The growth and development of personality from childhood to adult years: psychology and psychopathology

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  - Dr Laura Lomax, Dr Stuart Twemlow
  - Dr Brooks King-Casas, Dr Read Montague
  - Dr Helen Stein
- Yale Child Study Centre
  - Dr Linda Mayes
Quite a boring and long book.

Frankly, you are far better off listening to the talk!!!
The extended role for early attachments

- Attachment confers a selective advantage to humans by the opportunity it affords for the development of neurocognitive social capacities

- Evolution has charged attachment relationships to ensure the full development of the social brain
A working definition of mentalization

Mentalizing is a form of imaginative mental activity, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons).
Schematic depiction of the interaction of the 3 nodes of the social information processing network (SIPN)*

Brain structures directly relevant to mentalizing

- Reasoning about false beliefs
  - medial prefrontal cortex (anterior to the ACC)
- Attributions of desires & goals
  - the medial prefrontal cortex & posterior superior temporal sulcus
- Inhibitory controls
  - the anterior cingulate cortex (ACC)
- Understanding affect
  - amygdala, insula and basal ganglia
- A shared sub-personal neural mapping between what is acted and what is perceived
  - Mirror neurons in parietal and premotor cortical networks
The Confluence of Vulnerability Factors

1. Fragile affect regulative processes
The Centrality of Affect Regulation

- Diagnostic criteria:
  - Intense episodic dysphoria, irritability or anxiety
  - Other criteria – e.g. inappropriate anger

- Originally suggested by M. Schmittleberg (1947)

- Reaffirmed by
  - Siever et al. (2002) – one of two endophonotypes of BPD (other – impulsive aggression)
  - Linehan (1993) one of three key disabilities (other – non-validating environment, low distress tolerance)
The Centrality of Affect Regulation

Empirical phenomenological observations

- Zanarini et al. (2003) 6 year follow-along study, 90% endorse affective instability
- Factor analysis of symptom presentation in Collaborative Longitudinal Personality Disorder Study (Sanislow et al., 2002)
  - Disturbed relatedness
  - Behavior dysregulation (impulsivity)
  - Affect dysregulation

Studies of affective reactivity in BPD

- Experience more negative affect and negative experience has higher salience for BPD (Brown et al., 2002; Korfine & Hooley, 2000)
The Centrality of Affect Regulation

- Neuroscientific evidence
  - Cognitive effortful affect regulation recruits lateral ventral, dorsomedial, and dorsolateral regions of PFC (Davidson et al, 2003)
  - Automatic regulation of emotion in amygdala and OFC (Ochsner & Gross, 2004)
  - Evidence of structural and functional deficit in brain areas normally considered central in affect regulation
    - Disrupted amygdala functioning ➔ negative affect salience
    - Disrupted OFC functioning ➔ impulsivity
    - Disrupted hippocampal functioning ➔ fail to ignore task irrelevant affective stimuli
Models of Affect Regulation

- Two factor theories of affect
  - Generation of affect $\rightarrow$ Management of affect
  - Gross (1998) Antecedent focused (e.g. situation selection, attention deployment, cognitive change) vs. response modulation (e.g. substances, activity, self harm)

- One factor theory: regulation = modification of any process within the system that generates emotion (Campos et al., 2004)
Theory: Birth of the Agentive Self

Attachment figure “discovers” infant’s mind (subjectivity)

Infant internalizes caregiver’s representation to form psychological self.
Safe, playful interaction with the caregiver leads to the integration of primitive modes of experiencing internal reality ➔ mentalization.
The Development of Affect Regulation

- Closeness of the infant to another human being who via contingent (mirroring) actions generates a symbolic representational system of mental states and assists in developing affect regulation and selective attention
  ➔ secure attachment

- For normal development the child needs to experience a mind that has his mind in mind
  ➢ Able to reflect on his intentions accurately
  ➢ Does not overwhelm him
  ➢ Not accessible to neglected children
The development of regulated affect

