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Chapter 6

Mentalization and Attachment in Borderline Patients in Transference Focused Psychotherapy

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INTRODUCTION

Mentalization, or the capacity to think in terms of intentional mental states of self and other, is at the basis of human interpretive capacities, and as such it has been identified as both a major goal of treatment and a key mechanism of change in psychodynamic psychotherapy with borderline patients (Bateman & Fonagy, 2004a, 2004b; Levy, Clarkin, et al., 2006; Yeomans, Clarkin, Diamond, & Levy, in press). More specifically, mentalization refers to recognition that the mind is representational in nature, and that “what is in the mind is in the mind, and reflects knowledge of one’s own and the other’s mental states” (Bateman & Fonagy, 2004b, p. 36). Fonagy and his colleagues (Fonagy, Gergely, Jurist, & Target, 2002) have linked mentalization to an Interpersonal Interpretive Mechanism (IIM), which is a fundamental aspect of the evolutionary selective advantage of the attachment behavioral system. This mechanism, which involves the capacity for psychological interpretation—that is, the ability to make sense of the beliefs and desires that motivate human behavior, to distinguish psychological states of self and other, to create meanings, and to enrich symbolic thinking—is thought
to be deficient in patients with severe personality disorders. These theoretical formulations are supported by an impressive body of developmental and clinical research (Fonagy et al., 2002) that suggests that deficits in mentalization—which are developed in the context of insecure attachment relationships, often characterized by early unresolved trauma—is an enduring characteristic of borderline pathology (Fonagy et al., 2002). The development of the capacity for mentalization in the context of a secure attachment relationship with the therapist, leading to increased coherence, integration, and modulation in the representational world, has become the hallmark of psychodynamic approaches to treatment of severe personality disorders (Bateman & Fonagy, 2004a; Fonagy, 1999; Kernberg, 2004a). In this paper we will review and critique the concept of mentalization as it is applied to the theory and treatment of patients with severe personality disorders from the vantage point of object relations theory, particularly Kernberg’s object relations model.

Finding the most effective methods of treating this group of patients, who are characterized by chronic suicidal and parasuicidal behaviors; identity diffusion; dissociative states that may or may not be linked to early trauma (Paris, 1994); chaotic, unstable interpersonal relationships; affective volatility and impulsivity; impaired occupational functioning; and overutilization of health services (see Clarkin, Foelsch, Levy, Hull, Delaney, & Kernberg, 2001), has become increasingly important as borderline patients have become more prevalent among both inpatient and outpatient groups. Patients with borderline personality disorder now characterize 1–4% of the general population, 10–15% of psychiatric outpatients, and up to 20% of psychiatric inpatients (Lenzenweger, Loranger, Korfine, & Neff, 1997; Paris, 1999; Torgersen, Kringlen, & Cramer, 2001; Weissman, 1993). In keeping with the increased emphasis on the development and implementation of empirically validated treatments, investigations of borderline patients and their treatment have moved beyond theoretical elaborations about the nature of the pathology itself to the development of evidence-based treatment approaches that can be manualized and assessed for efficacy and outcome.

In the psychodynamic realm, the two major manualized treatments for BPD are Transference Focused Psychotherapy (TFP, Clarkin, Yeomans, & Kernberg, 1999, 2006) based on Kernberg’s (1984) object relations model, and Mentalization Based Treatment (MBT, Bateman & Fonagy, 2004a), based on Fonagy and colleagues’ (Fonagy, 2006) formulation of mentalization, which integrates philosophy, and attachment theory. In the dialectic approach is Linehan’s (1993) Dialectic Behavioral Therapy (DBT) that has demonstrated efficacy in utilizing, and suicidality in borderline patients (Linehan, Armstrong, Suarez, Allmon, & Comtois, 1993, Linehan et al., 2000).

Bateman and Fonagy (2004b) highlight that the latter methods for BPD are built, in part, on insights the former referring to the largely unacknowledged self-and that has its roots in nonverbal mirroring, relatively conscious intentional interplaying the mental states of self and of mentalization has been operationalized as the capacity to think in mental-state terms, (Fonagy, Target, Steele, & Steele, 2006). To date, however, TFP is the one empirically associated with improvement as assessed by increases in RF ratings improvement (Levy, Meehan, et al., 2006; see previous publications, we discuss the techniques that we believe lead to improvement for borderline patients in TFP, with a focus frame and on the techniques of clarification, interpretation (Levy, Clarkin, et al., 2006), most of our interpretative approaches and explicit mentalization. We first describe and divergence between TFP and MBT view of TFP and its theoretical foun
based on Fonagy and colleagues’ (Fonagy et al., 2002) developmental theory of mentalization, which integrates philosophy (theory of mind), ego psychology, and attachment theory. In the cognitive behavioral realm the major approach is Linehan’s (1993) Dialectical Behavior Therapy (DBT), which integrates cognitive behavioral theory with dialectical philosophy and Buddhist principles of mindfulness. All three groups have developed theoretically consistent, evidence-based, comprehensive treatment programs for BPD that have demonstrated efficacy in reducing symptomatology, service utilization, and suicidality in borderline patients (Bateman & Fonagy, 1999, 2001, 2003, 2004a; Clarkin & Levy, 2003; Levy, Meehan, et al., 2006; Linehan, Armstrong, Suarez, Almon, & Heard, 1991; Linehan, Kanter, & Comtois, 1993, Linehan et al., 2006).

Bateman and Fonagy (2004b) have proposed that all effective treatments for BPD are built, in part, on implicit and explicit mentalization, with the former referring to the largely unconscious, procedural mental activity that has its roots in nonverbal mirroring transactions, and the latter referring to relatively conscious intentional reflective processes involved in contemplating the mental states of self and others (Allen, 2003). The concept of mentalization has been operationalized in the Reflective Function (RF) scale (Fonagy, Target, Steele, & Steele, 1997), an attachment-based measure of mentalization, which provides us with a tool to evaluate changes in the capacity to think in mental-state terms over the course of treatment (Diamond, Stovall-McClough, Clarkin, & Levy, 2003; Levy, Meehan, et al., 2006). To date, however, TFP is the only therapeutic modality that has been empirically associated with improvements in the capacity for mentalization as assessed by increases in RF ratings over the course of one year of treatment (Levy, Meehan, et al., 2006; see summary of research below).

In previous publications, we delineated the specific treatment techniques that we believe lead to improvements in the capacity for mentalization for borderline patients in TFP, with a focus on the role of the treatment frame and on the techniques of clarification, confrontation, and particularly interpretation (Levy, Clarkin, et al., 2006). In this paper we will discuss more fully our interpretive approach and its relationship to implicit and explicit mentalization. We first delineate some of the points of contact and divergence between TFP and MBT, and provide a more detailed overview of TFP and its theoretical foundations. Next we summarize recent
research findings from three studies on the efficacy of TFP, which examine changes in attachment status, reflective function, and symptomatology in borderline patients over the course of one-year, twice-weekly TFP treatment. Finally, we present case material to illustrate our general outcome data, as well as data on reflective functioning (RF) as a mechanism of change in TFP, and discuss how our research and clinical investigations have led to an expansion of the concept of mentalization.

**MBT AND TFP: COMMON GROUND AND CONTROVERSIES**

The concept of mentalization as developed by Fonagy and colleagues, which emphasizes the cognitive aspects of the structuralization of the representational world, is complementary to the object relations foundations of TFP (Kernberg, 2004a). Improvements in the capacity for mentalization are sought by both approaches to go hand in hand with the capacity to develop fuller and more elaborated representations of the self and internal objects (Fonagy, 1999; Kernberg, 2004a). As Fonagy (1999) has observed, “enhanced reflective capacity allows patients to integrate split off parts of the self and create representations with complex thoughts, mixed emotions and differentiated desires” (p. 16). Further, the perspectives of TFP and MBT converge around the idea that changes in mentalization are catalyzed through the here-and-now experiences with the therapist rather than through excavation and exploration of past experiences. However, there are fundamental differences between the two approaches in the following areas: (a) the etiology of borderline disorders; (b) the centrality of affect; (c) the type and function of interpretation; and (d) the nature of the internal world.

**THE ETIOLOGY OF BORDERLINE PATHOLOGY**

Fonagy and his colleagues have made fundamental contributions to understanding borderline psychopathology by linking it with insecure attachment, and by articulating the basic mechanisms of early parent-infant interactions, including contingent marked mirroring in infancy, pretend play in early childhood, and talk about mental states in later childhood—all of which are thought to consolidate the development of object relationships, setting the foundation for mentalization and disorganized states of mind (e.g., the latter involving lack of resolution of earlier attachment trauma; Fonagy et al., 1996; Fonagy et al., 2003). Our research investigations, along with those of others, suggest that the majority of borderline patients are characterized by disorganization and disorientation and disengagement with others, and that this disorganization stems from disorganization of and/or boundary confusion (Fonagy et al., 2003, 2008; van IJzendoorn & Van den Bergh, 2008). The individual shuts down the capacity to mentalize the complexities of the internal world into rigidly idealized and persecutory representations.

