

Affect Regulation and Mentalization

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ABSTRACT

This article highlights the importance and effect of affect regulation on the development of thinking. Psychoanalysts suppose the new-born to be overflood by feeling, to say affects and emotions. At the beginning the baby is not only bodily but also psychically helpless. As the baby needs a specially prepared milk it needs a specially adapted emotional food. But how does this emotional food of affect regulation looks like? The mother takes in affects of the baby and modulates the affects. She will mirror this subtly changed to her baby. This leads to a soothing and satisfaction of the baby. By these constant repetitions it learns more and more about him and internalises this experience in him. The mechanism of internalisation is explained in this paper. Also different possibility of the development of the self are touched. Depending on the experiences in childhood of affect regulation clinical pictures are described.

Keywords

Mentalization, Attachment theory, projective identification, hyperactivation of the attachment system, marked affect mirroring, affect regulation

Introduction

A newborn baby is completely helpless and at the mercy of death without outside help. This helplessness does not mean that a baby is not already very active in perceiving and interacting with its environment. Reference should be made to books such as “The Competent Infant” by Martin Dornes (1992), which lists scientific studies on how active a newborn is. However, a helping person is still needed, who is always a mother in utero and usually the mother after the birth. After birth, the father or any other person can just as easily take on this function. In English literature the

term “attachment figure” is used for this person. Since “attachment person” is a bit awkward and is not (yet) common in our vocabulary, I will use the expression “attachment person” in the following. The caregiver will create an external, stable climate that allows the child to develop. The intrauterine situation allows the psychological function of the caregiver to be explained. In psychoanalysis, different images are used for psychological functioning. Freud, for example, initially used images of the steam engine with his drive model. This explains that he thought in terms of drive, repression and repetition compulsion. Something is repressed and wants to become conscious again.

The digestive model

Fonagy, the founder of the mentalization theory, on the other hand, primarily needs the so-called digestion model, which was proposed by Bion (1962). This is best explained by the interaction between the intrauterine baby and its mother. Not only does the mother provide the baby with a constant temperature of 37°C, but she also feeds the baby. However, unlike conjoined twins, the blood circulation of mother and embryo are separate from the beginning. The mother consumes food like cow's milk, meat, fruits, grains, etc. and digests these foods in her digestive tract. Digestion involves, for example, the proteins ingested by the mother being broken down before they enter the placental circulation. Through the placental barrier, the mother “offers” these broken down proteins to the embryo or fetus, which serve as the basic building blocks for the child’s physical development. This also applies to carbohydrates, fats, vitamins, trace elements... The child cannot take over larger building blocks from the mother, but must reassemble the building blocks itself.

We humans have to walk this arduous path of disassembly and subsequent reassembly. Vampires, so the myth goes, have found another way: As is well known, vampires cannot digest human food. They therefore rely on sucking blood directly from humans. This makes them very dependent on people, but at least they are expected to live much longer. The child, on the other hand, can under no circumstances, or only to a very limited extent, directly absorb entire assemblies. In summary, it can be said: the mother digests food that is indigestible for the baby, breaks it down and offers the baby food that it can absorb in its still immature digestive tract. This happens intrauterine via the

bloodstream and the placental barrier, in the first months of life through breastfeeding and in the first few years through the preparation of special children's food. If the baby or toddler is offered something indigestible too early, this can have fatal consequences. For example, feeding a 2-month-old baby penne (tube-shaped Italian pasta) will cause intestinal obstruction. It is very likely that the baby will end up in the emergency room and can only be kept alive through surgical intervention.

The Attachment Theory

But now to the psychological apparatus. The picture of digestion is valuable, but it cannot explain all processes. Psychoanalysis deals with the question of how a baby learns from its caregiver and what traces are left in its psyche. In recent years, scientific findings (e.g. Londerville/Main, 1981) have shown that a stable, i.e. secure, attachment promotes the development of inner security, self-esteem and autonomy. Attachment theory goes back to the English psychoanalyst John Bowlby. He postulated a biological attachment system that was responsible for the development of the emotional relationship between mother and child. Bowlby also based his work on animal experiments such as the behavior of Konrad Lorenz's geese. Through the intensive relationship that the child naturally seeks, the child forms "internal working models" which are internalized. If the caregiver offers the child a good bond, the child will develop a good bond. However, if the caregiver offers too little attachment, the child develops an avoidant attachment model. If the caregiver is irregular in the relationship offered, the child will develop an ambivalent attachment model.