Symbolization of Emotion

Expression
Reflection
Resonance

Representation of self-state: Internalization of object’s image

Symbolic binding of internal state

Expression of metabolized affect

Contingent display

Constitutional self in state of arousal

Non-verbal expression

Signal

Fonagy, Gergely, Jurist & Target (2002)
Mirroring sadness

Unmarked mirroring

Marked mirroring
Experimental Arrangements for the Contingency Performance Modified Still Face Study (Koos et al, 2000)

- Infant’s seat
- Mother’s chair
- One-way mirror

Orient to self (perfectly contingent stimulus)

Orient to mother
High congruent & marked mirroring
Low congruent & marked mirroring
Duration of Looking at Self During Three Phases of Modified Still Face Procedure

(Gergely, Fonagy, Koos, et al., 2004) $F_{\text{interaction}} = 6.90$, df = 2, 137, $p < .0001$
Duration of Looking at Self During Three Phases of Modified Still Face Procedure

(Gergely, Fonagy, Koos, et al., 2004)
Pretence task at 3 years
High and low attuned mothers in the MIS predicting the creative use of pretence

(Gergely, Koos, Fonagy et al., 2004)  Mann-Whitney=196, $z=2.4$, $p<.006$
Secure individuals, who had an attentive attuned carer, have more robust capacities to symbolically represent emotional states in their own and other people’s minds and this can serve to protect them from future psychosocial adversity.
The Confluence of Vulnerability Factors

1. Fragile affect regulative processes
2. The disorganisation of the self when associated with a history of hostile and violent attachments ➔ perpetual inescapable trauma
Theory: Birth of the “Alien” Self in Disorganized Attachment

The caregiver’s perception is inaccurate or unmarked or both

Absence of a representation of the infant’s mental state

Mirroring fails

Internalisation of a non-contingent mental state as part of the self

The child, unable to “find” himself as an intentional being, internalizes a representation of the other into the self with distorted agentive characteristics
The disorganisation of the self

- Most consistent finding from attachment and BPD studies is association between unresolved/disorganised attachment and BPD diagnosis (Fonagy et al., 1996; Patrick at al., 1994; Stalker & Davies, 1995)

- Longitudinal findings
  - Lyons-Ruth et al. (2005) 18 year study of mothers and infants found BPD symptoms in young adulthood
    - to be predicted by early maltreatment (50% vs 9%)
    - mother-infant disrupted communication (40% vs 12%)
      weakly associated with disorganized attachment
    - The strongest correlation reported was between inappropriate maternal withdrawal from her infant and borderline symptoms in her child 17 years later.
  - Carlson et al., (2003) early neglect and maltreatment ➔ self-injurious behaviour
Families of BPD Patients

- Low family cohesion and high instability (Feldman et al., 1995)
- Mothers of BPD adolescents rated less empathic, more ego-centric, less differentiated (Golomb et al., 1994; Guttman & Laporte, 2000)
Studies of caregiving by BPD mothers

- Given general consensus on the transgenerational transmission of attachment behaviours we might learn about the mothering received by BPD patients by direct observations of BPD parenting

  - More intrusiveness and insensitivity towards 2 month olds (Crandell et al., 2003)
  - More intrusive with 12 months olds who are more likely to be disorganised in their attachment (Hobson et al., 2005)
  - Children of BPD mothers have more psychiatric diagnoses including BPD symptoms
The Centrality of Abuse

- Maltreatment in childhood ➔ deficit in coherence of self representation and consequent disorganisation of attachment relationships (Cicchetti et al., 2006)

- Increasing BPD symptomatology with increasing level of severity of abuse (especially sexual)
  - Silk et al., 1995; Zanarini et al., 2002

- Maltreatment increasingly seen as causing disorganisation of coherent functioning within the brain
  - Kaufman et al., (in press) strongest correlate of maltreatment in structural brain imaging is poor connectivity across corpus callosum
  - Teicher et al. (2006) confirmed by studies on animals
**Theory:** Self-destructiveness following Trauma

Self-harm state

Attack from within is turned against body and/or mind.