These formulations advance our understanding of the development of borderline disorders in expanding the role of traumatic early attachment relationships. They also move us away from other formulations that have shown that early attachment trauma leads to a disorganization of affective understanding and emotional regulation, which may then lead to aggressive and uncontrolled behaviors (Luyten & Fonagy, 1993). Our model of borderline pathology emphasizes that the core pathology is a deficit in mentalizing ability, characterized by a critical deficit in understanding and interpreting the world, with low, effortful control—
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talization (Allen, 2003). Our research investigations, along with those of Fonagy and colleagues, suggest that the majority of borderline patients are characterized by insecure and/or disorganized states of mind with respect to attachment, with the latter involving lack of resolution of early traumatic experiences (Diamond et al., 2003; Fonagy et al., 1996; Levy, Meehan, et al., 2006. According to Fonagy and colleagues, borderline patients inhibit their capacity to comprehend the mental states, motivations, wishes, feelings, and thoughts that govern behavior—their own and that of others—either (a) as a defensive reaction to severe chronic abuse and/or neglect, which protects them from contemplating the frightening and heinous intentions of those who abused them; or (b) as a deficit resulting from early pathogenic, unmarked, and noncontingent interactions in which the caregiver either fails to accurately and empathically recognize the child’s mental states, or imposes her own mental states on those of the child. In either case the child is left with a legacy of overwhelming unmentalized psychic experiences and/or boundary confusion (Fonagy et al., 2002). As a result of either scenario, the individual shuts down the capacity to think in multifaceted or complex ways about the mental states of self and other, and instead splits the internal world into rigidly idealized and persecutory sectors.

These formulations advance our understanding of the etiology of borderline disorders in expanding the role of trauma into the realm of problematic early attachment relationships. There are now a number of studies that have shown that early attachment traumas and especially physical, psychological, and sexual abuse, are significantly more prevalent in patients with severe personality disorders than in patients with milder personality pathology or the general population (Paris, 1994). However, there is also increasing evidence that irregularities of the neurochemical and neurohormonal systems function as inborn dispositions to levels of intensity, rhythm, and threshold for affective response, and particularly to negative affect, leading to aggressive and uncontrolled behavior (Kernberg, 2004a; Stone, 1993). Our model of borderline pathology posits a dynamic interaction of temperament—especially a preponderance of negative affect over positive affect and low, effortless control—with the absence of a coherent sense of
self and others, under the influence of an insecure working model of attachment (Depue & Lenzenweger, 2005; Clarkin & Posner, 2005; Posner et al., 2003). While we take into account the etiological role of trauma, including trauma deriving from insecure/disorganized attachment, the emphasis of our treatment is on the ways in which trauma contributes to configuring the internal representational world. Fonagy and colleagues acknowledge that, for borderline patients, representations of self and others are imbued with rageful or idealizing affects that are not amenable either to reflection or modulation (Fonagy, 1999). Although these researchers highlight the contributions of deficits in affect regulation, they tend to play down the centrality of negative affect and difficulties with its regulation—which they attribute almost solely to deficits in mentalization—to the etiology of borderline disorders. (We will expand on our understanding of the etiology of BPD below.)

THE CENTRALITY OF AFFECT

In our view, mentalization encompasses not only a set of cognitive functions, such as representing and reasoning about beliefs and desires of self and others, but also the capacity to represent and regulate affects, to signify the subjective aspects of affects, and to connect affects with their representational roots. Kernberg’s (2004a) object relations model offers a comprehensive theory of the development of the capacity to symbolize and regulate affect, and of the complex processes through which the concepts of self and other evolve out of early affective experiences. These are all crucial aspects of the process of mentalization that have been perhaps under-theorized given the emphasis on mentalization as a set of cognitive skills and processes linked to theory of mind. In emphasizing the affective roots of mentalization we are contributing to a trend to propel the concept of mentalization (and the theory of mind with which it is linked) beyond the cognitive sphere into the affective realm by focusing on how young children’s efforts to manage and comprehend the feelings of self and others provide pathways to understanding of mental states (Carpendale & Lewis, 2004; Fonagy, in press; Gergely & Unoka, in press; Thompson, Laible, & Ontai, 2003). However, despite this recent emphasis on the role of affect activation and modulation in the development of mentalization, the focus of Fonagy and colleagues is on processes that are at the basis of mentalization, building up of complex object relations, affect activation and hence contribute to regulation. To this trend is the work of Jurist (2000) on “mentalyzed affectivity,” which integrates theory with the theory of mentalization, affectivity as an “exploration of how our affects are experienced through the lens of the representational world—in other words, affects are experienced through the lens of the imagined” (p. 429). Thus, mentalized affects are recognized, understood, and regulated.

Kernberg’s object relations model specifies physiological dispositions that are activated in the context of the development of object relations with self and object representations in ele-

ment and unpleasurable experiences accumulate, and come to form in their suprasympathetic blocks for libidinal and aggressive drives, and objects eventually evolve into the nuclear self (ego, id, and superego). In Kernberg’s view, a primary motivational system that governs momentary experiences of gratification or experience of pleasure or unpleasure in these relations. Affects, which are activated by facial expressions in early mirroring exchanges, serve a communicative function (Kernberg), and/or a cognitive component, as well as a subject affect, along with psychomotor activation phenomena. Thus, the early activation of the mother–infant relationship is necessary to facilitate the attachment behavioral system and the development of object relations, so that these two spheres do not overlap. Further, the early affective activation of a dyadic relation between self
The focus of Fonagy and colleagues is on the immediate interpersonal processes that are at the basis of mentalizing capacities, rather than on the building up of complex object relationships that structure and modulate affect activation and hence contribute to mentalization. The one exception to this trend is the work of Jurist (Fonagy et al., 2002; Jurist, 2005) on “mentalized affectivity,” which integrates Kernberg’s object relations theory with the theory of mentalization. Jurist (2005) defines mentalized affectivity as an “exploration of how our affective experience is mediated by the representational world—in other words how current (and future) affects are experienced through the lens of past experiences, both real and imagined” (p. 429). Thus, mentalized affectivity involves the capacity to recognize, understand, and regulate the self’s affective states.

Kernberg’s object relations model sees affects as the primary psychophysiological dispositions that are activated by early bodily experiences in the context of the development of object relations. Affects become linked with self and object representations in elementary dyads as highly pleasurable and unpleasurable experiences accrue in the course of early development, and come to form in their supraordinate organization the building blocks for libidinal and aggressive drives, while the representation of self and objects eventually evolves into the more complex tripartite structure (ego, id, and superego). In Kernberg’s view, then, primitive affects constitute a primary motivational system that integrates cognitive appraisal of the momentary experiences of gratification or frustration with the subjective experience of pleasure or unpleasure in the context of particular object relations. Affects, which are activated by crucial and distinctive patterns of facial expressions in early mirroring exchanges between infant and caregiver that serve a communicative function (Kernberg, 2004a), thus include a cognitive component, as well as a subjective component of pleasure and unpleasure, along with psychomotor activation and neurovegetative discharge phenomena. Thus, the early activation of affects in the context of the mother–infant relationship serves simultaneously to trigger and consolidate the attachment behavioral system and to build up the internalized world of object relations, so that these two spheres are inevitably linked although not synonymous. Further, the early affective exchanges set the foundation for mentalization since in the course of development each momentary activation of a dyadic relation between self and object contributes to and is
then confronted by a more permanent integrated view of self and others against which the momentary state can be evaluated.

From an object relations perspective, then, affects are the primary vehicles that give rise to primary representations (Kernberg, 2004a; Sandler & Sandler, 1998). The movement from primary to secondary representations involves a cognitive framing of affect that contributes to the building up of self and object representations. Through the process of marked and contingent mirroring transactions, which facilitate affect regulation and shape the infant's experience of internal and external reality, primary representations are transformed into secondary representations characterized by more realistic models of self and significant others that are gradually consolidated into a stable, overarching concept of self and object. In the treatment of severely disturbed patients, interpretation contributes to a move from primary to secondary representations, with a concomitant modulation and integration of affective states. In Bion's (1962, 1967, 1970) terms, interpretation functions as "an apparatus for thinking" that serves the purpose of transforming "beta elements" into "alpha elements." The object relations approach in TFP involves working directly with affect through interpretation as it is mobilized in the transference. By contrast, Bateman & Fonagy (2004a) believe that mentalization is most likely to be enhanced when affect is quiescent, and when the attachment behavioral system with its associated affects is not activated.