The caregiver observes the child and reflects his condition back to him. Over time, it learns to integrate the behavior of its caregiver and to be able to master future situations on its own. This means it acquires an "internal working model". However, Bowlby did not describe exactly why and how this happens. Infant research has helped here by discovering new mechanisms.

Daniel Stern et al.

A major new discovery in neuroscience was the description of the mirror neuron system (Rizzolati et al. 2004) and its role in humans. An important point in learning is imitation. An example is feeding the children: the mothers open their mouths even though they are not getting anything themselves. Nevertheless, it is useful because the child imitates it immediately. Furthermore, Daniel Stern (1985) has shown that the interaction between the infant and its caregiver is shaped by both self-regulation and a sensitivity to the state of the other, which we today refer to as “attunement.” This interaction is supported by the innate abilities of the infant, who, for example, are able to imitate the facial expressions of adults in the first phases of life (cf. Metzoff, 1993).

Extensive empirical studies, e.g. by Beebe and her colleagues (Beebe/Lachmann/Jaffe, 1997), have shown that the interactions between infant and mother are complementary and occur extremely quickly. This interaction does not occur in a vacuum; rather, the mutual reaction to changes in facial expression obviously obeys expectations that both participants have regarding the other's reaction. Furthermore, Tronick (1989) showed that interactions between infant and mother are not perfectly coordinated. The failure of the “vote” is both unavoidable and conducive to development. Tronick's assumption is that restoring misaligned micro-interactions promotes the establishment of a viable human relationship. This is consistent with the experience of many clinicians who observe that restoring a broken therapeutic alliance often has greater long-term effects than the mere presence of empathic understanding. Getting through a crisis together strengthens the trust that we will be able to overcome difficult situations in the future.

To summarize: Bowlby described attachment as central; Rizzolati the mirror neurons; Stern, Metzoff and Beebe the dance of interaction; and Tronick the microrepair of these interactions. But what happens in the interaction between two people and what intentions do the two participants pursue and what traces do the interactions leave on the child (and his caregiver)?

Theory of mind

One way to understand the function of our brain is to assume that it serves to best understand our surroundings in order to make predictions. These predictions are important because they make our actions more efficient. This also applies to the footballer who wants to calculate the trajectory of a ball in advance, to the police officer who has to assess whether his opponent will attack him or not, as to a mother who wants to understand her crying baby. Since humans have the most developed brain on this planet, they are able to understand and influence their environment like no other living being. Together with the interest in understanding our environment and our fellow human beings, we also want to know our inner psychological states. We sometimes perceive ourselves as foreign and therefore experience ourselves as being influenced from outside. Emotions can be experienced as foreign bodies. It is therefore not surprising that attempts to influence one's own feelings or those of others in a desired direction are as old as humanity itself.

The Theory of Mind (ToM), also called native theory, was developed in 1978 by the philosopher Dennett. This allows the prediction of behavior from three different perspectives (quoted from Fonagy et. al. 2006, p. 33f): “from the physical perspective, the design perspective and the intentional perspective. Dennett uses predicting the behavior of a chess computer as an example. At the simplest level, it can rely on knowledge of its physical properties (the physical perspective). The design perspective would be based on knowledge of the construction of the computer, including the programming that went into the development of the device. Finally, the third option is to predict the presumably best, i.e. most sensible, move that the computer can make. Here we attribute certain beliefs and desires to the computer - in other words: regulation by intentional states. ... A “theory of mind” is a construct of interrelated beliefs and desires that are attributed to a person in order to explain their behavior.”