- Self experienced as evil/hateful
- Unbearably painful emotional states
- Perceived other
- Torturing alien self
- Self representation
The Confluence of Vulnerability Factors

1. Fragile affect regulative processes
2. History of hostile and violent attachments → perpetual inescapable trauma
3. Failure of mentalisation → pre-mentalistic experiences of mind
A dynamic version of the Trust game (10 rounds)
BPD: The absence of Basic Trust

$20 \rightarrow \text{Subject 1} \rightarrow x 3 \rightarrow \text{Subject 2}

Investor

Camerer & Weigelt, *(Econometrica, 1988)*
Berg, Dickhaut & McCabe *(Games and Economic Behavior, 1995)*

Trustee

King-Casas, Fonagy, Sharp, Lomax and Read, (in preparation)
Average Repayment:

- repay everything
- repay investment (33%)
- repay nothing

*King-Casas et al, in preparation*
Investor Sent
MU sent / MU available
26 non-psychiatric investors
42 non-psychiatric investors

Trustee Repaid
MU sent / MU available
26 non-psychiatric trustees
42 BPD trustees

*King-Casas et al, in preparation
Region of maximum activity in the region of the anterior paracingulate cortex elicited when subjects adopted an ‘intentional stance’*

What are the dynamics between partners that could result in decreasing cooperation in NC/BPD dyads?
How do investor variables predict changes in repayment by group?*

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<thead>
<tr>
<th></th>
<th>Controls</th>
<th>BPD</th>
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<tbody>
<tr>
<td>negative investor reciprocity</td>
<td>0.32</td>
<td>0.32</td>
</tr>
<tr>
<td>p</td>
<td>4.0E-03</td>
<td>2.9E-04</td>
</tr>
<tr>
<td>(79)</td>
<td>(100)</td>
<td></td>
</tr>
<tr>
<td>positive investor reciprocity</td>
<td>0.43</td>
<td>0.13</td>
</tr>
<tr>
<td>p</td>
<td>1.8E-04</td>
<td>ns</td>
</tr>
<tr>
<td>(72)</td>
<td>(121)</td>
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both groups ‘punish’ betrayals similarly

controls ‘reward’ benevolence more than BPDs

Thus, controls strongly incentive further increases in cooperation, while BPDs do not.

*King-Casas et al, in preparation
Normal Controls

Change in Investment x Change in Repayment

\[ r = -0.39, \ p < .004 \]  
\[ (N = 50) \]

\[ r = +0.18, \ ns \]  
\[ (N = 60) \]

\[ r = +0.38, \ p < .002 \]  
\[ (N = 65) \]

*King-Casas et al, in preparation*
Normal Controls

Change in Investment x Change in Repayment

when investments increase into the ‘high range,’ trustees give back more – rewarding their partner’s generosity

when investments decrease, making the investment level dangerously low, trustees give back more – ‘cry uncle’

$r = -.39, p < .004$  
(N = 50)

$r = +.18, ns$  
(N = 60)

$r = +.38, p < .002$  
(N = 65)

*King-Casas et al, in preparation*
BPD group

Change in Investment x Change in Repayment

$r = .00, ns$  
(N = 108)

$r = -.08, ns$  
(N = 94)

$r = +.06, ns$  
(N = 72)

*King-Casas et al, in preparation*
BPD group

Change in Investment
x Change in Repayment

BPDs don’t ‘reward’ investments increases

BPDs don’t ‘forgive’ investments decreases

$r = .00, ns$
(N = 108)

$r = -.08, ns$
(N = 94)

$r = +.06, ns$
(N = 72)

*King-Casas et al, in preparation
Summary:

correlation of repayment change with
(a) investor reciprocity and (b) investment change change