**INTERPRETATIVE ACTIVITY AND MENTALIZATION**

The focus on interpretation differentiates TFP from both MBT and the cognitive behavioral approach of Linehan (1993). Bateman (Bateman & Fonagy 2004a, 2004b) has proposed that interpretation is at the heart of all psychodynamic treatments for borderline patients. However, he and his colleagues have stipulated that even in interpretive therapies such as TFP, the mutative factor in the treatment is not the specific content of interpretations, but the process of engaging the patient in the contemplation of his or her own mental states and those of the therapist. Furthermore, MBT advises against interpretation except in advanced stages of therapy.

Although we agree that the focus on mental states in the context of an attachment relationship with the therapist is a fundamental aspect of psy-

chodynamic treatment with borderline patients (Kernberg, 2004a), TFP does not limit its approach as defined by Bateman and Fonagy (2004a). The approach focuses first on clarifying and understanding states experienced in the moment and the exploration of mental states that are split off, and then to a more detailed explication of the relationship between our conceptualizations of transference, affect, and mentalization in TFP treatment.

**TRANSFERENCE FOCUSED PSYCHODYNAMIC THERAPY**

TFP is based on an understanding of both psychoanalytic (object relations) concepts of personality, especially the concept of the self, and the diffusion (Kernberg, 1984, 2004b, 2006) of behavior and neurobiological variables, such as the idea that early affective experiences are a major factor in course of development, and become structured as "object relations dyads"—units that appear in the self in relation to a specific representation, such as object relations dyads that are not exact, accurate, but rather reflect the complex nature of the transference and conflicts that are evoked in interactions in early development, as well as the actual or distorting influence (Diamond & Blatner, 1984).

In borderline individuals, as developed object relations dyads do not become integrated into self and others, as is the case in normal psychoanalytic dyads associated with sharply divergent object relations, as is the case in polarized and chaotic affects, the lack of continuity of the borderline individuals, as well as the ability to use differentiation, awareness than others, so that, for example, they may form a defensive configuration to protect against the threat of more loving, gratifying representations.
ent integrated view of self and others can be evaluated.

Objectively, then, affects are the primary presentations (Kernberg, 2004a; Sandler et al. 2004) primary to secondary representations affect that contributes to the building of self and object. Through the process of marked and rich affect regulation and shaping external reality, primary representations characterized by more others that are gradually consolidated of self and object. In the treatment of affect contributes to a move from pri-

with a concomitant modulation and 

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ence. By contrast, Bateman & Fonagy are most likely to be enhanced when affective behavioral system with its asso-

chodynamic treatment with borderline patients (Bateman & Fonagy, 2004a; Kernberg, 2004a), TFP does not limit its focus to improving mentalization as defined by Bateman and Fonagy (2004a). Rather, our interpretive approach focuses first on clarifying and understanding the conscious mental states experienced in the moment and moves gradually toward the exploration of mental states that are split off, denied, and/or repressed. We now turn to a more detailed explication of TFP to further clarify the relationship between our conceptualizations of BPD and of the roles of interpretation, affect, and mentalization in TFP treatment.

**Transference Focused Psychotherapy (TFP)**

TFP is based on an understanding of borderline personality that combines psychoanalytic (object relations) concepts of the structural organization of personality, especially the concept of the split internal world and identity diffusion (Kernberg, 1984, 2004b, 2006), and ideas of interaction between behavior and neurobiological variables, as delineated above. TFP is based on the idea that early affective experiences are cumulatively internalized in the course of development, and become established in the psychological structure as “object relations dyads”—units that combine a specific representation of the self in relation to a specific representation of the other linked by a specific affect. These dyads are not exact, accurate representations of early experience, but rather reflect the complex mesh of fantasy, drive, affect, wishes, and conflicts that are evoked in interactions with primary attachment figures in early development, as well as the activation of defenses and their adaptive or distorting influence (Diamond & Blatt, 1994; Kernberg, 1980, 2004a).

In borderline individuals, as development proceeds, these separate dyads do not become integrated into unified or mature concepts of self and of others, as is the case in normal psychological development. Instead, dyads associated with sharply divergent affects (e.g., idealized and persecutory) exist in polarized and chaotic relation to one another, and determine the lack of continuity of the borderline patient’s subjective experience of self and others. Furthermore, different dyads may be closer to conscious awareness than others, so that, for example, aggressively laden dyads may form a defensive configuration to protect the individual from awareness of more loving, gratifying representations of self and other, or vice versa.
While the patient has little conscious awareness of this split internal world, this structure underlies the symptoms of borderline personality such as chaos in interpersonal relations, emotional lability, black-and-white thinking, inchoate anger, contradictory behaviors, and proneness to lapses in reality testing.

TFP focuses on the transference because the patient lives out his or her predominant object relations dyads in the transference, as in other relationships. For the borderline patient, splitting leads to instability of the internal world, with chaotic alternating identifications with positive and negative, and idealized and persecutory representations or sectors of experience. The core tasks in TFP are to establish a stable relational context, to identify the patient’s predominant internal object relations dyads, and to help him or her observe, modulate, and integrate the split sectors of experience into unified coherent representations of self and other. The therapist’s task is to listen to the three channels of communication—the verbal, nonverbal, and countertransference—and first translate enactments and somatization (nonverbal channels through which borderline patients typically find affective expression without conscious awareness) into the corresponding affects, and then elaborate self and object representations that underlie the affect. As treatment proceeds, these dominant object relations are identified, and the roles of self and object are observed to repeat and reverse multiple times, as well as to appear alongside other dyads.

Hence, as treatment proceeds multiple sets of split-off object relations dyads that are derived from a number of behavioral systems emerge in the transference. These dyads’ impulsive or defensive functions must be systematically interpreted in order to be worked through. The combination of understanding and affective experience in the therapy leads to the modulation and integration of the split-off persecutory and gratifying representations, and the creation of an integrated identity and experience of others. By interpreting how the patient is experiencing the interaction at any given moment, and how the patient oscillates between identifying with the self and object aspects of the dyad, the therapist also introduces the observing third. Close monitoring of the countertransference, along with consistent attention to the multiple transference manifestations, fosters a split in the therapist in that one part of the therapist is a full participant in the affective maelstrom of the transference—countertransference—other part functions as a third, observing.

The nature and content of the interaction not only on the patient’s stage of treatment but also on the early stages of treatment, clarification and object representations predominate in the formation of the therapist’s view of the patient’s problem. If the patient is aware of self states and the perceptions of clarification of the patient’s appreciation of the moment, the therapist uses the techniques of attention, responses, or inconsistencies. These may be either within the patient or the therapist and are presented to the patient in a way that provides a clear, consistent understanding of the patient’s experiences.

The formulations of Fonagy and co-workers conceptualize and operationalize the patient’s experience as a process of self-construction and reorganization. This process involves the patient’s identification with the therapist, the patient’s perception of the therapist, and the patient’s representation of the therapist. The therapist engages the patient in reflection and interpretation of the patient’s experiences.

The patient’s affective experience is characterized by a highly emotional and impulsive nature, with frequent shifts in mood and behavior. The therapist’s role is to provide a stable relational context and to help the patient develop a sense of self and self-esteem. The therapist’s focus is on the patient’s inner world, and the patient’s experiences are interpreted and understood within this context.

TFP thus involves a stepwise interpretation of the patient’s experiences, moving gradually from clarification to clarification and from understanding to understanding. This process involves the patient’s identification with the therapist, the patient’s perception of the therapist, and the patient’s representation of the therapist. The therapist’s role is to provide a stable relational context and to help the patient develop a sense of self and self-esteem. The therapist’s focus is on the patient’s inner world, and the patient’s experiences are interpreted and understood within this context.
Mentalization and Attachment in Borderline Patients

The awareness of this split internal world, seen as an admixture of borderline personality traits, is a vital ingredient in treatment. The nature of borderline personality, such as emotional lability, black-and-white thinking, and proneness to lapses in mentalization, can lead to difficulties in the transference, as in other relational fields. Splitting leads to instability of the inner representations, with alternating identifications that are not always in sync with the therapist's mind. The therapist needs to establish a stable relational context, to establish object relations dyads, and to help the patient integrate the split sectors of expectations of self and other. The therapist's role in communication—the verbal, nonverbal, and physical enactments and somatic experiences—helps to provide a context in which the patient can experience mentalization.

The technique of clarification consists of the therapist's inviting the patient to expand his or her representation of present feeling states or other material, with the goal of becoming more aware of self-states and the perceptions of the other in the moment. After clarification of the patient's appreciation of the experience of self and other in the moment, the therapist uses the technique of confrontation to bring attention to contradictions or inconsistencies in the patient's communication. These may be either within the patient's verbal communication, comparing what he expressed at two different points in time, or between the verbal and nonverbal channels of communication at one moment in time. The therapist engages the patient in reflecting on these inconsistencies.