In the theory of mind, the assumption is to recognize conscious processes in others and oneself, i.e. to assume feelings, needs, ideas, intentions, expectations and opinions." I further quote Fonagy et al (2006, p. 34): "

Representatives of the philosophy of mind (Wollheim, Hopkins, 1992) have gone beyond Dennett's approach to also

explore unconscious processes. They showed that one of Freud's main contributions was to extend everyday psychology to unconscious mental states and to develop it into a theory of unconscious mental life. Man not only tries to predict how inanimate matter will behave, but also how his fellow human beings and himself will behave. This is done with the assumption that people have intentions, i.e. intentions. However, these are only partially conscious. From the very beginning, psychoanalysts assumed emotion or affect regulation. The defense mechanisms described by Sigmund Freud and later by his daughter Anna Freud, such as repression, denial or projection, are nothing other than affect regulation. These mechanisms are directed against unpleasant emotional states that are triggered by mental conflicts between different internal motives (such as desires or "drives" on the one hand and evaluations of reason or conscience on the other). But it was only Peter Fonagy and Mary Target (2002, German 2006) who included this affect regulation at the center of their theory with their mentalization theory. In particular, they managed to build a bridge between theory and clinical practice by seeking to understand the beginning of the development of the psychic apparatus.

Mentalization

Mentalization is a psychological ability to interpret one's own behavior or the behavior of other people by attributing mental states. Not only is the behavior considered, but above all an intention is attributed to this behavior. Intentions include qualities such as needs, desires, fears, feelings, beliefs, goals and others. Mentalization allows us to "read" from behavior what is going on in other people's heads. However, most mentalizing functions are not conscious, intentional, and explicit, but rather automatic, intuitive, and implicit. So, as Fonagy emphasizes, it is less about knowing what is happening in the other's head than about grasping "with heart and psyche" what is happening "in the heart and psyche" of the other. Mentalization assumes that an intention is attributed to the other person in their actions and actions, i.e. in their behavior. The better we understand our counterpart's intentions, the more efficiently we can predict why they will behave the way they do.

But how does a baby learn to assign intention to another's behavior? Everyone agrees that this ability develops gradually, probably based on maturation processes that come to the fore between the ages of six and twelve months. At this age, infants apparently begin to think about objects and people in terms of their "goals" (end states as distinct from intentions) and to view their actions as "rational" or "appropriate" relative to such hypothetical goals. Gergely and Csibra (1996) have shown that the principle of rational action is applied by infants to human and nonhuman objects alike. For example, nine-month-old babies react with surprise when disks of different sizes appear to behave irrationally on a computer-controlled display. When a small circle, wanting to "reach" a large circle, chooses an unnecessarily long path (the same route that had previously been necessary to avoid an obstacle), the face reflects the infant's astonishment. This surprise is avoided when the small circle finds the direct route, even if this route differs from the previous one to which the baby had already become accustomed. The baby "assumes" the intention of the small circle, which if formulated would mean something like: reach the large circle as quickly as possible and do not run into any obstacles.

But is this "assumption" innate or did the baby learn this because its mother assumed intentions from the beginning by carrying a representation of the child's psychological state? (Image 2)

How is it that young children learn abstract concepts such as true and false beliefs with such ease and that this step is mastered at about the same age? Baron-Cohen and Swettenham (1996) postulate, in the spirit of Chomsky, an innate learning mechanism to which they assign a specific location in the brain. Other theories, such as simulation theory, assume that when we want to guess someone else's intentions, we draw conclusions based on what we ourselves would do under the imagined circumstances. This simulation rarely remains just a thing that happens in the brain, but there is learning through motor imitation. Fonagy et al (2006, p. 37f) list a few more theories, all of which have in common that they largely ignore the child's emotional relationship with his/her caregivers. The mentalization theory assumes that the mother-child relationship plays a central role in the development of thinking. These functions are explained below.

How attachment is related to affect regulation

Anyone who has ever held a baby can attest to the fact that they have a hard time regulating their emotions on their own. This requires the adult to change his condition. "The baby learns that excitement in the presence of the caregiver does not have to lead to disorganization that overwhelms his or her coping skills. The caregiver will be there to restore balance. In uncontrollable states of excitement, the infant will ultimately seek the physical closeness of the caregiver because it expects them to provide comfort and the restoration of homeostasis." (Fonagy et al. 2006, p. 45)

