Attachment and borderline personality disorder: A theory and some evidence

Peter Fonagy, PhD, FBA

Peter Fonagy, PhD
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

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Attachment and mentalising

Mary Main and Inge Bretherton independently drew attention to what the philosopher Dennett called the „intentional stance". Dennett (1987) stressed that

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

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 important, to anticipate each others‘ actions. If the child is able to attribute an unresponsive mother‘s apparently rejecting behaviour 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 3-4 years that behaviour 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 term mentalisation or reflective function which denotes the understanding of one‘s own as well as others‘ behaviour in mental state terms. 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 states with reality. His friend cannot see what is inside the tube, yet the pre-mentalising child assumes an isomorphism between what he knows as realty and what he imputes as his friend‘s mental state. This literature has been carefully cosidered from a psychoanalytic perspective by Linda Mayes and Donald Cohen (Mayes & Cohen, 1993; Mayes, Cohen, & Klin, 1991).

In a program of work over the last ten years we have attempted to operationalise individual differences in adults‘ mentalising capacities. Our operationalisation 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 I.Q. and educational background. We were curious to know if the extent of reflective observations about the mental states of self and others in AAI narratives could predict infant security. Reflectiveness ratings made before the child‘s birth powerfully predicted the child‘s attachment security in the 2nd year of life. *Both fathers and mothers who were rated high in this capacity were three or four times more likely to have secure children than parents whose reflective capacity was poor* (Fonagy, Steele, Moran, Steele, & Higgitt, 1991).

The capacity for understanding false beliefs may be particularly important when the child is exposed to unfavourable experiences, in the extreme, abuse or trauma. We divided our sample into 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 rating was high. *All of the mothers in the deprived group with high reflectiveness ratings had children who were secure with them, whereas only 1 out of 17 of deprived mothers with low ratings did so.* Reflective function seemed to be a far less important predictor for the non-deprived 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, Steele, Steele, Higgitt, & Target, 1994).

Mentalising 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 also secure attachment may be a key precursor of robust reflective capacity (Fonagy et al., 1995). In our longitudinal study of 92 children with Miriam and Howard Steele, the proportion of secure children was twice as high in the group which passed a false belief task, compared to the group which failed. Mother‘s reflective function was also associated with the child‘s success. 80% of children whose mothers were above the median in reflective function passed, whereas only 56% 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 mentalisation. We assume that a secure attachment relationship provides a congenial context for the child to explore the mind of the caregiver, and in this way to learn about minds. The philosopher Hegel (1807) taught us, 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 endeavours 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 internalised 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 mentalising individual. The

development of awareness of mental states in oneself can then be generalised to the caregiver. *Thus a „theory of mind" is first of all a theory of self.*

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 caretakers who were themselves within the so called ‚borderline spectrum' of severe personality disorder (Barach, 1991; Benjamin & 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, 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 further reduced (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 mentalise; 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 (Schneider-Rosen & Cicchetti, 1984; 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 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. They could not solve puzzles requiring 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. Their ability to adapt to, modify or avoid the perpetrator's behaviour 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 disorganised 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 recognises 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 behaviour. 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 which 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 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, institutionalised 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 disorganised 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 which result in mentalizing deficit.

Personality disorder and deficit in mentalising

So, 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 & 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 hyper-sensitive 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. Just as the understanding of conservation of liquid does not generalise to conservation of area, reflective capacity in one domain of inter-personal interaction may not generalise to others. 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 comes to dominate over integration.

In certain contexts then, the understanding of mental states of the maltreated individuals is developmentally retarded. It is „teleological“ rather than intentional (Gergely & Csibra, 1997). Within this simpler model, which has been demonstrated in 9 months old infants (Gergely, Nadasdy, Csibra, & Biro, 1995) the behaviour of physical as well as human objects is interpreted in terms of visible outcomes rather than desires, and 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 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). As a small child the same action would have been interpreted as a rational act given the 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 mentalising inferences of the intentional stance are no more likely to be correct than the physicalistic ones of the teleological mode. 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 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.

