

Mentalization and the Changing Aims of Child Psychoanalysis

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The interface of empirical work with child psychoanalysis at the Anna Freud Centre is part of the tradition of systematic study and research pioneered over many years by Anna Freud and her colleagues (A. Freud, 1962; Sandler, 1962; A. Freud 1965).

George Moran initiated a program of work at the Anna Freud Centre, which, starting with the work on juvenile onset diabetes (Fonagy et al., 1991b), led us to ask fundamental questions about the nature of the child psychoanalysis, with important implications for technique. We acknowledged our debt by dedicating the lecture on which this paper is based to George Moran, whom we see as a worthy successor to Marianne Kris, both of them working within the tradition of Anna Freud.

This article starts with observations that imply the need for a change in some aspects of our psychoanalytic model. Throughout child psychoanalysis is used to illustrate both the need for change and the character of the revision that is required. The authors, however, assert that, as is so often the case for explorations in child analysis, these ideas may be extrapolated to psychoanalytic approaches to adults, specifically individuals with borderline personality disorder.

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An earlier version of this article was presented as the 1997 Marianne Kris Memorial Lecture at the annual meeting of the Association for Child Psychoanalysis Inc., March 1997, Cancun, Mexico. The authors would like to acknowledge the vital contributions of Dr. Efrain Bleiberg and Drs. Miriam and Howard Steele to the thinking and empirical work that are drawn on in this article.

HERE HAS BEEN GENERAL AGREEMENT ON THE INDICATIONS FOR CHILD analysis. Anxious, inhibited, neurotic children are thought clinically to be particularly suitable. Glenn (1978); Sandler, Kennedy, and Tyson (1980); Hoffman (1993); Kernberg (1995); and others have identified further criteria:

- 1) Superior intelligence, particularly verbal skills, and psychological mindedness.
- 2) A supportive and stable environment, including parents who can form an alliance with the analyst, respect the boundaries of the treatment, and support their child's participation in it.
- 3) Internal conflict, judged to be the primary cause of the child's symptoms.
- 4) An absence of major ego deviations—that is, developmental “deficits” that are not the result of unconscious conflict and thus cannot be “resolved” by insight.
- 5) Motivation to engage in a lengthy and sometimes difficult therapy, stemming from anxiety, guilt, or shame.
- 6) A capacity to form relationships and trust that help can be found in relationships with others.

A glance at such daunting criteria makes apparent that the number of children qualifying as adequate candidates for child analysis must be small indeed. Furthermore, such criteria beg the question of whether children, so endowed with inner resources and environmental supports do in fact require a very time-consuming and costly process. The “luxury” of child analysis appears more dissonant when mental health professionals face extraordinary pressures to cut costs—pressures intersecting with a rising clamor to do something to address the problems of violent, drug-using, impulsive youngsters and their overwhelmed parents, a population for whom child analysis can seem to have relatively little to offer.

Child analysis' claims to legitimacy rest heavily on case reports that, however moving or dramatic, tend to resist objective assessment and controlled scrutiny. As the old quip goes, psychoanalytically oriented therapists can fail to realize that *data* is not the plural of *anecdote*.

An effort to remedy this state of affairs is the chart review and detailed examination of over 750 case records of children and adolescents in psychoanalysis and psychodynamic treatment at the Anna

Freud Centre (Target, 1993; Target and Fonagy, 1994a, b; Fonagy and Target, 1994, 1996b). Our study confirmed that psychodynamic treatment was particularly effective for groups of children whose diagnosis included an emotional disorder. Over 80% of children with a single diagnosis of an emotional disorder and relatively high levels of adaptation—that is, those closest to what the child analytic literature considers optimal candidates for child analysis—showed reliable improvement. Surprisingly, however, they appeared as likely to benefit from nonintensive therapy—one to two sessions per week—as from intensive treatment—four to five sessions per week. Even more surprising was the finding that intensive treatment was remarkably effective for some children with relatively severe, long-standing, and complex psychosocial problems, including conduct disorder, given the presence of at least one emotional disorder diagnosis (anxiety disorder, dysthymia, etc.). This heterogeneous group of children with complex psychopathology was less likely to gain clinically significant change from nonintensive psychotherapy. Even more disturbing was our observation that nearly 60% showed negative outcomes following once- or twice-weekly treatment.

Inspired by our first reports of these findings in 1994, the Child and Adolescent Ambulatory Psychiatric Clinic in Heidelberg undertook a similar retrospective study, with many findings matching ours. They identified a similar difference between the effectiveness of intensive and nonintensive treatments, as well as the beneficial impact of length of treatment. They also found the same pattern of declining responsiveness to intensive treatment with age. Interestingly, they found an interaction between gender and treatment intensity (wherein girls were more likely to benefit from intensive treatment, having controlled for the age effect); we did not find this.

Ongoing detailed analysis of our therapeutic records is revealing further suggestive findings. The most helpful interventions for the cases with more complex disorders seem to differ from those previously described as central to child psychoanalytic technique. In particular, interpretations of unconscious conflict aimed at promoting insight—long held as the centerpiece of analytic technique—appear to be of limited value to these youngsters. Less severely disturbed youngsters with emotional disorders do seem to benefit from an interpretive approach.