The formulations of Fonagy and colleagues have led us to expand our conceptualization and application of the technique of clarification. For example, in the case of patients who present with psychic deadness and severe affective constriction, or with severe history of trauma, a prolonged phase focusing on the identification, differentiation, and exploration of affect at the verbal and nonverbal level may be necessary. These techniques set the stage for early interpretations that deal with material that is generally conscious or preconscious, with interpretation of unconscious material coming into play only when the patient shows the capacity to make use of it.

TFP thus involves a stepwise interpretive process in which the therapist moves gradually from clarification and confrontation in the early stages to increasingly complex and multifaceted interpretations in the later stages. In the first phase of the interpretative process, interventions tend to be therapist- or analyst-centered (Steiner, 2002) in that they function to identify and articulate the patient's often polarized and inchoate experience of the therapist at any given moment, without exploring it. Such therapist-centered interpretations function to provide cognitive containment for primitive
affects that may be elicited as archaic split object relations are activated in the transference. The second phase involves identification of the dominant object relational dyads that are activated in the transference relationship, and of the role reversals that occur as the patient alternately identifies with the self and object aspects of the particular object relation. The concept of the patient ultimately identifying with the entire object relationship rather than just one pole of it is central to TFP. The third phase involves the integration of the split-off, idealized, and persecutory sectors of experience as they emerge in the here-and-now of the transference, and interpretation of how consciously held and prominent object relational dyads may defend against split-off material represented by other dyads (e.g., the aggression-laden dyads defending against gratifying or libidinal dyads). Finally, in the fourth stage object relational dyads and primitive defensive operations that emerge in the transference are linked to unconscious motivations, conflicts, and anxieties, and/or are placed in the context of past relationships. The interpretative process outlined above is epigenetic in nature, but involves repeated cycles involving different levels of interpretation adjusted to the patient's progress toward integration or movement away from it.

Although we believe that the more complex and advanced interpretations are an essential ingredient for integration of the internal world and the resolution of identity diffusion, we also hold to the idea that interpretation of any sort for borderline patients whose primary defense is splitting must deal with conscious self-states that are experienced sequentially in a fragmented way or dissociated. It is only in the later stages of treatment, when the patient’s primitive defenses have shifted to more mature ones, and in the context of a more consolidated identity, that interpretation deals with assumed unconscious states and motivations. The focus on unconscious meanings in the here-and-now in the arena of the transference follows Sandler & Sandler’s (1987) idea that analysis of “the present unconscious” provides a route to the unconscious template reflecting “the past unconscious.” That interpretations of split-off material are made primarily as this material emerges in the arena of the transference insures that they will have immediate affective resonance and that the treatment will not be derailed into intellectual speculation or pseudo-collaboration on the part of the patient. Through systematic attention to the transference, there is a “gradual transformation of pathological character patterns into an emotional experi-

ence and self-reflection in the transference” (Kernberg, 1992). The therapist’s interpretation of the patient’s direct therapeutic relationship is viewed as the route to the representational world, to the shift from insight and to improvements in the capacity for mentalization.

Our interpretative approach is based on the function of interpretation as the preserved reality testing and the capacity for mentalization, and are thus able to symbolize a range of intense affect, when symbolization may determine how we view, symbolization is a cognitive function that may reside in object relations alone although it is certainly found in other functions. Our approach differs somewhat from those of Fonagy, who hypothesized that borderline patients are incapable of mentalization as well as symbolization. Mentalization is not amenable to an interpretative approach. According to Fonagy and colleagues, the patient remains either concrete, functional, and over (or with little capacity to elaborate a separate intelligence), or, most often, sequestered in a mode (or pretend mode) leading in extreme forms to schizophrenia and thinking (Target & Fonagy, 1997). The way we enhance our understanding of the development of borderline disorders, they do not take into account the patient’s fantasy world in the transitional phase invested emotionally, and that this enlivens the therapeutic interactions.

The question has been raised about whether object affect dyads as they are mobilized in the reflective capacities of borderline patients through the course of treatment (Bateman & Fonagy, 2004a; Gabbard, 1998; Allen, Frieswyk, Newsom, et al., 1994). One talks about complex mental states in interpreting of treatment, there will be a pseudo-agreement without insight or scrutiny; mentalization may not lead to changes in behavior or in exter-
Mentalization and Attachment in Borderline Patients

Enne and self reflection in the transference” (Kernberg, 2004a, p. 126). The therapist’s interpretation of the patient’s direct affective experience of the therapeutic relationship is viewed as the route to increased integration of the representational world, to the shift from insecure to secure attachment, and to improvements in the capacity for mentalization.

Our interpretative approach is based on the idea that the symbolic function is not totally deficient in borderline patients, most of whom have preserved reality testing and the capacity for abstraction under most circumstances, and are thus able to symbolize except under conditions of intense affect, when symbolization may deteriorate defensively. In our view, symbolization is a cognitive function that does not depend on object relations alone although it is certainly fostered by it. These formulations differ somewhat from those of Fonagy and colleagues, who have hypothesized that borderline patients are inherently deficient in the capacity for symbolization as well as mentalization, and that they therefore are not amenable to an interpretive approach until late in the treatment. According to Fonagy and colleagues, the thinking of borderline patients remains either concrete, functional, and overly attuned to external reality with little capacity to elaborate a separate internal world (psychic equivalence), or, most often, sequestered in a mode of idiosyncratic fantasy (the pretend mode) leading in extreme forms to a sphere of dissociated experience and thinking (Target & Fonagy, 1996). While such formulations enhance our understanding of the developmental underpinnings of borderline disorders, they do not take into account that, even for borderline patients, the fantasy world in the transitional state may be in fact intensely invested emotionally, and that this enlivens rather than deadens the therapeutic interactions.

The question has been raised about whether interpretations of self-object affect dyads as they are mobilized in the transference are beyond the reflective capacities of borderline patients through the initial and mid phases of treatment (Bateman & Fonagy, 2004b; Gabbard, 2006; Gabbard, Horwitz, Allen, Frieswyk, Newsom, et al., 1994). One concern is that if the therapist talks about complex mental states in interpretive work before the later stages of treatment, there will be a pseudo-agreement on the part of the patient without insight or scrutiny; mentalization may appear to improve but it does not lead to changes in behavior or in external relationships. We view such
a therapeutic process as the result of badly formulated or poorly timed interpretations. While there are certainly individual differences in the ways borderline patients respond to interpretations at different stages of the treatment—which necessitate a flexible, stepwise interpretative approach as outlined above—our research investigations have shown substantial improvements in borderline patients' capacity for mentalization (as measured by the RF scale), as well as in psychosocial functioning and symptomatology, in the interpretive climate of TFP (see summary of research below).

In TFP the therapist's interpretations of self-object affect dyads as they are activated and expressed in the transference in frequent role reversals are designed to present patients with split-off experiences as they emerge in the transference situation, leading to increased tolerance of contradictory affects and identifications and an expanded capacity to take multiple and diverse perspectives on self and others, and in this way help the patient to acquire a deeper sense of mental states of self and others. This in turn makes the patient more capable of making use of transitional phenomena or transitional modes of relatedness in which internal and external experience are both linked and differentiated. It is important to note that Fonagy and Target (1996) have stipulated that psychoanalytically oriented treatment and psychoanalytic interpretation take place in the pretend mode: "Psychoanalysis is in many respects a 'pretend' experience. Play is essential to it, just as it is essential to our psychoanalytic model of the developing mind. Analyst and patient discuss fantasies, feelings and ideas they 'know' at the same time to be false" (p. 459). While this statement applies to psychoanalytic treatment, it is also in our view applicable to the psychoanalytic psychotherapy of borderline patients, who—in the interpretive climate of TFP—develop, in conjunction with the capacity for mentalization, a tolerance of fantasy and the opening of the transitional space that enables them to understand and play with interpersonal distortions as they emerge in the transference (Clarkin, Yeomans, & Kernberg, 2006).

**INTERPRETIVE ACTIVITY AND THE ALIEN SELF**

The object relations approach in TFP also has implications for understanding Fonagy and colleagues' (Fonagy et al., 2002) concept of the alien self, defined as an "internalized other" that is "unconnected to the structures of the constitutional self" (Fonagy et al., 2002) and represents a self-state that develops in situations in which the child internalizes an affective state that thus must be repeatedly externalized and understood in the context of self-stabilization.

From our point of view, what Fonagy and colleagues conceptualize as a split-off object representation, which coexists with an opposite, highly polarizing defensive and covering attitude of the child, is an object, not just an alien self, but as an aspect of the developing self. This alien object is represented not just as an alien self, but as an aspect of the developing self, with the alien self and its corresponding object representations coexisting and contributing to the development of the transitional space that enables them to understand and play with interpersonal distortions as they emerge in the transference (Clarkin, Yeomans, & Kernberg, 2006).
of badly formulated or poorly timed interpretations at different stages of treatment. A stepwise, interpretative approach that recognizes the child's own self-states as reflected in the caregiver's mirroring but not contingent on it, rather represents the imposition of his or her self-states onto the child. In such situations, instead of developing a second-order or symbolic representation of the child's self-states, the child internalizes an alien representation that does not correspond to the constitutional self, is experienced as persecutory, and that thus must be repeatedly externalized or projected onto others in the interest of self-stabilization.

