consequences, not 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 to intervene appears to be through physical action. This may include words, which although they sound like an attempt at changing the other person’s intentions, are in fact intimidation: efforts to force the other person into a different course of action. Only a physical endstate is envisioned. This may be represented in terms of the other person’s body; these patients 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 favorite, and beat his son so hard that he fractured the child’s arm as he raised it to protect himself. The father’s mind in this example is working in a nonmentalizing (teleological) mode. 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 mentalization reduces the complexity of this representation; only one version of reality is possible, there can be no false belief (Fonagy and Target 1996). If the behavior of the other and knowledge of reality do not fit, normally we try to understand the behavior in mentalizing terms. For example, "He mistook my \$20 bill for a \$10 bill (false belief). That is why he only gave me \$5 change." If such 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 nonreflective, coercive caregiving, leads to paranoid constructions of the other's desire state.¹

Mentalization acts as a buffer: when actions of others are unexpected, this buffer function allows one to create auxiliary hypotheses about beliefs that 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 mentalization buffer allows one to play with reality (Target and 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 an analyst, 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 recognizing alternative underlying motivations and beliefs to account for the observed behavior.

¹The striking facet of such constructions is that they tend to be self-related. The individual with a self-representation constructed around an abusive caregiver is constantly on the alert to externalize this persecutory self-representation. He needs enemies to prevent the destructiveness within.

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 with which such patients are forced to live. When the other is needed for self-coherence, abandonment means the reinternalization 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 *them*.

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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 mentalizing 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 including 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 and oversimplified, and allow for only the illusion of mentalized interpersonal interchange.

6. A further common experience of such patients is the feeling of *emptiness* that 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 mentalization creates a deep sense of isolation. To experience being with another, the other person has to be there as a mind; mental states provide the link that are required to feel the continuity between past and present. Emptiness (and in extreme cases a sense of dissociation) is the best description such individuals can give of the absence of meaning that the failure of mentalization 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 mentalization. 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, a subtle bidirectional causal process is inherent in such biological vulnerabilities. Vulnerabilities do not only place limitations on the child's capacities; they also provoke situations of interpersonal conflict. Thus biological factors can limit mentalizing potential, but they may also act by generating environments where mentalization 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 mentalization is not a core dysfunction? The likely solution to this puzzle is that patients with severe personality disorders do develop a certain level of nonconscious mind-reading skills. Clements and 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 nonverbal reactions, such as eye movements. It is conceivable that, at a stage when such nonconscious mind-reading skills begin to evolve, the implications for the child of 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 nonconscious level to mental states, although they repudiate consciousness of it. It is not that borderline patients are "mind blind"; it is rather that they are not "mind conscious." They pick up on cues that influence the behavioral system, but these do not surface in terms of conscious inferences. It is psychoanalysis that removes the inhibition against conscious awareness of mental states.

Third, not all parents of individuals with problems related to mentalization 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 mentalization (Slade et al. 1999). Arietta Slade's pioneering work on the measurement of parental representations of the specific infant is a major development in this context.

PSYCHOTHERAPY, PSYCHOANALYSIS, AND MENTALIZING

It is our premise that the *crucial* therapeutic aspect of psychoanalysis—for both children and adults—lies in its capacity to activate the patient's ability to find meaning in their own and other people's behavior. Psychoanalysis has always aimed at strengthening the patient's capacity to recognize mental states. To achieve this, the treatment needs to be intensive and multifaceted, yet also organized within a common theoretical frame. We believe that a therapeutic program that engages in a *systematic* effort to enhance mentalization holds the promise of increasing the therapeutic effectiveness of psychoanalysis for individuals with more severe and complicated difficulties, by specifically tailoring therapeutic intervention to their particular configuration of clinical and developmental problems. Psychoanalysis with severe personality disorders in the context of the model we have been discussing has three aims: (1) to establish an attachment relationship with the patient; (2) to use this to create an interpersonal context where understanding of mental states becomes a focus; and (3) to create situations (mostly implicitly) where the self is recognized as intentional and real by the therapist, and this recognition is clearly perceived by the patient.

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Let me briefly summarize some technical implications of this model. Interpretations, as traditionally conceived, may not have their expected consequence because the process that mediates these forms of pathology is not a symbolic representational one. The analyst inevitably becomes entangled in a relationship dominated by a teleological mode of thinking, wherein the patient is determined to bring about visible outcomes through impacting on the reality constraints of the analytic situation. The analyst, all too often, is faced with an impossible task: unless he allows this form of infringement, the patient's unconscious goal of externalizing an alien part of the self will fail, and premature termination of treatment may be the consequence. For the patient, the outcome must be real, yet the analyst's acceptance of such visible or

concrete projections naturally threatens his capacity to think, and to make the analysis worth the patient's while. The analyst must become the person the patient needs him to be, yet simultaneously retain in a part of his mind a representation of the patient's mental state, and represent this to the patient with sufficient clarity to provide the basis of a mentalizing self-representation.

There is a danger in crediting borderline patients' material with more meaning than it really contains. There is a genuine countertransference resistance against recognizing the barrenness of the internal world of a nonreflective patient. In some other patients reflective function may appear to exist, but it does so in a vacuum, in outer space, painfully and rigidly separated from actual psychic experience. The progress of such an analysis might resemble that of a car whose wheels are stuck in sand. To overestimate the patient's mental capacity, to consider that his psychic reality is similar in quality to that of the analyst, can lead to a fruitless and repetitive search after truth. Reflective function can exist separately from actual affective experience.

Accepting and recognizing the mental chaos of the patient and abandoning the traditional stance of piecing together memories may be the first step of the process. The therapist adopts a nonpragmatic, elaborative, mentalistic stance, which places a demand on the patient to focus on the thoughts and feelings of a benevolent other. This stance, in and of itself, enhances, frees, or disinhibits the patient's inborn propensity for reflection and self-reflection. Perhaps more important, he is able to find himself in the mind of the therapist as a thinking and feeling being, a representation that never fully developed in early childhood and was probably further undermined subsequently by painful interpersonal experience. In this way, the patient's core self-structure is strengthened, and sufficient control is acquired over mental representations of internal states so that psychoanalytic work proper can begin. Even if work were to stop here, much would have been achieved in terms of making behavior understandable, meaningful, and predictable. The internalization 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 that drives and organizes the therapeutic endeavor, and speaks with greatest clarity to our psychoanalytic heritage.

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