We are in the process of replicating these findings with young adults, 18- to 25-year-old young people with more than two Axis I and at least one Axis II diagnoses, assigned to treatment either once per week or five times per week. Although the results of the project, led by Mrs. Anne-Marie Sandler, are only in the process of being analyzed, it is clear that once-weekly treatment frequently fails to prevent a deterioration of these young people's condition, whereas treatment five times per week has moderate to good therapeutic effects.

The current plans of the Centre, under its new director, Julia Fabricius, include a prospective study of treatment outcome, in collaboration with the local National Health Service Trust. The present director's vision, building on the earlier work of George Moran and Anne-Marie Sandler, is to make the outcome of child psychoanalysis a priority for the Centre's research work. We are now at a fairly advanced stage of planning a randomized controlled trial of child psychoanalysis, in comparison with once-weekly psychodynamic psychotherapy, cognitive behavior therapy, and treatment as usual. The theoretical framework we describe represents the conceptual underpinnings for this trial.

A Widening Scope for Psychoanalysis?

The children with "complex psychopathology" that appeared to benefit from intensive psychodynamic therapy in our chart review constituted a rather heterogeneous lot, not easily captured by DSM-IV's diagnostic categories. These children's clinical and developmental characteristics suggested to us that many could be grouped by clusters of disturbance, with the common element of at least one emotional disorder (such as depression, dysthymia, generalized anxiety disorder, separation anxiety disorder, or social phobia).

These children generally present a severe disturbance of social and emotional development, including marked impairment of peer relationships, affect regulation, frustration tolerance, and self-image. Reading these records, together with discussions with Dr Efraim Bleiberg, President of the Menninger Clinic, revealed two clusters (Bleiberg, Fonagy, and Target, 1997). Some of them, which we design-

nate as Cluster A, show a more fragile reality contact and thought organization. Idiosyncratic or magical thinking pervades their lives, but it is more intense in emotionally charged contexts. They tend to retreat into an isolated world of bizarre fantasies, suspiciousness, and social anxiety. Their abilities to make sense of human exchanges and empathize with others are strikingly limited. They are often equally impoverished in their capacity to communicate, hampered by odd speech and inappropriate affect. Descriptively, they generally resemble a range of DSM-IV (American Psychiatric Association, 1994) diagnoses that include schizotypal and schizoid personality disorders and milder forms of pervasive developmental disorder. They also resemble the children described by Towbin et al. (1993) and Cohen et al. (1994) as showing "multiple complex developmental disorder."

By contrast, a second cluster of children, which we designate as Cluster B, show intense, even dramatic, affect and hunger for social response. Clinginess, hyperactivity, and temper tantrums are common features of their early development. By school age, they may meet diagnostic criteria for attention deficit hyperactivity disorder, conduct disorder, separation anxiety disorder, or mood disorder. Many appear anxious, moody, irritable, and perhaps explosive. This affective lability mirrors the kaleidoscopic quality of these children's sense of self and others. One moment they feel elated, in harmony with an idealized partner. But at the next moment, they plunge into bitter rage, self-loathing, or despair.

By the time they reach adolescence, drugs, food, or promiscuous sex may be used to block feelings of being out of control, fragmented, and lonely. Self-mutilation and suicidal gestures are common among girls, whereas aggression, coupled with hidden fears of rejection, is more typical of boys. We have some evidence to suggest that if analysts are successful in maintaining Cluster B children in treatment, their outcome is comparable to that of children with neurotic disorders. Children in Cluster A generally have a poorer outcome, although less likely to terminate prematurely (Fonagy and Target, 1996b).

Undoubtedly, no single pathogenic factor can explain this heterogeneous subgroup of the children we classified as showing severe emotional disorder. Constitutional vulnerabilities interact in various combinations with developmental factors, such as chronic illness or disability in the child, early parental loss, parental psychiatric distur-

bance, abuse and neglect, or restriction of autonomy. In spite of the heterogeneity, these youngsters seem to share a characteristic that we think is crucial and that we focus on: Some pervasively (Cluster A) and others intermittently (Cluster B) seem to lack the capacity to make use of an awareness of their own and other people's thoughts and feelings. This capacity is referred to as "mentalization" or "reflection function" by both cognitive developmentalists (Morton and Frith, 1995) and psychoanalysts (Fonagy, 1991; Fonagy and Target, 1995) and is maintained by neural structures that Baron-Cohen and others have termed "Theory of Mind Mechanisms" and localized with functional Positron Emission Tomography scans to the frontal lobe (Baron-Cohen, 1995).

Mentalization:

A Protective Factor and a Focus of Psychotherapy

Mentalization or reflective function is the developmental acquisition that permits children to respond not only to another person's behavior, but to the child's conception of others' attitudes, intentions, or plans. Mentalization enables children to "read" other people's minds. By attributing mental states to others, children make people's behavior meaningful and predictable. As children learn to understand other people's behavior, they can flexibly activate, from the multiple sets of self-object representations they have organized on the basis of prior experience, the one(s) best suited to respond adaptively to particular relationships.

Exploring the meaning of others' actions, in turn, is crucially linked with the child's ability to label and find meaningful his own psychic experiences, an ability that we suggest underlies affect regulation, impulse control, self-monitoring, and the experience of self-agency.