The mother-child attachment system is that for the baby and toddler system by finding a way to control its excessive emotions. In attachment theory, four different types of attachment are distinguished: the secure, the insecure-avoidant, the insecure-ambivalent and the disorganized child. The securely attached child approaches the caregiver because they have experienced that this can help them reduce their stress and calm them down again. The insecure-avoidant child will approach his caregiver less because he has experienced that he is often not understood and comforted by him. It will therefore try to over-regulate its affect in a pseudo-autonomous manner (because it is overwhelmed). The insecure, ambivalent child turns to his caregiver when the slightest disturbance occurs because he has experienced that the caregiver has little confidence in the child's autonomy and constantly offers himself to reassure him. The disorganized child is, as the name suggests, disorganized because he does not know whether to approach his caregiver or not. There are usually traumatic experiences with the caregiver (e.g. inconsistent behavior, physical or psychological violence).

In summary, it can be said that, contrary to what many cognitive scientists postulate, affect regulation occurs primarily within the mother-child (caregiver-child) relationship. Authors such as Lane and Schwartz (1987) have postulated five stages of development in which the ability to perceive and verbalize one's own feelings is developed. These are seen as an emotional-cognitive ability, which, similar to the sensory-cognitive abilities defined in stages by Piaget, can reach very different levels of maturity individually but are fundamentally independent of the caregiver. However, it is clear from attachment theory that the caregiver plays a complicated role, as for many children they are not only a source of security, but also a source of stress and anxiety. The child gets to know himself in this

relationship. Winnicott was one of the first psychoanalysts to connect the development of the self with the caregiver. Winnicott ([1967] 1993) wrote: “What does the child see when it looks into its mother’s face? I guess generally what it sees in itself. In other words, the mother looks at the child, and how she looks depends on what she sees herself. [...] But I am of the opinion that one should not take for granted what mothers [...] naturally do. What I mean becomes even clearer when I ask directly what a child sees in a mother's face that reflects her own mood or, even worse, the rigidity of her own defenses! [...] You look - and don't see yourself again.« (p. 129)

The psychic self arises when a child can perceive themselves as a thinking and feeling being in the psyche of another person. The human psyche needs another person for its creation. A baby cannot feed itself any more than it can develop its psyche on its own. But what effect does the caregiver's psyche have on the baby's psyche? Bateman and Fonagy (2006) presented this graphically as follows.

The caregiver observes the baby and draws conclusions from the baby's behavior (inference). For example, if the baby cries, the caregiver will assume that the baby is hungry, scared, upset, bored, too cold or too warm, gassy, etc. - so they attribute an intention of communication to the baby's cry. Yes, an intention is attributed to screaming. In fact, the infant does not know what is wrong with him, but is crying because he is stressed and cannot process the unbearable emotion himself. This is where the view of Fonagy et al. differs radically from many more cognitively oriented researchers. Fonagy is of the opinion that the human psyche is absolutely dependent on another human psyche for its development; in short, “brains need brains”. The baby does not yet know what it means to be hungry, tired, bored, angry, ... This idea ultimately means that psychological self-development represents an intersubjective process in the course of which the caregiver's reaction to his statements becomes increasingly clear to the infant and organized perception of internal states. The research findings show that the infant initially experiences his emotional states as completely confusing. How should a baby, in which a physiological state of arousal is building up and whose behavior expresses avoidance, know that what he is perceiving is fear?

A clinical example may explain this. Patients with psychosomatic symptoms have great difficulty attributing an emotion to what is happening within them. An 18-year-old patient who was in therapy with me came to me one day

and said that his doctor had diagnosed a stomach ulcer and asked him if he was stressed. He told the doctor that he wasn't stressed at all. I look at him in surprise and say: "You have so much argument during your apprenticeship that you are on the verge of quitting, your relationship with your girlfriend is threatening to break down, you don't feel like you are being taken seriously by your colleagues and your mother wants you put on the street. What else does it take for you to say that you are under stress?" The patient says in astonishment: "That's right, when I listen to you, I'm really under stress, but I don't feel it." Here was the therapist the caregiver who drew conclusions (inference): a psychosomatic patient who is obviously under stress is suffering from a stomach ulcer. The patient felt pain, but he could not understand that his physical symptoms were an expression of multiple internal and external conflicts. A clinician naturally wonders whether such a patient is unaware of his or her stress due to incompetence or internal conflict. However, this does not play a clinical role at this point. It was important to first make him understand that he did not see his physical sensations as signs of stress. Later, the defensive aspects could also be addressed in therapy. Without going into the theory of psychosomatics too much, it can be said that he had no reference persons who discovered his psyche, his subjectivity. He learned that it wasn't just "something" happening to him, but that he had a way to influence and understand his condition. In this way it learns to perceive itself as a feeling and acting subject.