<table>
<thead>
<tr>
<th>Low Investor Ratio</th>
<th>Normal Controls</th>
<th>Borderline PD</th>
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<tbody>
<tr>
<td>Reciprocity</td>
<td>Change</td>
<td>Reciprocity</td>
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<tr>
<td>0.29</td>
<td>-0.39</td>
<td>0.44</td>
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<td>p</td>
<td>ns</td>
<td>4.0E-03</td>
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<td>N</td>
<td>45</td>
<td>50</td>
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<th>Middle Investor Ratio</th>
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<tr>
<td>Reciprocity</td>
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<td>0.64</td>
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<tr>
<td>p</td>
<td>5.4E-07</td>
<td>ns</td>
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<tr>
<td>N</td>
<td>50</td>
<td>60</td>
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<table>
<thead>
<tr>
<th>High Investor Ratio</th>
<th>Normal Controls</th>
<th>Borderline PD</th>
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</thead>
<tbody>
<tr>
<td>Reciprocity</td>
<td>Change</td>
<td>Reciprocity</td>
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<tr>
<td>0.56</td>
<td>0.39</td>
<td>0.33</td>
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<tr>
<td>p</td>
<td>1.0E-05</td>
<td>2.0E-03</td>
</tr>
<tr>
<td>N</td>
<td>55</td>
<td>65</td>
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Unlike controls, individuals with borderline PD do not vary their strategy based on investment level.

*King-Casas et al, in preparation
BPD patients think less about the mental state of the person they are playing with.

BPD patients noticed when the other person reacted contingently with them (gave more when they gave more, less when they gave less).

BPD patients did not react to what their partner did independently of their actions.
Examples from the Reading the Mind in the Eyes (Baron-Cohen et al., 2001)

surprised

joking

sure about something

happy
Examples from the Reading the Mind in the Eyes (Baron-Cohen et al., 2001)

friendly

sad

surprised

worried
Performance on Eyes Test and Early Physical, Sexual and Psychological Abuse

(Fonagy & Stein, 2005)

R² (all CECA subscales)= .35, p<.005
Performance on Eyes Test and Adolescent Physical, Sexual and Psychological Abuse

(Fonagy & Stein, 2005)  

R² (all CECA subscales) = .43, p < .005
Mean Eyes Scores of Self-harming/Suicidal patients (n=25), PD controls (n=25), Axis-I (n=24) and non-Psychiatric Controls (n=25)

F(3,95) = 6.1, p<.001

(Fonagy, Stein, Allen & Vrouva, 2005)
Structural Equation Model for BPD and Mentalizing

$\chi^2 (32, N = 147) = 40.5, p = .144$

CFI = .978

NNFI = .962

RMSEA = .043

(Fonagy & Stein, 2005)
Interaction of Abuse, Reflective function and BPD (Fonagy et al., 1998 J.Cons Clin)

Likelihood ratio: Chi-squared=8.67, df=1, p<.004

Non-Abused

Abused

High RF

88.2%

11.8%

Low RF

83.3%

16.7%

83.3%

96.6%

3.4%
The hyperactivation of attachment in BPD

- We assume that the attachment system in BPD is “hypersensitive” (triggered too readily)
- Indications of attachment hyperactivity in core symptoms of BPD
  - Frantic efforts to avoid abandonment
  - Pattern of unstable and intense interpersonal relationships
  - Rapidly *escalating tempo* moving from acquaintance to great intimacy
**Theory:** Self-destructiveness and Externatisation Following Trauma

Perceived other

Unbearably painful emotional states:
Self experienced as evil/hateful

Self-harm state

Projective identification is used to reduce the experience of unbearably painful emotional state of attack from within – externalisation becomes a matter of life and death and addictive bond and terror of loss of (abusing) object develops

Victimized state
Countertransference and externalisation

- Gabbard and Wilkinson (1994) common forms of countertransference (anger and hatred, helplessness and worthlessness, fear and worry, urges to save and rescue the patient)

- Betan, Heim, Bradley & Westen (2005)
  - Evidence for push-pull and love-hate dynamic with BPD
  - “I feel used and manipulated”
  - “I feel mistreated and abused by him”
Mentalisation and the attachment system
The mesocorticolimbic dopaminergic reward circuit in attachment & addiction processes.
Common regions of deactivation with maternal and romantic love (Bartels & Zeki, 2004)
Attachment and the deactivation of the social judgment network

- Both maternal and romantic love elicit an overlapping set of deactivations
  - temporal poles, parietotemporal junction and paracingulate in prefrontal cortex ➔
  - social trustworthiness, moral judgements, ‘theory of mind’ tasks, solely negative emotions, attention to own emotions
    - underpin determining other people’s emotions and intentions
The inhibition of reciprocally active systems by attachment system explains aspects of BPD