To appreciate the nature of this developmental process we have to delineate two levels of mental functioning not often distinguished in psychoanalysis. All mind is representation, but representations are themselves represented in the mind. In cognitive science, this is

¹For clarity, we have sometimes referred to the child as he and to the caregiver or therapist as she. This makes it easier to follow and corresponds to the actual gender in the larger majority of instances.

referred to as the distinction between cognition and metacognition. Some analytic authors, who contrast symbolic with concrete representations, touch on a similar dimension, although the concepts have become overburdened.

The deficit or dysfunction we address here is a difficulty in generating meta-representations, a disorder of a mental process, in terms we have elaborated before (Fonagy, Edgumbe, et al., 1993). Patients with certain personality disorders in childhood or adulthood cannot reliably access an accurate picture of their own mental experience, their representational world. Children with limited mentalization or reflective abilities are unable to take a step back and respond flexibly and adaptively to the symbolic, meaningful qualities of other people's behavior. Instead, these children find themselves caught in fixed patterns of attribution; rigid stereotypes of response; nonsymbolic, instrumental uses of affect—mental patterns that are not amenable to either reflection or modulation.

Most modern psychoanalytic theories of self-development (e.g., Fairbairn, 1952; Winnicott, 1960; Kohut, 1977; Target and Fonagy, 1996; Fonagy and Target, in press) assume that the psychological self (the part of the self-representation where the self is represented not as a physical entity but as an intentional being with goals based on thoughts, beliefs, and desires) develops through perception of oneself, in another person's mind, as feeling and thinking (Davidson, 1983). It is assumed that the parent who cannot think about the child's particular experience of himself deprives him of a core of self-structure that he needs to build a viable sense of himself. We suggest that developmental personality disturbances arise first from the child's failure to find the image of his mind, his experience of himself as a thinker of thoughts, believer of ideas, feeler of emotions, in the mind of the caregiver (see Fairbairn, 1952).

We assume that for the infant, internalization of this image performs the function of the "containment of mental states" (Bion, 1962), which Winnicott (1967) described as "giving back to the baby the baby's own self" (p. 33). Through the internalization of these perceptions the infant begins to learn that his mind is not a direct replica of the real world but a version of it (though this process is not complete until around four years of age; Target and Fonagy, 1996). The experience of containment involves the presence of another being who not only

reflects the infant's internal state, but re-presents it as a manageable image, as something that is bearable and can be understood. The perception of self in the mind of the other becomes the representation of the child's experience, the representation of the representational world.

To give an example, like all emotion, anxiety for the infant is a confusing mixture of physiological changes, ideas, and behaviors. When the mother reflects, or mirrors, the child's anxiety, this perception organizes the child's experience, and he now "knows" what he is feeling. The mother's representation of the infant's affect is internalized and becomes the higher order representation of the child's experience. If the mirroring is too accurate, the perception itself can become a source of fear, and it loses its symbolic potential. If it is frequently absent, reluctant, or contaminated with the mother's own preoccupation, the process of self-development is profoundly compromised. We may presume that individuals for whom the symptoms of anxiety signify catastrophes (e.g., heart attack, imminent death, etc.) have meta-representations of their primary emotional responses, which are ineffective in containing their intensity through symbolization, perhaps because the original mirroring by the primary caregiver exaggerated the infant's emotions.

Admittedly this is a speculative model, but it is also empirically testable and might help answer the thorny question of why individuals with panic disorders consistently attribute immense significance to physiologically relatively mild levels of disequilibrium. In collaboration with the eminent Hungarian developmentalist currently at the Anna Freud Centre, Dr. György Gergely, we are in the process of designing a series of studies of the infant's emotional understanding that will more directly test these ideas. In recent studies we have confirmed that mothers who soothe their distressed eight-month-old babies most effectively following an injection rapidly reflect the child's emotion, but this mirroring is "contaminated" by displays of affect that are incompatible with the child's current feeling (humor, skepticism, irony, and the like), which reflect coping, metabolization, or containment. In displaying such complex affect, they ensure that the infant recognizes their emotion as analogous, but not equivalent, to their experience, and thus the process of symbol formation can begin.

We believe that the security of attachment between infant and caregiver is the critical mediator. A secure bond is one where the infant's signals are accurately interpreted by the caregiver, thus giving them meaning in terms of the caregiver's response. Normal affect regulation develops from the expectation of re-equilibration following arousal, through physical proximity to the object. The infant's signal of distress and the caregiver's coping-mirroring are combined into a single representation that comes to signify distress and becomes a critical part of the child's capacity to autoregulate emotion.

But what of the child whose caregiver cannot be depended on in this way? Missing the normal experience of reflection of his own mental states the child is most likely to take as the core of his representation of himself the caregiver's distorted and often barren picture of the child. The child who fails to develop a representation of an intentional self is therefore likely to incorporate in his image of himself the representation of the other, sometimes mental, sometimes physical. The picture of the self will then be distorted, and the child's experience of himself is overly influenced by his early perceptions of what others think and feel, and strangely out of touch with what he himself or others are currently experiencing. We believe, along with Edith Jacobson, that prior to the establishment of firm boundaries between representations of self and other, the infant's perception of the other comes to be internalized as part of that representational domain that will eventually become the reflective part of the self.