From our point of view, what Fonagy calls the alien self is really a composite structure consisting of a highly fantastic, primitive self and a correspondent object representation. In the language of TFP, the alien self is conceptualized as a split-off object relation of a highly negative sort, which coexists with an opposite, highly positive object relation representing a defensive covering attitude of idealization. In other words, we think the “alien self” concept encapsulates a specific relationship framed by a particular affect state. This alien object relation is split off and activated not just as an alien self, but as an alien self relating to an alien object or bad internal object. The patient will alternatively identify with both while projecting the corresponding other onto the therapist. Thus, transference evokes not just an alien self, but an alien object relation with a constituent self and object representations controlled and distorted by severely negative affect. In our view, it is typical for borderline patients to alternately behave as the alien self, or see the therapist as an alien self; whether they enact it or project it, they are in a complementary role. Through our technique, which fosters the bringing together of split-off experiences, the alien self and its corresponding objects are transformed into self, and respectively, object representations that can be integrated with their opposite. This permits the modulation of affect, particularly the mastery and sublimation of aggressive affects, and the strengthening of cognitive functions, including the beginning of reflective function. (See case illustration for an example.)

In contrast, Fonagy and colleagues stipulate that the emotional truth and valence of the alien self, as an element that colonizes rather than is part of the patient’s internal world, must be acknowledged and accepted by the therapist who is in the position of carrying this projection. Accordingly,
the therapist’s task is to gently question the patient’s misperception of the therapist in ways that clarify and validate the perception, while offering an alternative view of the therapist’s intentions in the interests of containing and ultimately dissolving the alien self. We agree that clarification of the alien self—or rather, of the object relation that it represents—is the first step. However, in our view, if one tries to dissolve the alien self through containment and other supportive techniques with the assumption that improved mentalization will move the patient beyond it, then one may be neglecting the splitting mechanisms that underlie and characterize the alien self and that may in fact drive conflict into a deeper, less-accessible level.

Finally, according to Fonagy and colleagues, in borderline patients who have experienced trauma, the interpretation of the transference may actually stimulate states of arousal (in both the prefrontal and posterior cortical and subcortical systems) such that the individual shuts down mentalization in the face of increased activation of attachment via the transference. In such cases, interpretations are thought to range from being useless to harmful (Bateman & Fonagy, 2004a). We agree that in such situations—as always—interpretations must be tailored to the patient’s capacity to work with them productively. However, the work of LeDoux (1996, 2002) points to the importance of interpretation for the ultimate resolution of trauma. There is neurophysiological evidence that the emotional charge associated with experiences, stored subcortically, cannot change without cortical involvement (LeDoux, 1996, 2002); therefore, a therapy that uses the transference and thus brings such implicit structures into play in an emotionally meaningful way, and utilizes cortical techniques such as transference interpretations, seems not only desirable but arguably a critical component of therapeutic action in the context of trauma.

**RESEARCH INVESTIGATIONS**

In developing an object relations outpatient treatment for patients with borderline personality disorder, we have systematically followed the steps of treatment development (Kazdin, 2001), including (a) describing the treatment in a manual; (b) investigating the impact of the therapeutic approach on a small group of patients; (c) comparing the clinical progression of these individual treatments to a comparison group that received a different treatment in the clinic; and finally (d) comparing TFP to other treatments for these patients over a one-year period. For seven sessions with borderline patients conducted by senior therapists and gradually developed our principles of treatment into a treatment manual (Clarkin, Yeomans, & Kernberg, 2003), we have been investigating and refining the manual, along with the investigations, has been delineated in our work (Levy, & Schiavi, 2003).

Encouraged by the positive results of our initial study (Clarkin, Levy, Poelsch, & Kernberg, 2003), we embarked upon a randomized clinical trial (Clarkin, Levy, Lenzenweger, & Kernberg, 2003) of the effectiveness of TFP, DBT, or a psychodynamic supportive treatment model for BPD patients, which was funded by the National Institute of Mental Health (O. Kernberg and J. Clarkin, Co-PI). The study was unique in a number of ways. Perhaps most notable was the focus on not only symptom change, emphasized in many previous studies, but also on the organization of the personality as reflected in the internalization of mentalization (reflective functioning) and identity.

Preliminary results indicate that patients in the TFP condition showed significant clinical change in many domains at the end of treatment, including diminution of depression and anxiety, improvement of affective and interpersonal functioning (Clarkin, Kernberg, 2007). Patients in both TFP and DBT showed significant improvement in the domain of suicidality, while only patients in TFP showed diminution of factors related to aggression such as dissociation, aggression, and direct assault (Clarkin et al., 2007).

We were also interested in examining the impact of the transference and the therapeutic alliance on the outcome of treatment. For these investigations, we used the reflective attachment-based index of mentalization obtained from the Attachment Interview (AAI, George, Kaplan, & Main, 1985) after one year of treatment for patients in all three conditions.
individual treatments to a comparison group that received treatment as usual in the clinic; and finally (d) comparing TFP to other plausible treatments for these patients over a one-year period. For several years we videotaped sessions with borderline patients conducted by senior clinicians in our group, and gradually developed our principles of treatment that are explicated in a treatment manual (Clarkin, Yeomans, & Kernberg, 1999, 2006). This process of developing and refining the manual, along with the initial empirical investigations, has been has been delineated in detail elsewhere (Clarkin, Levy, & Schiavi, 2005).

Encouraged by the positive results of our initial studies of TFP (Clarkin et al., 2001; Levy, Clarkin, Foelsch, & Kernberg, 2004), which showed large effect sizes, we embarked upon a randomized clinical trial (RCT) of TFP (Clarkin, Levy, Lenzenweger, & Kernberg, 2004, 2007), in which borderline patients were randomly assigned to one-year ambulatory treatment with TFP, DBT, or a psychodynamic supportive treatment. This RCT of psychotherapy of BPD patients, which was funded by the Borderline Research Foundation (O. Kernberg and J. Clarkin, Co-PIs) and NIMH (K. Levy, PI), is unique in a number of ways. Perhaps most importantly, we examined not only symptom change, emphasized in most studies, but also changes in the organization of the personality as reflected in such domains as mentalization (reflective functioning) and identity.

Preliminary results indicate that patients in all three treatments showed significant clinical change in many domains at the end of one year of treatment, including diminution of depression and anxiety and improved psychosocial or interpersonal functioning (Clarkin, Levy, Lenzenweger, & Kernberg, 2007). Patients in both TFP and DBT fared significantly better in the domain of suicidality, while only patients in TFP showed a marked diminution of factors related to aggression such as impulsivity and verbal and direct assault (Clarkin et al., 2007).

We were also interested in examining the mechanisms of change; that is, how does TFP bring about change, as compared to the other treatments? For these investigations, we used the reflective functioning score (RF), an attachment-based index of mentalization obtained from the Adult Attachment Interview (AAI, George, Kaplan, & Main, 1998) given prior to and after one year of treatment for patients in all treatment conditions. The AAI
involved her perception of others as hostile or negative. She stopped working when news of her belligerent and aggressive attitude spread, and she was not hired. The patient understood her conflictual behavior as the result solely of racial discrimination. She had a history of abusive relationships except for one occasion when a man she had been with began to make love to her. She panicked, stopped sexual intercourse, and later brought formal rape charges against him. She had a limited history of overt self-destructiveness, cutting herself on occasion, but had persistent wishes to kill herself. She had experienced psychiatric hospitalizations and had been diagnosed with a personality disorder. She had been on many medications, all of which had been tried during the first year of TFP.

In the research evaluation, she met criteria for a dissociative personality disorder, but also for narcissistic and avoidant personality disorders on the International Personality Disorder Questionnaire (Loranger, 1999; Loranger, Sartorius, Andreoli, & Bech, 1982; SCID-I (First, Gibbon, Spitzer, & Williams, 1996). Her reflective functioning (RF) score prior to treatment was minus one (−1), indicating that she did not consider mental states of self and other, had organizational and confusion in the face of questions about mental states. In the few instances in which she gave unintegrated and bizarre responses, she showed contradictory understanding of mind with respect to attachment, shifting chaotic and disorganized devaluation of early attachment figures, and angry outbursts and destructive acts with whom she was emotionally absent. TFP's attachment classification of Cannot Classify, with Dismissing states of mind (CC/E2/D2). Finally, her personality Organization (IPO) (Lenzenweger, Clark, & Widiger, 2001), she scored very high on identity diffusion, compromised reality testing, and aggression.