In the infant (as well as in the patient), the “discovery of subjectivity” leaves a trace that can be called the psychological core self. Parents who cannot think about their child's inner experience in an understanding manner and react accordingly are preventing him from developing the core psychological structure that he needs in order to be able to build a stable sense of self. But how does this core self come into being? The psychoanalytic term is “internalization.” Freud, Klein, Bion and also Winnicott were very imprecise and vague when they described exactly how this internalization should take place. It remained rather hypothetical. These mechanisms can be better described using infant research and the theory of mentalization.

Marked affect reflection

One of the most central discoveries of mentalization theory is marked affect reflection. What does that mean? Fonagy (1995, with Steele et. al.) were able to demonstrate that “mothers who are most successful in comforting their whining eight-month-old infants after an injection mirror the infant's feeling very quickly, but in doing so incorporate affective expressions into the reflection, that are incompatible with the infant's current feelings (smiling, teasing facial expressions, etc.). ... [they enable] the infant to recognize that their emotion is analogous to, but not identical to, his or her own feeling. (Fonagy et al, 2006, p. 44) A mother who calms her baby, on the one hand, worsens the affect (“The injection hurt you so much that you now have to scream so much. Yes, my little one, that is real "horrible") and on the other hand she trivializes the situation ("It was just a small, harmless peck" or she distracts the child). The discovery by Fonagy et al. So it wasn't that mothers mirror their baby's current affective state. Rather, the mothers mixed in a foreign affect. They not only reflect the child's stress, but also offer him a way to deal with the pain of the vaccination. A mother can only offer a solution if she can empathize with her child and identify with the problem. In terms of the digestive model of the psyche, one could say that a mother absorbs (i.e. identifies) the psychological state of her child, “breaks it down” and then gives it back in a digestible form. In this case, this means recognizing the unbearable physical pain and giving it back in a modulated way. This leads to regulation of affect. The

mother comforts the baby by combining "mirroring" its affect with statements or behaviors that suggest different states.

This complex process has little to do with that of a simple mirroring. A simple mirroring poses the following question: how can a baby tell whether its mother is showing her own emotions or those of the child? Why do babies notice very early whether their mother is mirroring the emotional state of the mother or the baby? If a mother is actually very worried about her child (e.g. the baby is in severe respiratory distress), she will not say: "How terrible my little one", but will look very worried and call an ambulance. The mother will forego a marked affect reflection ("How terrible my little one") and will show and thus reflect her worry and fear directly. Marked affect reflection is reserved for states in which the caregiver empathizes with the baby and communicates with the baby through marked, i.e. exaggerated, mirroring. The infant learns that the caregiver can change stressful situations and identifies with them. This leads to internalization into the core self. It will be able to use what it has learned as part of a strategy for affect regulation. The growing ability to control (English contingency) helps the child to understand his inner experience as his own, subjective experience. He trusts that the caregiver will help him regulate his emotions. This is the prerequisite for later learning to understand itself and others as people whose behavior is organized by mental states - thoughts, feelings, beliefs and desires (Fonagy/Steele et al., 1995).

To summarize what has been written so far: The caregiver observes the child's behavior and tries to understand this behavior from the child's perspective. She assumes that this behavior is based on an inner logic and intention. Above all, it assumes that the baby is a personality that has its own, independent subjectivity and pursues goals. She therefore reacts to his behavior. Specifically, she will perceive his emotions and mirror them. This mirroring is marked, i.e. exaggerated. This allows the baby to recognize that the mother reflects his condition. Thanks to this mirroring, which involves affect regulation, the baby develops a psychological self. Mothers intuitively follow the following basic principles:

- 1 Attention regulation (control of arousal and impulsivity, even of excessive blockage, important also joint attention of mother and child). This is achieved through shared rhythm, pitch, speaking along, singing along, exaggerated affect reflection, clapping, etc.
- 2 Affect regulation (the psyche is in the body - but is influenced by interaction with the environment)
- 3 Mentalization and development of the psychological self.