Many of these children show apparent failures of object permanence, leading to primitive separation anxiety or feelings of merger or fusion with the object. In reality, they continue to existentially depend on the physical presence of the other both for self-sustaining auxiliary metacognitive function (to continue to seek and find their intentionality in the mind of the other) and, more subtly, as a vehicle for the externalization of parts of the self-representation that are experienced as alien and incongruent with the self. This is why it is essential, as Winnicott (1967) pointed out, that the other acts in harmony with the infant's self to the detriment of and, at times, the temporary abolition of her own self as an entity. If the other is consistently incongruent with the state of self, the other's presentation is still internalized as part of the self structure, but without the appropriate links and associa-

tions that would enable a coherent functioning of the infant's self-representation.

The ultimate consequences of this process can be clearly discerned, we suggest, in later borderline personality structure. In order for the self to be coherent, the alien and unassimilable parts require externalization; they need to be seen as part of the other where they can be hated, denigrated, and even destroyed. The physical other who performs this function must remain present for this complex process to operate. The borderline child or adult cannot feel that he is a self unless he has the other present (often the analyst) to frighten and intimidate, to seduce and excite, to humiliate and reduce to helplessness. The other's departure signals the return of these "exterojects" and the destruction of the coherence the child achieves by such projection. This we believe is the root of that type of projective identification where the patient feels an overriding need to control the other, as his self is only actualized when the other's behavior can be forced to be consistent with this projective process. One of Cynthia Carlson's cases treated at the Anna Freud Centre used to take such control to extremes. This nine-year-old boy's mother permitted him to treat her as an extension of himself both physically and psychologically. In the analysis, he had to resort to far cruder devices, revealing the same underlying need. He frequently tied the therapist up as well as constantly ordering her to do things for him. In our view, with cases as severely impaired as this child was, understanding such behavior as an extension of the eroticized transference is unlikely to be sufficient. In this case, what turned out to be important was the child's need to make Cynthia's thoughts and feelings (of rage, hatred, disgust, helplessness) predictably present and to eliminate other ideas or feelings that Cynthia presented to him, which he found unpredictable and therefore terrifying.

At the root of disturbance such as this boy's is, we suggest, a failure to achieve mentalization, which we see as the integration of two more primitive forms of representing psychic reality (Fonagy and Target, 1996a; Target and Fonagy, 1996). In early childhood, reflective function is characterized by two modes of relating internal experiences to the external situation.

In a serious frame of mind, the child expects the internal world in himself and others to correspond to external reality, and subjective experience will often be distorted to match information coming from

outside (psychic equivalence mode), (e.g., Perner, Leekman, and Wimmer, 1987; Gopnik and Astington, 1988). While involved in play, the child knows that internal experience may not reflect external reality (e.g., Bartsch and Wellman, 1989; Dias and Harris, 1990), but then the internal state is thought to have no relationship to the outside world and to have no implications for it (pretend mode).

In normal development the child integrates these two modes to arrive at the stage of mentalization, or reflective mode, in which mental states can be experienced as representations. Inner and outer reality can then be seen as linked, yet they are accepted as differing in important ways and no longer have to be either equated or dissociated from each other (Gopnik, 1993; Baron-Cohen, 1995).

We have hypothesized that mentalization normally comes about through the child's experience of his mental states being reflected on, prototypically through experience of secure play with a parent or older child, which facilitates integration of the pretend and psychic equivalence modes through an interpersonal process that is perhaps an elaboration of the complex mirroring of the infant by the caregiver. In playfulness, the caregiver gives the child's ideas and feelings (when he is "only pretending") a link with reality by indicating the existence of an alternative perspective, which exists outside the child's mind. The parent or older child also shows that reality may be distorted by acting upon it in playful ways, and through this playfulness a pretend but real mental experience may be introduced.

In traumatized children, intense emotion and associated conflict can be thought of as having led to a partial failure of this integration, so that aspects of the pretend mode of functioning become part of a psychic equivalence manner of experiencing reality. This may be because where maltreatment or trauma has occurred within the family, the atmosphere tends to be incompatible with the caregiver playing with the most pressing aspects of the child's thoughts; these are often disturbing and unacceptable to the adult, just as they are to the child. The rigid and controlling behavior of the preschool child with a history of disorganized attachment, as with Cynthia's patient, thus is seen as arising out of a partial failure on the part of the child to move beyond the mode of psychic equivalence in relation to specific ideas or feelings, so that he experiences them with the intensity that might be expected had they been current, external events.

We believe, the almost impossible challenge patients present is rooted in this aspect of the transference. For the relationship to serve a function and to be tolerable, the analyst must do something fresh and creative, "an act of freedom" (Syrnnington, 1983), which has as one component the real impact of the real patient on the analyst, yet through its novelty reassures the patient that his attempt at control and tyranny has not completely succeeded. Through identification with the externalized part of the patient's self, the analyst has validated the patient's psychic reality, yet by bringing a new perspective, the patient is forced to see his own action with another dimension and thus overcome the one-to-one correspondence between thought and reality in his mind. Without such a creative spark the analysis is doomed to become an impasse, a rigid stereotypic repetition of pathological exchanges.

The challenge is the preservation of the "as if" nature of the therapeutic exercise, and sometimes playfulness is the only ally. A man with a violent disposition was greatly distressed by a rather clumsy interpretation made to him. Aiming to be empathetic, the analyst referred to the pain he felt about a canceled session. The patient promptly got up, shoved his fist under the analyst's nose, and said, "I'll show you what pain is, you little shit!" Without thinking, the analyst said "You know, as I get older I can't see things so clearly when they are too close to my eyes," and with that gently moved the clenched fist away from his face. To the analyst's relief and surprise, the patient immediately calmed down and smiled. On reflection, the analyst realized what was critical to this exchange: forcing this patient to experience the world through the analyst's somewhat long-sighted perspective and thus to see him as a real person, allowing the patient to enter his mental world.