From the first session, Sara's interactions were characterized by a nonstop monologue that blocked any feedback. If he tried to speak, she spoke over him, and the conversation consisted of clarification of this self-state. In the in-

CLINICAL ILLUSTRATION OF IMPROVEMENT IN MENTALIZATION: THE CASE OF SARA

Sara, a single, unemployed Asian-American woman, started TFP at age 36 after many years in other treatments. Her condition had worsened to the point where she spent the six months prior to beginning TFP isolated in her apartment, lying in bed with chronic suicidal ideation, binge eating, and only rarely bathing. She was the middle of three daughters in an upper-middle-class family. Although Sara described her father as emotionally absent and preoccupied with his legal career, she also experienced him as obsessed with his children's educational performance to the point of abusing them verbally and sometimes physically if they did not perform up to expectations. She described her mother as an emotionally unstable woman whose frequent panic attacks made her unable to consistently care for her children. The patient dropped out of college and then held a series of jobs, but was repeatedly fired because of interpersonal difficulties that often
involved her perception of others as hostile or negative toward her. She stopped working when news of her belligerent character kept her from being hired. The patient understood her conflictual relations with others as the result solely of racial discrimination. She had no history of sexual relations except for one occasion when a man she had dated three times began to make love to her. She panicked, stopped the interaction before intercourse, and later brought formal rape charges against him. Sara had a limited history of overt self-destructiveness, cutting herself superficially on occasion, but had persistent wishes to kill herself. She had had three psychiatric hospitalizations and had been diagnosed with bipolar disorder. She had been on many medications, all of which were discontinued during the first year of TFP.

In the research evaluation, she met criteria not only for borderline personality disorder, but also for narcissistic and avoidant personality disorders on the International Personality Disorders Examination (IPDE, Loranger, 1999; Loranger, Sartorius, Andreoli, & Berger, 1994), and she met SCID-I (First, Gibbon, Spitzer, & Williams, 1996) criteria for current dysthymia. Her reflective functioning (RF) score prior to the initiation of treatment was minus one (−1), indicating that she actively repudiated any consideration of mental states of self and other, and showed cognitive disorganization and confusion in the face of questions designed to elicit reflection on mental states. In the few instances in which she spoke in RF terms, she gave unIntegrated and bizarre responses. On the Adult Attachment Interview (AAI) she showed contradictory and inconsistent states of mind with respect to attachment, shifting chaotically between dismissive devaluation of early attachment figures, and angry preoccupation with parental objects with whom she was emotionally entangled, leading to an attachment classification of Cannot Classify, with mixed Preoccupied and Dismissing states of mind (CC/E2/D2). Finally on the Inventory of Personality Organization (IPO) (Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001), she scored very high on identity diffusion, and high on primitive defenses, compromised reality testing, and aggression.

From the first session, Sara’s interactions with her therapist were characterized by a nonstop monologue that blocked his participation in the therapy. If he tried to speak, she spoke over him. His first interventions consisted of clarification of this self-state. In the initial sessions, he directed
her attention to this behavior, offered a description of it, and wondered what might motivate this way of interacting, which appeared designed to exert control over him. Sara tearfully responded that if she did not control him, he would leave. Such interventions brought into focus a dyad—that of the abandoner and the abandonee, with the abandonee trying to prevent abandonment by controlling the other. It was only after repeated clarification of this dynamic in the context of the therapeutic relationship that Sara was able to sort out the feelings of anger and fear of abandonment that fueled her controlling behavior and begin to question her view of the therapist. With a clearer articulation of her experience of self and other, she began to occasionally notice that, while she chronically complained of others treating her harshly and rejecting her, she could treat others, including her therapist, in a similar way; this was the beginning of understanding her projection of aggressive affects within her, as the process became apparent in observing the oscillations of a dyad involving a harsh critic and the object of the criticism. So, in the initial phases of therapy Sara became able first to articulate how she saw the therapist, to consider that he might have a different state of mind than that which she attributed to him, and then to recognize that she could behave in the way she had experienced him behaving.

In a session that took place six months into the first year of treatment, Sara initially presented with a similar defensive structure, but was able more quickly to reflect on the interaction and consider other perspectives. She began by stating that she had been feeling suicidal and had taken a minor overdose. As the therapist tried to understand the affect and the fantasied relationship motivating her suicidal gesture, Sara said: “My wanting to kill myself has nothing to do with your going away.” (The therapist was leaving for a week.) The therapist pointed out that Sara had made this connection herself and that it may be humiliating to care so much about him when she felt he did not care about her.

She replied: “You say the same thing to every one of your patients! I’m not like all of them!”

Therapist: “You feel like you’re one on an assembly line.”

Sara: [with sudden change of affect, from angry to sad]: “I don’t feel that I deserve to be here ... I don’t know [patient covers her face with her hands]. I just feel badly that I have to walk around with other human beings. I just don’t feel like ...”

Therapist: “I think you don’t want me to see you feel. You don’t mind if I see you in your anger, like. You don’t want me to see the longing, because that to humble you, by rejecting, by turning away. The therapist then suggested that her fear of the off-putting way in which she interacted: she might feel she controlled it.

Sara: “You mean because I think that rejecting confirm it, like by dressing this way? I just feel like, things, of all of this, is that I have help available ... with me . . .”

The oscillation or alternative distribution of the noted above must be differentiated from the split carrying polarized affective charges. The final story consists in linking the dissociated positive and negative to an integration of the mutually split-off idealizations of experience with the corresponding resolution. As Sara shifted from her discussion of wanting she was feeling toward her therapist, she moved to a negative affect that served defensive purposes (rejecting the helpless unworthy self) to a dyad involving her. She continued “I guess there’s a longing in a way, I didn’t really want to come, but I do long, I guess I do. And it’s not the same thing between you, I’m more attached to you than I was to him. I remember this boy in high school. There weren’t students there. . . . I was one of the only ones. I speak to me. One day . . .”

Her questioning and relinquishment of her different stance toward others can be understood in begin to “take back” and metabolize the negative temporarily projected onto others, which in turn allowed more positive and nuanced states of mind with the therapist. Her therapist’s approach was to ask her states as they played out between them. Thus, the on clarifying which part of her experience beli
Therapist: “I think you don’t want me to see you in the longing that you feel. You don’t mind if I see you in your anger and your rejection of me. You don’t want me to see the longing, because you think I’ll just use that to humiliate you, by rejecting, by turning away from you.”

The therapist then suggested that her fear of rejection could explain the off-putting way in which she interacted: she might induce rejection to feel she controlled it.

Sara: “You mean because I think that rejection is inevitable I try to confirm it, like by dressing this way? I just feel like the tragedy of everything, of all of this, is that I have help available . . . You’re actually working with me . . .”

The oscillation or alternative distribution of the roles of the dyad noted above must be differentiated from the split between opposite dyads carrying polarized affective charges. The final step of interpretation consists in linking of the dissociated positive and negative transferences, leading to an integration of the mutually split-off idealized and persecutory segments of experience with the corresponding resolution of identity diffusion. As Sara shifted from her discussion of wanting to kill herself to what she was feeling toward her therapist, she moved from a dyad imbued with negative affect that served defensive purposes (the harsh critical object rejecting the helpless unworthy self) to a dyad imbued with positive affect. She continued “I guess there’s a longing in a way, ’cause I did come on time, I didn’t really want to come, but I do long to come here, in a way, I guess I do. And it’s not the same thing between seeing Dr. Smith and you. I’m more attached to you than I was to him . . . I like you more . . . I remember this boy in high school. There weren’t many Asian–American students there . . . I was one of the only ones . . . I never thought he’d speak to me. One day . . .”

Her questioning and relinquishment of her chronic defensive belligerent stance toward others can be understood in relation to Sara’s having begun to “take back” and metabolize the negative affects she had consistently projected onto others, which in turn allowed her to experience other more positive and nuanced states of mind with regard to herself and the therapist. Her therapist’s approach was to ask her to reflect on these shifting states as they played out between them. Thus, the therapeutic work focused on clarifying which part of her experience belonged to the other person
and which part to her self, ultimately expanding her capacity to experience a range of mental states with respect to self and therapist.

In her external life, Sara’s complaints of mistreatment decreased. She reported less anxiety and more positive interactions in her volunteer work setting, where she was offered a paid position. With regard to intimate and sexual relations, in the period of time when Sara was still utilizing primitive defense mechanisms—omnipotent control and projective identification—she was attracted to a narcissistic, unavailable man into whom she had deposited her critical judgmental part. An erotic transference emerged fitfully during the first year of treatment, first in moments of seductive posture and only rarely verbalized. Her mention of sexual feelings alternated between shame and a sense of danger. In the course of treatment, as she progressed in taking back projected anger and hostility, she started a relationship with and eventually married (after three years of therapy) a more appropriate loving and empathic man.