- Further weakens capacity to mentalise
- Removes the system responsible for maintaining a normal emotional barrier between self and others and generates an impression of entangled and preoccupied relationships
- Somewhat unwisely, may remove the need to assess the social validity of the partner
- Excessively positive character of the initial phase relationships that individuals with BPD form (often labelled ‘idealization’) may reflect the suppression of negative relationship specific affects

Prefrontal capacities

Posterior cortex and subcortical capacities

Performance

Changing switchpoint threshold

Arousal

Low → High

Point 1

Point 1a
The implication of the temporary loss of mentalising – the re-emergence of prementalising thinking

1. Psychic Equivalence
2. Pretend Mode
3. Teleological Stance
The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

- ** Psychic equivalence:**
  - Mind-world isomorphism; mental reality = outer reality; internal has power of external
  - Experience of mind can be terrifying (flashbacks)
  - Intolerance of alternative perspectives (“I know what the solution is and no one can tell me otherwise ”)
  - Self-related negative cognitions are TOO REAL! (feeling of badness felt with unbearable intensity)
The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

**Pretend mode:**

- Ideas form no bridge between inner and outer reality; mental world decoupled from external reality
- Linked with emptiness, meaninglessness, endless rumination and dissociation in the wake of trauma
- Lack of reality of internal experience permits self-mutilation and states of mind where continued existence of mind no longer contingent on continued existence of the physical self
- In therapy endless inconsequential talk of thoughts and feelings
  - Pseudo-mentalisation or hyperactivation of mentalisation
Neural correlates of attachment dysregulation in BPD (Buchheim et al, in prep)

The right superior temporal sulcus

The parahippocampal gyrus

dyadic pictures

BPD (n=11) vs. control

resolved controls
unresolved controls
unresolved patients
The Modes of Psychic Reality That Antedate Mentalisation and Characterize Suicide/Self-harm

Teleological stance:

- Expectations concerning the agency of the other are present but these are formulated in terms restricted to the physical world.
- A focus on understanding actions in terms of their physical as opposed to mental outcomes.
- Patients cannot accept anything other than a modification in the realm of the physical as a true index of the intentions of the other.
- Only action that has physical impact is felt to be able to alter mental state in both self and other:
  - Manipulative physical acts (self-harm)
  - Demand for acts of demonstration (of affection) by others.
Understanding suicide and self-harm in terms of the temporary loss of mentalisation

Temporary Failure of Mentalisation

- Pretend Mode
- Psychic Equivalence
- Teleological Mode
- Pseudo Mentalisation
- Concrete Understanding
- Misuse of Mentalisation

Dysfunctions of Interpersonal Relationships
- Suicide
- Self-Harm
- Impulsive Acts of Violence

loss ➔ attachment needs ➔ failure of mentalisation ➔ intensification of unbearable experience ➔ dissociation ➔ teleological solutions to crisis of agentive self
Indications of disruptions of mentalising in ED
Current ‘insurmountable’ life challenges

- Excessive demand for excellence
- Becoming a woman
- Rejection
- CSA
- Adverse parenting
- History of physical maltreatment

Disruption of mentalization
Active wish to stop oneself thinking (de-couple mentalisation)

Q: “What do you remember thinking and feeling?”

“Just being very focused on what I had to do during the day and not having to think about the things that I would have to think about normally. I had been quite introspective before. I had to drive out any mental experience and just focus on what had to be done. Not question things. My experience of everything was rather flat and empty.”