The objection could be raised that the role of the caregiver is overestimated. After listing the behavior for good and bad mentalization, let's address this objection. It is shown that where the mother-baby interaction has gone wrong, specific psychopathological symptoms develop, which are an indication of the important role of this very interaction.

Level of mentalization

Mentalization, according to the definition, "is a psychological ability to interpret one's own behavior or the behavior of other people by attributing mental states." People who are good at empathizing with others are more efficient in their behavior. In general, it can be said that the less stressed someone is, the more they are able to correctly assess a situation. But even a bout of hunger or lack of sleep reduces our ability to mentalize. These are the signs of someone who is good at mentalizing:

Taking someone else's perspective.

Genuine interest.

Openness to the unknown.

Acknowledge that assumptions are being made.

Absence of paranoia.

Ability to forgive.

Reliable behavior.

Poor mentalization, on the other hand, is associated with the following behavior:

hostility

Active evasion

Non-verbal reactions

Lack of integration and explanation, pseudo-explanations instead

Content is taken literally (concretism)

Pseudo-mentalization.

From the points above it becomes clear that this self-reflective position takes place not only in the cognitive area, but also and especially in the emotional area. At the same time, by definition, mentalization refers not only to the perception of cognitive and emotional content in other people, but also to the perception of corresponding content in oneself. Processes of affect regulation can take place consciously or unconsciously. People with a tendency

towards integrative emotion regulation generally have a higher level of well-being and better mental health than those with a repressive or suppressive style or only weak cognitive influences on emotion regulation.

Hyperactivation of the attachment system

So far, the main thing that has been described is the healthy development of the core self. In order to understand the pathological conditions that are primarily observed in personality disordered patients, it is necessary to see what can go wrong in the development of the core self. The theory of mentalization is particularly helpful in the treatment of severely disturbed patients in the area of personality disorders. Bateman and Fonagy (2006) initiated the so-called “mentalization based psychotherapy” and tried to manualize it. Although psychoanalytic concepts are helpful, they are also often confusing. Therefore, these authors attempted to use as few psychoanalytic concepts as possible to explain the behavior of personality disordered patients (PDD).

As already mentioned, the basic emotions such as joy, anger, fear, sadness, disgust and surprise are experienced without the baby being able to classify them. Bays, for example, cannot initially determine that they are “scared” themselves. The child must first develop this ability to distinguish between different emotional states. The baby externalizes his indigestible affect and hopes that someone will help him. It takes a bond with a person who feels addressed by the need. This is usually the caregiver: a helpful person absorbs the emotions that are indigestible for the baby. As described above, these will return the affect in a modified form via a variety of processes (attention regulation, affect modulation) so that the baby can calm itself down. This corresponds to the digestive process described above. But what happens if the caregiver cannot find a way to deal with the problem (e.g. unbearable affect)?

When this process goes wrong, it is often understood in psychoanalysis as “projective identification.” This consists of the “projection” of the baby and the “identification” of the caregiver. It is a condition in which the caregiver cannot regulate the baby's affect, but rather identifies completely with the indigestible projection. This mechanism can often

be observed in parents who, because of their own psychopathology, are unable to regulate their emotions, but rather feel specifically attacked by the child. The inability to help your child can be experienced as a reproach of the same child for being an incompetent and therefore no good person. This is originally the child's feeling, but the parent now experiences it as an intolerable reproach.

In a second course, the parent will project this “accusation” back into the child. The caregiver can no longer differentiate between their own distress and that of the child. This process is mostly unconscious. The child now has a double problem: not only is his original problem unresolved, but he also becomes a “victim” of a projective identification: he identifies (in this example) with his parent's insufficiency and now thinks for his part that it amounts to nothing is good.