The work described so far took place mostly in the first year of therapy. It is interesting to look more closely at the AAI that was given at admission and at the one given after this year of TFP. As mentioned previously, on the AAI, Sara advanced from a reflective functioning score of minus one (−1), to a score of 6, which indicates not only the capacity to form stable and multifaceted mental models of the minds of self and other, but also some flashes of complex and original thinking about mental states of self and others. A comparison of Sara’s responses to the AAI question “How do you think your childhood experiences have affected your adult personality?” at time 1 and time 2 illustrate the dramatic increase in her capacity for mentalization and coherence. At time 1, she gave a response that began with some explicit references to mental states in that she wondered what she would have been like if she had had parents who assured her that “nothing bad was going to happen,” but became increasingly bizarre, incoherent, and even shocking—a hallmark of deficient RF—as she veered off into describing a movie she saw as a child with her father in which a woman is tricked and raped.

I think that if somebody had been in my room, put me to sleep, and assured me that there was nothing bad going to happen, I think a lot of this stuff would have gone all right, I don’t think I would be talking about all of this . . . My dad and I, we went to a movie once . . . and it was a movie about this um, the woman that I remembered upset me a lot. maybe third or fourth grade then. It was about them married, and she goes to this party, and um, her husband doesn’t come with her to the party. And well you know, [you] like this guy, he’ll take He doesn’t exactly take her home. He rapes her.

After one year of TFP, Sara responds to the question a coherent response that not only explores the impactors on her mental states, but also shows recognizing mental state might have had on her choices and behaviors.

Oh my God, my adult personality . . . . I remember an argument that . . . I was born overly sensitive . . . Not when I can remember experiences 3 years old and my parents not being there . . . an interest in us . . . . I didn’t live up to my parents . . . I just couldn’t do it like now . . . certainly better now . . . I regret the fact that I’m 37 and program at 36 . . .

This response shows the development of a stable mind of self and parents along with a transactional states—that is, the way in which her mental state biological predisposition but by her reactions to and behaviors.

While the patient’s reflective functioning was in the AAI after one year of TFP, the therapist capacity for mentalizing in the therapy session was that the patient was more capable of reflectivity, but would regress to unreflective thinking primitive defense mechanisms in threatening capacities faltered when sexual feelings arose in seductive looks or gestures toward her therapist.
expanding her capacity to experience self and therapist.

plaints of mistreatment decreased. She was interactions in her volunteer work position. With regard to intimate and when Sara was still utilizing primitive control and projective identification—available man into whom she had fallen erotic transference emerged fitfully in moments of seductive posture and of sexual feelings alternated between course of treatment, as she progressed (tently, she started a relationship with her therapist) a more appropriate

ence mostly in the first year of therapy.

the AAI that was given at admission TFP. As mentioned previously, on the functioning score of minus one not only the capacity to form stable links of self and other, but also some about mental states of self and other the AAI question "How do you think ur adult personality?" at time 1 and her capacity for mentalization and use that began with some explicit ordered what she would have been later that "nothing bad was going to incoherent, and even shocking—ended up into describing a movie she woman is tricked and raped.

in my room, put me to sleep, putting bad going to happen, I done all right, I don't think I My dad and I, we went to a movie once... and it was a movie about this woman... and um, the woman that I remembered upset me a lot. And I was about, maybe third or fourth grade then. It was about this woman—she's married, and she goes to this party, and um, her friend—and her husband doesn't come with her to the party. And her friend says, well you know, [you] like this guy, he'll take [you] home... He doesn't exactly take her home. He rapes her.

After one year of TFP, Sara responds to the questions with a multifaceted, coherent response that not only explores the impact of her parents' behaviors on her mental states, but also shows recognition of the role her own mental state might have had on her choices and behavior.

Oh my God, my adult personality... I really don't buy that argument that... I was born overly sensitive I don't think so. ... Not when I can remember experiences as far back as like 3 years old and my parents not being there... They didn't take an interest in us... I didn't live up to my potential... so I may have had dreams and wishes and I had the potential to do it but I just couldn't do it like now... certainly my life is so much better now... I regret the fact that I'm 37 and I only found this program at 36...

This response shows the development of a stable coherent model of the mind of self and parents along with a transactional perspective on mental states—that is, the way in which her mental states were shaped not only by biological predisposition but by her reactions to the parent's mental states and behaviors.

While the patient's reflective functioning went from -1 to +6 as rated in the AAI after one year of TFP, the therapist reported variability in her capacity for mentalizing in the therapy sessions. His clinical impression was that the patient was more capable of reflection in situations of stability, but would regress to unreflective thinking under the influence of primitive defense mechanisms in threatening situations. Sara's reflective capacities faltered when sexual feelings arose in sessions. She often directed seductive looks or gestures toward her therapist without any capacity to

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talk about the meaning of her nonverbal behavior. Periodically she would burst out with a comment that he wanted to force her to talk about sex. When he wondered about this impression, she either referred to her experience with the man she had accused of rape, an accusation she began to question, or talked about her own sexually aggressive behavior toward her sister when they were prepubertal. It was only after the emergence and working through of an erotic transference that she was able to integrate loving and sexual feelings.

AN EXPANDED VIEW OF MENTALIZATION

Detailed examination of our clinical process and outcome data has led us to identify three phases in the development of mentalization. In this section, we present a theoretical model that links these three phases to the interpretative process that characterizes TFP. In our view, mentalization is a process whereby, sequentially, the individual develops (a) the capacity to know that he or she has a mind that is like another; (b) the capacity to think about the other in mental state terms and to recognize one’s own mental states in the mental states of the other; and (c) the capacity to observe his or her own mind as if it is another mind, which involves placing mental states of self and other in a wider historical and temporal context where understanding in the moment is linked to a broader set of integrated positive and negative representations of self and others. Working independently, Semerari and colleagues (Semerari et al., 2003) identified three phases in the attainment of mentalizing capacities including (1) understanding one’s own mind; (2) understanding the mind of the other; and (3) mastery of mental states. Each of these levels of mentalization is reflected in the level and aim of the interpretative activity of the therapist in TFP and in the progression of changes in object relations and ego and superego development that occur in TFP treatment.

The first phase of mentalization involves the capacity to cognitively frame mental states out of diffuse psychic experience. The capacity to cognitively clarify mental states in one’s own mind develops in early life via the child’s experience of congruent, marked interactions. In the therapeutic situation, the first step in the development of the capacity for mentalization involves helping the patient to understand her own state of mind, through identifying initially how she sees the self in TFP as tolerating the confusion and the therapist to introduce the idea that a different state of mind than that which corresponds to the patient’s realization that he necessarily correspond to what is in the patient’s mind. Thus, the therapeutic task involves helping the patient to identify the process that is being experienced by the patient, and to recognize that the specific representations of self in interaction and the understanding of the interaction can transform the patient’s understanding of his or her own mind. At the second level of mentalization, the patient experiences the therapist in quite a different way, where the therapist is perceived as a site of conflict and interaction, which can be experienced as a new and powerful, devalued self in interaction. The therapist’s interaction and object representations of a particular
identifying initially how she sees the therapist, a process that is referred to in TFP as tolerating the confusion and clarification. It is also important for the therapist to introduce the idea that it is possible that he or she may have a different state of mind than that which the patient attributes to him or her. The patient’s realization that her perception of the therapist does not necessarily correspond to what is in the therapist’s mind enables her to learn that there is a discrepancy between her own mind and that of the other. Thus, the therapeutic task involves helping the patient to accurately identify the affect that is being experienced in the immediate interaction with the therapist, and to recognize that these polarized affects are linked to specific representations of self in interaction with others. In borderline patients, this understanding can transform an action powered by an unarticulated and split-off affect into an understanding of self and other in the momentary experience so that the patient can tolerate and modify the affect without the need to discharge it immediately into action. In our case illustration, for example, Sara’s coming to awareness of her relentless attempts to control the interaction with the therapist, and the way that this represented an avoidance of split-off fear and rage linked to an object relational dyad of a powerless, devalued self in interaction with a controlling, rejecting object, epitomizes the first level of mentalization.

At the second level of mentalization, the patient recognizes that he or she experiences the therapist in quite disparate and even opposite ways that cannot be reconciled. Further, the patient realizes that some of her mental states regarding the therapist correspond to states that she had previously perceived in the therapist, while the therapist is perceived as experiencing a state akin to what the patient formerly experienced. This involves the recognition that aspects that she attributed to the object actually represent aspects of the self. At this stage the awareness of the alternation or interchange of roles within the same object relational constellation is crucial. The therapeutic task at this phase is to help the patient to understand and tolerate the double identification with self and object representations, through interpretation of the many repetitions and reversals of specific object relational dyads as they emerge in the transference relationship, and to interpret the splitting of the libidinal from the aggressive aspects of self as represented by different dyads. The patient’s alternation between identification with self and object representations of a particular dyad infused with a particular affect
leads to an expanded understanding of the mind of the other as well as her own mind in that it enables her to recognize that her mind is representational in nature; that is, that her experience of self and others is shaped in part by myriad mental models of self in relation to others. In the case illustration, interpretation of Sara's attempt to omnipotently control the supposed rejecting other led to an awareness of rejecting and critical elements in herself, and this identification with both poles of the dyad enabled her to take back the projection, clearing the way for more libidinally charged gratifying experience of the self in relation to the therapist to emerge, and for integration of her disparate experiences of self and object.