Self, Action, and the Body

Over 10 years ago, Stern (1985) summarized findings and offered theories tracing self-development back to the actions of the four-month-old. A sense of authorship of one's own actions, whether derived from the experience of forming plans, proprioceptive feedback, or the consequences of physical action, contributes to the continuity of the sense of self. Where actions are significantly curtailed, self-agency and

continuity are threatened. Bolton and Hill (1996), in their outstanding book *Mind, Meaning and Mental Disorder*, make a strong case for the "close connection between thoughts and action, and of the experience of effective agency as crucial to the sense of self" (p. 368). This crucial link of intentionality between thought and action cannot be totally sustained by actions of the child, as these usually continue to be limited because of his immature physical and cognitive capacities, in certain respects until adolescence. Playful interpersonal interaction that permits (a) the registration of perceptions, thoughts, and emotions as causes and consequences of action and (b) the contemplation of these mental states without fear provides the basis of self-agency.

Coercive, rigid, frightening, and, at an extreme, abusive parenting can undermine not just the understanding of mental states, but also the establishment of a firm connection between the self and action, as this connection crucially depends on the perceived bidirectional link between mental state and action. Disorders of conduct may be understood as the consequence of the child having failed to link his sense of self with his actions. In the case of abuse, the meaning of intentional states is also commonly compromised by the parent's denial of the child's internal reality. Abuse, particularly within the family, prevents the child testing representations of mental states for their applicability, truth, and possible modification. The representations thus become rigid and unhelpful and are partially and sometimes almost fully abandoned.

The experience of helplessness and defensive decoupling of painful bodily experiences associated with maltreatment may cause the individual to blame his body for the abuse. The body is less likely to be experienced as a potent agent of action, and actions on it are less integrated with the self. It is nonetheless perceived as the cause of difficulties, and thus action directed against it relieves both frustration and anger.

Another possible outcome is that the representation of the body may be used as if it was part of the psychic apparatus. In these cases the child's own body is used in representing and expressing feelings, ideas, and wishes. The child's or another's body may be attacked in an effort to grapple with feelings and ideas in others (most commonly in boys) and in the self (mostly in girls). Young women with apparently uncontrollable insulin-dependent diabetes often fall into this group (Moran,

1984; Fonagy and Moran, 1993). In other young children, the search for the psychological self in the other may lead to the physical image of the object being internalized as part of the child's identity, and gender identity disorder, for example, may be the consequence (Coates, Friedman, and Wolfe, 1991).

The decoupling of self-representation and action because of the disruption of the child's intentional stance is as relevant for violence against the other as for violence against the self. In conduct-disordered children, the broken link between action and psychological self is painfully clear, as those of you who have treated kicking and biting children would probably testify. A critical obstacle to interpersonal aggression, the innate responsiveness to another person's suffering through identifying with his or her state of mind, is lost. This is not, as is often claimed, to be attributed to the absence of empathy, although to be sure there is little evidence of this. Rather, violence reflects the absence of a critical precursor of empathy, the capacity to link action and mental state, which normally begets the psychological self.

Another consequence of the weak link between thinking or feeling and action is that violence or aggression may be resorted to as the only acts that succeed in linking intentional state to external events. Both violent and self-harming individuals feel real when attacking someone physically. We believe (Fonagy, Moran, and Target, 1993; Fonagy and Target, 1995) that violent acts combine two powerful motivations for such people: The aggression and damage can lend a sense of coherence to the self (self-actualization) and at the same time it expresses the need to attack externalized, alien aspects of the self, felt to be either in one's own body or represented by somebody else.

Empirical Support

There is a certain amount of empirical data, from experimental studies of the development of social cognition in normal and abnormal children and from studies of parent-child attachment, that is consistent with this model.

As we mentioned, developmentalists for the most part refer to mentalizing as maintained by a theory of mind mechanism (ToMM). There is substantial accumulating evidence that ToMMs are dysfunctional in

children with autism (Baron-Cohen, 1995), some of whose symptoms children with developmental disturbances share to a milder degree. Dennett (1978) convincingly argued that the understanding of mental states, such as belief, could only be unequivocally demonstrated by the individual showing an understanding that someone else could have a false belief. The capacity to mentalize is thus operationalized as the child being able to pass a false belief task, to show understanding that someone else would act or desire something based on a mental state the child knows to be mistaken. The child is shown a tube that normally contains chocolate, but this time it has a pencil inside it. When asked what his friend will say when shown the tube, most three year olds reply, "A pencil." Four year olds, having acquired the capacity to represent false belief, will say, "Chocolate!" Various versions of this task exist. Our interest is principally in belief-desire reasoning, which tests the child's capacity to attribute appropriate emotion based on false belief.

We believe that lesser degrees of ToMM deficit, with a large psychosocial component, are prevalent in the group of children with developmental disturbances we considered previously. This suggestion fits the expectations of developmental psychologists working on the development of ToMM in normal children, who have explored the likely consequences of a child not "discovering the mind" in the normal way: impairment of family and peer relationships, the capacity to learn, and emotional control (see, e.g., Astington, 1994, pp. 146-147). A number of distinct lines of evidence converge to underline the plausibility of the model we are proposing.