“Especially anything to do with eating, or getting food ready, or actually eating it, I would do in a very very mechanical state when I was not thinking or feeling anything. I was going through the motions in a very ritualised way. I did things like buying stuff from the same place so I wouldn’t have to think about it. I remember feeling hunger and satisfaction that I was not giving into it”.
Concern with physical trivia

- I was completely overtaken by minute details of calories and magnified attention to anything to do with food. As if it was a life and death matter. As someone with serious illness managing their medication, that degree of preoccupation with it. Small potatoes would have terrible effect. Very concrete the way these things represented things about me and what I had become.
Blocking representing feelings by the mechanics of dieting

- Often when I got up in the morning I would get sad and depressed about living on my own and feeling that I could not look forward to anything I could enjoy. I worried that I would get into some new relationship. That was what I think I was worried about. So I would start making mental lists about what I should do. How little I could eat between meals, what would be the minimum possible food I could eat. Where I would buy low calorie food. How it could fill me up.
Lack of understanding or concern with others’ point of view

- The self-centeredness of it was remarkable. Rather than focusing on others and thinking of finding them attractive I got preoccupied with my own body and trying to control it. So rather than thinking of people I thought if my clothes being too tight or not.
Avoid seeing oneself in the mind of the other (refuse to mentalise the other to avoid implications for the self)

You don’t want to let yourself think about what you look like to other people but more important that I would not want to be anywhere in my mum’s mind. It was probably true actually. And I felt my boyfriend had a quite unrealistic view of me as if I was another person and therefore he did not have me in his mind either. People I lived with, on my course for example, with friends and colleagues, I wanted to be at a distance from them, did not want them to know about me. I was focused on taking a caring role with them. I was keen to maintain that they had problems and I was looking after them and they were not allowed to ask me about how I was living my life. To make that impossible I had to be opaque in general.
Alexithymia (emotion processing) in AN patients (Zonnevijlle-Bendek et al, 2002)

- Incidence of alexithymia estimated at 2/3-3/4 of ED population across 3 studies vs 6%-26% in non-patient controls
- Alexithymia is not disorder but reflection of disrupted mentalizing

Zonnevijlle-Bendek et al  

![Mean TAS-20 scores](chart.png)
Deficit in emotional processing for AN patients (Zonnevijlle-Bendek et al, 2002)

- Deficit in emotion recognition test
- Suggests that ED patients misinterpret or fail to recognise emotions in themselves as well as other people
- Similar findings from sizable established literature


Mean scores on emotion recognition test:

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<tr>
<th></th>
<th>ED n=30</th>
<th>Control n=33</th>
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<tbody>
<tr>
<td>Mean</td>
<td>14.9</td>
<td>16.2</td>
</tr>
<tr>
<td>SD</td>
<td>1.4</td>
<td>0.9</td>
</tr>
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P = 0.002
Changes in the experiencing of ones own mind

“I felt mechanical. I felt my emotions controlled my secret behaviour. My mind, my official mind, controlled my public behaviour and there was no connection between them. That was something that I had not felt before. There were whole periods of time I felt like (I was) a spectator, I did not feel I was in my head or in control of what I was doing. This is what I meant by mechanical. I was watching it and managing it.”
Failure of cognitive regulation

- Experience of mind as uncontrolled ➔
- Desperate need to reassert control ➔
- Control reasserted in non-mentalistic manner
Re-emergence of the pre-mentalistic psychic equivalence mode

Indications that mental event (thought, belief or wish), while recognised as internal, has the same status as physical reality
Current ‘insurmountable’ life challenges

- Excessive demand for excellence
- Becoming a woman
- Rejection
- CSA
- Adverse parenting
- History of physical maltreatment

Disruption of mentalization

Psychic equivalence
Normal weight-related cognitions become oppressive

- I just knew that thin was attractive, desirable. It was everything that was good. I had always known it, but it somehow became like an edict.

- I don’t think it was primarily about losing weight or getting thinner. So in that sense I was not typical. It was far more about self control and deprivation and seeing that I was thinner just showed me that I was more good than bad.
The mere thinking of food is experienced as eating it makes you fat

- I would have “a bad thought” about a cake in a shop window. Then I would think that I had eaten it and then I would have to exercise the corresponding amount.