In our view, non-reflective internal working models come to dominate the behaviour of personality disordered individuals only in emotionally charged complex attachment relationships. Traumatised individuals can be disadvantaged because a) their caregivers did not facilitate mentalising capacity within a secure attachment relationship (vulnerability); b) they have an emotional disincentive for taking the perspective of others who are hostile as well as non-reflective (trauma); c) subsequent relationship are jeopardised 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 incomprehending of their own states (uneven adaptation).

Why should emotionally charged interactions trigger a „regression“ to non-mentalistic thinking. Karolyn Lyons-Ruth has recently provided evidence for Main and Hesse‘s hypothesis that caregivers of disorganised infants frequently respond to the infant‘s distress by frightened or frightening behaviour. 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.

Thus far we have skirted around the central implication of this model. 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. 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 internalised, and eventually serve as a symbol for the internal state (Gergely & Watson, 1996). The representation will be true to the child‘s primary experience. Maltreatment and difficulty in mentalising 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 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 another representation. Disastrously, in the case of some maltreated children, this is not a neutral other but rather a torturing one. Once internalised 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 (Carlsson & Sroufe, 1995).

This state of affairs places a massive burden on those with a borderline personality structure. In order for the self to be coherent, the alien and unassimilable parts require externalisation, 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 for this complex process to operate. The borderline child or adult cannot feel that he is a self unless he has the other present (often the therapist) to frighten and intimidate, to seduce and excite, to humiliate and reduce to helplessness. The other‘s departure signals the return of these „extrojects“ and the destruction of the coherence the child achieves by such projection.

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 externalised 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, behaviour of the other is interpreted in terms of its observable consequences, rather than as being driven by desire. It is only when behaviour 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 behaviour 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 this example. 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 behaviour of the other and knowledge of reality do not fit, we normally try to understand

the behaviour 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[2].

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 traumatised 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 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 recognising alternative underlying motivations and beliefs to account for the observed behaviour.

4. A brief word about <u>suicidality</u>. Clinicians are familiar with the enormous fear of physical abandonment in borderline patients. This, perhaps more than any other aspect, alerts clinicians to the disorganised 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 fantasised 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

[2] The 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 externalise this persecutory self-representation. He needs enemies to prevent the destructiveness within.

been that only something extreme would bring about changes in the adult's behaviour, and that their caregivers' used similarly coercive measures to influence their own behaviour.

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 idealised and a persecutory identity. The individual finds it impossible to use both representations simultaneously. Splitting enables the individual to create mentalised images of others but these are inaccurate, over-simplified and allow for only an illusion of mentalised 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 behavioural system but this does not surface in terms of conscious inferences. It is psychoanalysis which removes the inhibition over conscious awareness of mental states.

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). 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 mentalising

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 behaviour. Psychoanalysis has always aimed at strengthening the patient's capacity to recognise mental states. To achieve this the treatment indeed needs to be intensive, but also multi-faceted yet organised 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 more 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) the aim to

establish an attachment relationship with the patient; 2) the aim to use this to create an inter-personal context where understanding of mental states becomes a focus and 3) an attempt, mostly implicit, to create situations where the self is recognised as intentional and real by the therapist and this recognition is clearly perceived by the patient.

Let me briefly summarise some technical implications of this model. Interpretations, as traditionally conceived, may not have their expected consequence because it is not a symbolic representational process which mediates these forms of pathology. The analyst inevitably becomes entangled in a relationship dominated by a teleological mode of thinking where 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 externalising an alien part of the self would have failed. The 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 make the analysis worth the patient‘s while. The analyst must simultaneously become the person the patient needs him to be at the same time as retaining in a part of his mind a representation of the patient‘s mental state, and re-present this to the patient with sufficient clarity to provide the basis of a mentalising self representation.

There is a danger in crediting borderline patients‘ material with more meaning than it really contains. There is a genuine counter-transference resistance against recognising the barrenness of the internal world of a non-reflective 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. The over-estimation of the patient‘s mental capacity, the consideration of his or her psychic reality as being similar in quality to that of the analyst, can lead to a fruitless and repetitive search after truth. Reflective function can exist separately from the actual affective experience.

Accepting and recognising 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 non-pragmatic, 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, the representation that never fully developed in early childhood and was probably further undermined by subsequent 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 behaviour 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 psychoanalytic heritage.

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