- 1) In a program of work over the last 10 years several laboratories, including the London Parent-Child Project initiated by Miriam Steele, have been able to demonstrate the importance of the caregiver's capacity to think about their own past relationships in terms of their own and others' mental states to ensure the child's security of attachment. We have developed a reliable coding scheme (Fonagy, Steele, et al., 1997) that assesses reflective capacity from the autobiographical narratives obtained from Adult Attachment Interviews (George, Kaplan, and Main, 1985):
 - (i) In the London Parent-Child Project of 100 first-time parents, the large majority of both mothers and fathers,

who were rated above the median in reflective function before the birth of their first child were observed to have secure relationships with these children 12 to 18 months later (Fonagy, Steele, et al., 1991).

- (ii) The presence of social deprivation in the mother's background greatly increases the importance of reflective capacity; all the children of reflective mothers with a history of deprivation had infants who were securely attached to them, but only 1 of 17 low reflective mothers with similar histories did so (Fonagy et al., 1994). Thus the capacity to mentalize permits the individual to cope with disadvantage. The parent's efforts to make sense of the infant's behavior convey to him that mental states underlie behavior and that finding this meaning is the most effective strategy to relate and cope with the social environment. The child's sense of himself as an intentional being evolves to the extent that he can clearly perceive those intentions in the mind of the parent.
- 2) Harris (1994) and Dunn (1996), in their recent review of emotional development, identified many of the social determinants of the capacity to understand mental states, particularly emotional states. For example, recent evidence has demonstrated that mother-child and sibling-child relationships influence the rate of development of ToMM as assessed by both young children's spontaneous conversation about feelings (Brown and Dunn, 1991) and the false-belief task (Perner, Ruffman, and Leekman, 1994).
- 3) Studies of parent-child attachment have demonstrated that mentalization is a biologically prepared capacity triggered by an attachment figure who treats the child as an intentional being. A secure attachment relationship creates the emotional environment within which the child's opportunity to discover his intentional state, mentalizing capacity, or theory of mind is maximized:
- (i) Insecure attachment at five years has been shown to be negatively correlated with performance on ToMM tasks (Fonagy, Redfern, and Charman, 1997).
 - (ii) Insecure attachment to the mother at one year predicts poor performance on ToMM tasks at five years (Fonagy

et al., submitted) and limited metacognitive capacities in an autobiographical task at 10 years (Main, 1991).

- (iii) Insecure attachment at 1 year predicts poor social adaptation at 10 years (Sroufe, 1988) and identity problems and low ego resilience once in adolescence (Grossmann et al., 1993).

4) The capacity to mentalize not only permits the individual to cope with disadvantage, but ensures the transgenerational transmission of this protective capacity:

- (i) Parents' mentalizing ability (or reflective function), assessed before the birth of the child, predicts the child's mentalization capacity (performance on ToMM measures) at five years (Steele et al., 1995).
 - (ii) This process is mediated by the quality of the child's attachment to the primary caregiver at 12 to 18 months and is independent of verbal skill in either caregiver or child (Fonagy et al., submitted).
- 5) In a number of clinical papers (Fonagy, 1991; Fonagy and Target, 1995), we reported that individuals with features of borderline personality disorder appear to have specific difficulties in understanding mental states both in themselves and in others and that this dysfunction may be seen as an adaptation to intolerable experiences of maltreatment and abuse in childhood. Rather than contemplate the intolerable idea of what may be going on in the mind of their abuser, these children opt to inhibit their capacity to think about minds altogether; decouple the link between self-representation and action, and turn away from the world of thoughts, feelings, beliefs, and desires, at least in the context of intense attachment relationships:
- (i) Studies of maltreated children show that they have both disrupted attachment (Cicchetti and Barnett, 1991) and a specific difficulty in acquiring mental state words (Beeghly and Cicchetti, 1994).
 - (ii) A study of adult nonpsychotic psychiatric in-patients show that those who have documented histories of severe maltreatment with current significant impairments in understanding mental states almost invariably meet DSM-IV

diagnostic criteria for borderline personality disorder (Fonagy, Leigh, et al., 1996).

- (iii) Our recent studies of young incarcerated adults have shown even more dramatic reductions in the reflective capacity amongst criminals contrasted to a group matched for psychiatric diagnosis, with the lowest levels amongst those individuals convicted for violent offenses (Levinson and Fonagy, submitted).

We are currently involved in prospective work at the Menninger Clinic to demonstrate that the difficulties of children with developmental disorders may be understood in terms of insecure attachment in infancy and the sequelae of this which seem to include impairment in the full development of mentalizing. This, in turn, leaves them vulnerable to subsequent psychosocial stress (or may contribute to the generation of such stress) to which they respond by the sometimes dramatic inhibition of mentalizing function. It is our view that a metacognitive deficit brought about by psychosocial experiences, which undermine the healthy development of the ToMM, may account for self-regulation deficits such as problems of affect regulation, frustration tolerance, impulsiveness, and self-esteem problems, as well as social deficits, such as poor peer relationships, poor communication skills, and aggressive or violent behavior (Bleiberg et al., 1997).