If further interactions follow the same pattern, a vicious circle occurs that is difficult to break. The child feels not understood and the caregiver feels attacked. What can also be referred to as “hyperactivation of the attachment system” occurs. The more the child wants to be understood, the more the caregiver will feel attacked. There are variable attacks. The result is the insecure attachments described by Bowlby. The insecure-ambivalent child sometimes tries excessively to relate to the caregiver and sometimes withdraws abruptly because he notices that an escalation in the sense of projective identification is occurring. The insecure, avoidant child seeks to distance himself from the eternal conflict. However, because its vital conflicts are not resolved, it will repeatedly try to approach the adult. These interaction patterns become established in further development.

Depressive picture

Instead of there being a clear separation between two people, the child may internalize the caregiver's feelings of guilt. This results in a part of the (internalized) caregiver constantly attacking the core self. Depressive people, for example, overwhelm themselves with self-blame, which can be understood as a trace of accusations from a caregiver. The following illustration represents this situation:

What was once between two people becomes an internal conflict. The main complication with this constellation is that the boundaries between I and you are no longer respected. Instead of boundaries being maintained, the child is colonized by aspects of the caregiver. As a result, psychological mechanisms that help people deal with emotions better are no longer available. Instead, the child has to defend itself against constant internal accusations (which come from others). This leads to a false self that torments and wants to destroy the true self. This can lead to anything from depressive images to self-destructive behavior.

Violent image

The constellation with violent patients and with so-called argumentative relationships is different. The interaction between an attacker and the attacked from childhood is repeated. However, the false self will attack the true self in another person.

In this constellation, the previously misunderstood child becomes violent. He can push away the misunderstood child within him and can feel powerful and great as a violent partner. All weak, powerless parts of the self are attributed to the partner and thus enable emotional stability. However, this breaks down as soon as the relationship breaks down. This is a hyperactivation of the attachment system. Problems that should be solved intrapsychically are dragged into an interpersonal level and are therefore not accessible to a solution. In addictive relationships, the circle of argument is always maintained. However, a separation is not possible because the attacking partner (in marriages the spouses often alternate roles) would have to admit their own powerlessness. Violent patients react even more extremely, often reacting massively to separation, for example with self-attacks, emotional breakdowns or suicide attempts.

Victim state

Conversely, it can happen that the false, attacking self is projected into a partner. These are patients who repeatedly find themselves in destructive and violent relationships and become victims there. The inner false self, which always

attacks her from within, is experienced as so alien and terrible that it cannot be seen as a part of her own. The consequences would be too terrible, so this part is projected into another person. The prerequisite for this is an addictive relationship. When such relationships break down, the factor that has provided stability for a while collapses. Patients who become victims of violent partners often collapse, become depressed or hurt themselves. This can be understood when one becomes aware that the false, destructive self can no longer be projected, but is active within the person himself.

Clinical consequences

Three mental states in personality disordered patients with different clinical pictures were described here: self-harming or depressive behavior, the violent state, and the victim state. What they all have in common is that these conditions can be explained by the early relationship with the caregiver. The clinical interventions therefore follow the understanding of the pathology:

1 The therapeutic relationship offered should under no circumstances be too close, otherwise it will represent a repetition of the child-parent relationship, which is referred to as hyperactivation of the attachment system as described above. A general overexcitation occurs, which is hardly helpful.

2 Next, attention regulation is important. Kernberg, for example, suggests therapeutic goals (in TFP, transference focused psychotherapy), agreements. Bateman and Fonagy (2006) take a less directive approach, but controlling arousal and impulsivity is also important in MBT (Mentalization based treatment). This is achieved through clear agreements and not too close proximity. Patients have a relationship pattern in which they are usually either too far away or too close to their partner.

3 Only then can affect regulation take place. This is used in a similar way to how it is used by mothers with babies: on the one hand, the affect is dramatized (“You can never forget an event like that”), and on the other hand, it is

trivialized (“Steve Jobs was also given up for adoption by his mother”). . This dramatization and trivialization must be done carefully and tactfully.

4 Over time there is an increase in mentalization. Patients initially begin to look at themselves and others more realistically during rest periods. They learn to see that when they are stressed, they have a harder time assessing what is happening in others and themselves and they fall back into old patterns (e.g. paranoid, obsessive-compulsive, depressive, etc.).

5 This leads to the development of the psychological self. This also includes recognizing how limited our ability is to really know what is happening in ourselves, let alone in another person!

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