- But I was always worried that I would trick myself in turn. My mind would play tricks on me and that I had eaten more than I had thought or had not done the exercise that I thought I had done. (*The mere thought means that it has happened or could have happened.*)
Negative beliefs about the self feel oppressively real

- Sense of complete unacceptability
- Belief that you have to get rid of the badness to become acceptable
- I had no right to exist. I was a fraud. I felt like a cuckoo in the nest, alien, too big, too obtrusive, unwanted. Not fitting in. Not belonging anywhere. The most real thing emotionally that went on was completely secret and unacceptable. Yet necessary if I was allowed to exist at all.
Re-emergence of the pre-mentalistic pretend mode

Indications that subjectivity is completely separated from physical reality
Current ‘insurmountable’ life challenges

- Excessive demand for excellence
- Becoming a woman
- Rejection

Disruption of mentalization

- Psychic equivalence
- Pretend mode

- CSA
- Adverse parenting
- History of physical maltreatment
Pervasive self-deception

- “I was cheating eating things that had no calorie in them – cabbage, carrots, celery. But while I was doing I kind of believed it was nutritious.”
Rejection of alternative realities that threaten pretend mode

“I spent a lot of time trying to hide from people. I was more conscious of how they would see me rather than how I would see myself. They might interfere if they noticed I was anorexic. Minimal calorie meals and I would try to hide it from people because I thought they would not understand why I would do it. I did not have the thought that I was anorexic, rather the thought that other people might think I was and would not understand. Occasionally people would comment and I would get angry and feel intruded on – anxious that they would try and stop me.”
Rejection of alternative realities that threaten pretend mode

The participant describes a confrontation with GP with considerable experience. The GP warns of various complications (low electrolytes, other graphic descriptions of teeth and gums). “It was hopeless because: A. I know anyway because I am not stupid and B. It is nothing to do with me. He was treating it as a physical thing and I had actually become disembodied and it was something going on in my head. It felt like a game or pretense to me even though it was real.”
Pretend mode experienced in the mode of psychic equivalence

- “I am proud to be anorexic”
- A patient who was transferred to adult team said to her doctor in an angry tone: “you are treating me like an anorexic” – she knew she was starving herself and had spent last year doing it. “How can you not realize what this is about? This is quite different”.
- “I also like the fact that scales went down, and legs getting muscle and bone – that physical reality was pleasurable but when it was in someone else’s mind it was completely wrong.”
Re-emergence of the pre-mentalistic teleological stance

Indications that physical action is seen as the only way to alter mental state
Current ‘insurmountable’ life challenges

- Excessive demand for excellence
- Becoming a woman
- Rejection
- CSA
- Adverse parenting
- History of physical maltreatment

Disruption of mentalization

- Psychic equivalence
- Pretend mode
- Teleological thinking
The mind can be controlled by making the body work

- I remember feeling about self-deprivation as I would have done about self-indulgence – to see it as a pleasure. [triumphantly] My body was incredibly weak but the weaker it was the stronger it made me feel - I could keep myself feel strong if I could keep up not eating.

- If I triumphed over my body I triumphed over my mind.
Confusion about the meaning of being accepted

“I hope to arrive at something indescribable and good inside that will make others be different towards me.”

“The goal was for the smallest size to be too baggy and to have to wear Japanese sizes. That was a goal in itself.”
Re-emergence of disorganisation of self-structure

The absence of mentalising reveals pre-existing discontinuities in the self-structure
Current 'insurmountable' life challenges

- Excessive demand for excellence
- Becoming a woman
- Rejection
- CSA
- Adverse parenting
- History of physical maltreatment

Disruption of mentalization

The disorganised self
- Psychic equivalence
- Pretend mode
- Teleological thinking

Teleological thinking
"I've gotta be me... but I can't help thinking someone else would be more qualified!"
Attachment theory of distortions of self development

- Disorganised early attachment can segue into a discontinuities within the self amplified by trauma

- With inadequate mentalisation part of self can be experienced as persecutory “I felt like somebody outside myself bullying me and not taking any notice of what I thought or felt. It was like being tortured by someone else.” [tell me about this person?] “Like a bully at school. Someone who did not care, who would just push and push. Totally unsympathetic with no patience with any feebleness who wanted to see if I was tough on myself and not self indulgent.”

- Self-harm can be experienced as relief (concrete act against) such persecutory aspect of self