It is our premise that a crucial therapeutic aspect of psychoanalysis, for both children and adults, lies in its capacity to activate people's ability to find meaning in their own and other people's behavior. Child psychoanalysis has always aimed at strengthening children's capacity to recognize mental states. We believe that a therapeutic program that engages in a systematic effort to enhance mentalization holds the promise of increasing the effectiveness of psychoanalysis for the children with more severe and complicated difficulties by more specifically tailoring therapeutic intervention to their particular configuration of clinical and developmental problems.

So what does a child analytic approach focused on enhancing mentalization look like? Work at the Anna Freud Centre for over three decades has evolved a set of techniques for helping children with, primarily developmental disturbances, or more borderline pathology, and our formulations began with studying this work in the records of

completed cases. In collaboration with Rose Edgcombe and Jill Miller, as well as George Moran and Hansi Kennedy, together with vital input from other clinical staff at the Centre, we have tried to provide an integrated view of both traditional technique and what has come to be known as developmental help (Fonagy et al., in press). For now we only consider three aspects, which are covered at greater length in a recent article by Efrain Bleiberg and the two of us (Bleiberg, Fonagy, and Target, 1997).

Enhancing Reflective Processes

How does one go about enhancing mentalizing capabilities? First of all, such patients need to learn to observe their own emotions and understand and label their emotional states, including their physiological and affective cues. They need help to understand the both the conscious and the unconscious relationships between their behavior and internal states, for instance of frustration or anxiety.

As part of that process, the analyst focuses children's attention on the circumstances that lead them, for example, to be aggressive in particular situations in which they feel misunderstood or made anxious by those around. The analyst introduces a mentalizing perspective that focuses on children's minds as well as the mental states of people who are important to them.

The focus is kept, at least initially, on simple mental states. These children are unable to accept complex mental states of conflict or ambivalence but may understand simple states of belief and desire. They will typically fail to grasp how mental states may change over time. Thus, working with current, moment-to-moment changes in children's mental states within the therapy is crucial. Likewise, analysts generally refrain, early in the process, from linking children's feelings with dynamically unconscious thoughts. An individual who fails to recognize his subjective experience can hardly relate to an even more inaccessible realm. Of course, by definition, the analyst is always addressing a nonconscious realm—feelings and ideas that the patient has limited capacity to become aware of.

Clinical experience has shown that some patients find it helpful to focus interventions around their perceptions of the analyst's mental states, as a precursor to self-reflection (Steiner, 1994). They can get to know the way they are seen by others, which can then become the core of their own self-perceptions. Analysts, of course, do not necessarily reveal to the children what they actually experience; rather, they speculate about how the child might be experiencing their state of mind at that moment. Some analysts have used guessing games along these lines (Moran, 1984), "What do you think I am thinking about you today?"

Play Helps Children to Strengthen Impulse Control and Enhance Self-Regulation

Children with mentalizing problems tend to require considerable help in curbing impulsivity. Rosenfeld and Sprince (1965) described a six-year-old child, Pedro, who frequently urinated over the analyst and her possessions. Other features of the material led the analyst to understand this as a crude attempt to coerce her into mutual activity, or simply to maintain a sense of connection. Neither interpretation nor physical restraint reduced the behavior. The analyst then devised a way of meeting what she had felt to be his need by saying that she would continue with the interrupted joint activity while he went to the lavatory, and she would give him a running commentary on what she was doing while he was there. He then stopped urinating in the treatment room and was able to still feel in contact through her voice. Pedro's analyst identified the gap in mentalization that triggered impulsivity and compensated for it.

Cluster B children often seem more impaired in their impulse control and self-regulation as their attachment to the analyst becomes more intense. The temporary impairment of mentalization appears linked to the activation of traumatic responses triggered by closeness to or separation from attachment figures (Van der Kolk, 1989, 1994; Terr, 1994; van der Kolk and Fisler, 1994). For example, Joe, a 13-year-old boy, had been subjected to brutal physical and sexual abuse by an alcoholic father, while his mother pursued her theatrical career. Almost in spite of himself, he began to feel more comfortable with the

analyst, even to look forward to the sessions. Yet desires for closeness were almost unbearable for him; thus, he began to carefully look for "mistakes" (e.g., the analyst interrupting him or "invading" his space while walking). These would trigger hateful barrages. He let the analyst know of his plans to run away and find out the analyst's address ("I have good sources, you know") so he could set the analyst's house on fire after raping his wife and murdering his children with slow, intravenous injections of cocaine. He would spare the analyst's life, but only to ensure that he would suffer the devastation of the loss of everything he held dear.

Sensing his desire to maintain a relationship, while overtly disowning it, the analyst commented on the meanness and cruelty of his imagery. Where did that come from? Joe looked at him with a mix of contempt and amusement and proceeded to describe, in a wildly exaggerated fashion, the toughness of his neighborhood and its brutal gang wars. He was sure that the analyst's wimpy, nerdy self had been shielded from such roughness. The analyst entered the role and created play. He replied with an even more fantastic account of his own heroic battles as a gang kingpin—a secret identity hidden behind his deceptively mild appearance. The banter continued over several sessions, but gradually the analyst was able to return Joe's attention to the rage he had experienced and the abuse he inflicted on the analyst.

This vignette illustrates how these youngsters often require a transitional area of relatedness akin to Winnicott's (1953) transitional experience. In this transitional, as-if area (often jointly created by patient and analyst) standing between fantasy and reality, patients can both own and disown their rejection feelings and experiences and test out the analyst's attunement, respect, and responsiveness to the vulnerable aspects of the self. The essence of the interaction appears to be the provision of a safe context in which to play with ideas and come to experience them as ideas.