The process of identifying the various self-object—affect clusters or dyads that emerge in relation to the therapist in TFP, along with increased awareness of and tolerance for identifications with both aspects of each dyad, leads to increasing integration of the representational world and a concomitant modulation of affective experience, which sets the stage for the third phase in the development of mentalization. This stage involves the capacity to integrate and modulate the positive and negative segments of experience, which occurs when the patient recognizes that he or she experiences loving and aggressive feelings toward the same person, and that these contradictory states correspond to divisions in his or her own internal world (Klein, 1946, 1957). The recognition that the individual can have completely opposite feelings toward the same person—feelings that he or she may have previously attributed to that person—enables the individual to feel a sense of responsibility over aggressive or negative feelings or states, instead of having to project them. This leads to the development of a sense of concern about the object that the individual wants to preserve.

The emergence of the sense of concern and of responsibility for others sets the stage for the development of superego functions. Insofar as the superego derives from the awareness of the effects of the internalized prohibitions and demands of others, it consists of mental states. The capacity to connect disparate mental states with each other and with their historical antecedents enables one to understand how mental states that derive from the demands and prohibitions of others can be compared with other states. Mental states that involve awareness of parental prohibitions and strictures are recognized as only one set of mental states among others. This recognition in turn expands conscious awareness and tolerance of mental states that might engender conflict. Mentalization thus, in the sexual realm, in that it enables one to intensely passion and/or erotic excitement states in which one experiences reality correctly identify—and identify with—the sexual passion.

Sara provides an example of a patient prohibitive superego elements accompanying functioning, which was significantly more At the beginning of treatment she represented a she allowed herself to think of them, in exploiter and exploited. As her reflective of treatment, this patient was able to establish erotic relationship in which tender. The progress in this area paralleled her improvements of herself, but with a delay. Even a relation between her fear of verbal attack discovered in herself for angry criticism remained a source of anxiety. Her anxious sensitive elements that her sexual feelings could not control; she worried that sexual feeling ince. Sara anticipated condemnation lengthy and intermittent period of into and her imagined consequences even sexual fantasies.

As mentioned above, clinical ob suggests that VP is variable across different may be evoked in response to the active. It may be that the attachment relation well consolidated in the early to mid substantial increase in mentalization, but ence is a recapitulation of an erotic early attachment figure, or aggression. Different levels of mentalization thus activation of different behavioral sys In our case illustration, the patient's ca...
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in the sexual realm, in that it enables one to recognize that states linked to
intense passion and/or erotic excitement are transient heightened mental
states in which one experiences reality differently, while the capacity to
correctly identify—and identify with—the mental states of the other, en-

Sara provides an example of a patient with excessively persecutory
and prohibitive superego elements accompanied by a severe inhibition in sexual
functioning, which was significantly modified in the course of treatment.
At the beginning of treatment she represented all sexual relationships, when
she allowed herself to think of them, in the most primitive form—that of
exploiter and exploited. As her reflective capacities improved in the course
of treatment, this patient was able to establish and sustain a fully intimate emo-
tional erotic relationship in which tenderness and sexuality were integrated.
The progress in this area paralleled her integrating projected aggressive
elements of herself, but with a delay. Even after she was able to understand the
relation between her fear of verbal attacks from others and the capacity she
discovered in herself for angry criticism and rejection, sexual feelings re-
ained a source of anxiety. Her anxiety was related not only to the aggres-
ive elements that her sexual feelings carried, but also to her fear of lack of
control; she worried that sexual feelings would lead to uncontrolled pro-
miscuity. Sara anticipated condemnation each time these came up, and a
lengthy and intermittent period of interpretation of her fear of her desires
and their imagined consequences eventually led to her ability to enjoy sex
and sexual fantasies.

As mentioned above, clinical observation, as in the case of Sara, sug-
ests that RF is variable across different self and object representations that
may be evoked in response to the activation of different behavioral systems.
It may be that the attachment relationship between patient and therapist is
well consolidated in the early to mid phases of treatment, leading to a sub-
stantial increase in mentalization, but if later what emerges in the transfer-
ence is a recapitulation of an eroticized or seductive relationship with an
early attachment figure, or aggression, then mentalization may decrease.
Different levels of mentalization thus may be activated in response to the
activation of different behavioral systems (e.g., attachment and sexuality).
In our case illustration, the patient's capacity for reflective function was noted
link the improvement in RF to the increasing mentalization that is unique to our treatment. In support of recent investigations of Högglund and colleagues showed that transference interpretations were more severe pathology of object relations. Ult (2006), Blatt (1992), and others have pointed to the particular character more or less amenable to different therapies.

Our use of the RF measure to assess mentalization has made us more aware of the strengths and weaknesses at both the theoretical and empirical level. Observations suggest that mentalization is a concept that involves transformations in cognitive and affective structures. In particular, our findings on improved mentalization, along with the development of methods to assess it, are cumulative processes that relate to ongoing mentalization, integration of the particular character. The study indicated that the affective components of RF that can distinguish relationships, are not necessarily captured by the RF scale as it is now constant. It is a complex array of variables. In addition, the study showed that the RF scale can be reflective under certain circumstances. The study also noted that the AAI interview, from which RF ratings are derived, addresses the situations and issues that are unique to each individual patient, and that may lead to later formulations. Our results suggest that significant change in the capacity for mentalization during TFP treatment may be in part a result of the interpretive climate of TFP not present in the other treatments. Our hypothesis is that the improvements are in part a result of the interpretive process that is unique to TFP. In this process, the therapist moves from directly addressing the object relations, identifying role reversals between self and object poles of the object relational dyads as they occur in the transference, and confronting splitting of idealized from persecutory aspects of self in different dyads, to then offering a hypothesis about why it occurs and gradually linking these primitive defensive operations to unconscious wishes, fears, and motivations. This interpretive process leads to the gradual integration of disparate, split-off self and object representations into an overarching stable concept of the self and objects. We propose that the consolidation of identity in turn fosters mentalization in that it provides a stable and consistent working model of self and others against which momentary mental states, even those that are affective or drive-laden, can be assessed and evaluated.

Further investigation of other factors in the treatment that might account for gains in RF will have to be conducted before we can definitely
through the later stages of treatment; it distinc
tive transference developed, even though it
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ted at one year.

AND CONCLUSION

Suggest that after one year of TFP, border-
ment in their capacity for mentalization
ings described above), an improvement
ment autobiographical narrative (as indi-
the subscale scores of the AAI), and a de-
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ink the improvement in RF to the increasingly complex interpretive focus
that is unique to our treatment. In support of our formulations are the re-
vestigations of Høglend and colleagues (Høglend et al., 2006), which
owed that transference interpretations were more helpful for patients with
more severe pathology of object relations. Ultimately, however, as Gabbard
(2006), Blatt (1992), and others have pointed out, the challenge is to refine
our understanding of the particular characteristics that might make patients
more or less amenable to different therapeutic approaches.

Our use of the RF measure to assess mechanisms of change in TFP
has made us more aware of the strengths and limitations of the instrument
at both the theoretical and empirical level. Our research and clinical inves-
tigations suggest that mentalization is a complex and multistaged process
that involves transformations in cognitive and affective ego and superego
structures. In particular, our findings on improvements in mentalization in
TFP lend support to the idea that a focus on the identification, articulation,
and regulation of affect, and the ways that it is linked to specific constellation
of self and object representations, is a significant catalyst for understand-
mental states. In our view, the development of the capacity for
mentalization, along with the development of secure attachment with which
it is linked, are cumulative processes that reflect the building up, modula-
tion, and integration of object relations. These complex processes, particu-
larly the affective components of RF that cannot be disconnected from object
relationships, are not necessarily captured by one reflective function global
rating. Thus, the RF scale as it is now constituted reduces to one numerical
score a complex array of variables. In addition, mentalization may fluctuate
markedly within the same individual as different behavioral systems are
invoked in individual maturation, in different interpersonal contexts, and at
different stages in treatment. As Fonagy (Fonagy et al., 2002) and others have
noted (Diamond et al., 2003; Yeomans et al., in press), borderline patients
can be reflective under certain circumstances and not under others. It is not
clear that the AAI interview, from which the RF rating is derived, captures
or addresses the situations and issues that are particularly difficult for the
individual patient, and that may lead to lapses in mentalization. The above
formulations are offered in the interests of advancing the fruitful dialogue
between MBT and TFP, two psychodynamic perspectives on borderline

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pathology and its treatment that continue to enrich and enhance each other. An honest assessment and exploration of points of contact and divergence can only lead to increased precision in our treatment approaches and their theoretical underpinnings.

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