The patient's threat, even if it is verbal rather than physical, is experienced by him as action; its modulation by the analyst into an idea allows it to be played with, mentalized, thus creating the potential for understanding. For the abused child, the adult's mental world is too real a threat to permit play and is thus shunned and avoided. The analyst's attitude and verbalization permit the opening of a window on the mental world of self and other, but the child has to find the courage

to use this, to look through it and find his own feelings and ideas—something that has never before felt safe. In other words, the therapeutic intent is to facilitate the establishment of a beachhead, an area of self–other relatedness. Prematurely confronting the patient's defenses before this beachhead is established only exacerbates the need for distance, control, or devaluation of the analyst and the therapy.

The capacity to take a playful stance may be a critical step in the development of mentalization as it requires holding simultaneously in mind two realities: the pretend and the actual, in synchrony with a moment-by-moment reading of the other person's state of mind. Analysts often need to create a context in which an attitude of pretense is possible. For example, they may exaggerate their intonations to mark for children the pretend nature of interactions or may choose objects that are clearly incapable of adopting any intentional stance (e.g., crude toys).

Gradually, children are nudged to introduce small modifications in their play to better encompass the complexities, limitations, conflicts, and frustrations of reality. The transitional space of play and fantasy offers borderline children the magic of anonymity in which to attempt to bring together split-off representations of the self and others.

Working in the Transference

Finally, the emphasis is on working in the transference, not “transference” in the classic sense of expecting children to “transfer” their thoughts and feelings about their parents onto the analyst. The relationship with the analyst, however, remains central because the clarification of children's feelings about themselves and about the analyst is the most effective route toward acquiring mentalizing capacity.

The analyst uses her relationship with the child as a vehicle for all the processes described earlier, helping him to find, through involvement in a therapeutic relationship, a way of thinking, understanding, and coping with feelings; of recognizing the connections and differences between oneself and somebody else; and of being with another person. Accepting and recognizing the mental chaos of the patient and abandoning the traditional stance of recovering forgotten memories is

the first step of the process. The past makes no sense as a cause of the present, as it is the present that cannot be thought or felt about. The analyst has to teach the patient about minds, principally by opening his mind to the patient's explorations. “Deep interpretations” will be experienced as persecutory taunts, intrusions, distractions, or seductions. The appropriate focus of work is the exploration of triggers for feelings, small changes in mental states, highlighting differences in perceptions of the same event, bringing awareness to what would be almost conscious for most people. Work takes place strictly in the analyst–patient relationship and focuses on the mental states of patient and analyst. Interpretations are not global summaries, but rather attempts at placing affect into a causal chain of concurrent mental experiences. The patient's actions on the analyst are not intended as communications (and interpreting them as such is therefore not appropriate). They are desperate attempts at coping with the intolerable closeness that analysis brings.

The analyst adopts a nonpragmatic, elaborative, mentalistic stance that places a demand on the patient to focus on the thoughts and feelings of a benevolent other. This stance, in and of itself, enhances, frees, or disinhibits the patient's inborn propensity for reflection and self-reflection. Perhaps more important, he is able to find himself in the mind of the analyst as a thinking and feeling being; the representation that never fully developed in early childhood and was probably further undermined by subsequent painful interpersonal experience. In this way, the patient's core self-structure is strengthened, and sufficient control is acquired over mental representations of internal states so that psychotherapeutic work proper can begin. Even if work were to stop here, much would have been achieved in terms of making behavior understandable, meaningful, and predictable. The internalization of the analyst's concern with mental states enhances the patient's capacity for similar concern toward his own experience.

Conclusion

Psychoanalysis is under savage attack in most countries where it is practiced. Yet intensive psychosocial treatments for severe psychologi-

cal disorders are increasingly seen as essential by behaviorists, cognitive therapists, and those practicing systemic work with families. We recommend a shift in analytic technique for certain particularly disturbed or traumatized children, from the conflict- and insight-oriented approach to a focused, mentalization-oriented therapy, which we believe is already widely used by those treating severe psychological disturbance. Psychoanalytic training, supervision, and personal treatment remain crucial in enabling clinicians to use their emotional reactions to better understand their patient's subjective world, rather than be entrapped in the quicksand of rigid, unthinking patterns of relatedness. The techniques suggested here and the theoretical ideas on which they are based may also be put to good effect in prevention, informing parenting training, home visitation programs, nursery education, and crime prevention initiatives.

The change of aims and priorities we are suggesting is not radically new or exclusive of other approaches, which of course includes more classical technique with the "good, neurotic case." At its strongest, our claim is that severe disorders of character require modifications of technique in the direction of prioritizing a mentalizing approach. At its weakest, we are introducing new jargon into an area already bursting with terminological confusion. However, even here, there may be value added by harmonizing our language with that of developmental cognitive science.

Of course, as analytic readers, you will see through this false modesty. Deep down we do believe that we are doing analysis with these patients, in that we are trying to understand the roots of psychological problems in early emotional development, encompassing the whole range of conscious and unconscious motivations within the intense relationship with the analyst. Thus, we believe that we may contribute to the advancement of Freud's vision of development, psychopathology and therapeutic action. But then we would think that, wouldn't we?

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