Title

No Audience: Mind Constructed Through Representation of Self.

In cutting and photographing her cuts is the patient, a performing artist, expressing through this 'performance' the need for an audience?

Is this facsimile of the mother infant dyad (in the absence of a stable core self) replacing mentalization with psychic equivalence, pretend mode and teleological stance?

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This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature _____ Date: _____

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Philippa Martin

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INTRODUCTION

This study uses the single case study method to provide an illustration of aspects of mental representation and its relationship to mirroring. People with Borderline Personality Disorder often perform self-destructive behaviours, and cutting and bulimia are frequent symptoms (Fonagy, Target, Gergely, Allen & Bateman 2003; DSM-IV-TR, 2007). These behaviours have been linked to early attachment relationship difficulties, which result in problems with affect regulation (Fonagy & Target, 2006), and the ability to mentalize and maintain a clear sense of a core self (Bateman & Fonagy, 2004).

In this research I am looking at the representation of affective states and beliefs, thoughts and intentions in current behaviour, and its link to early attachment difficulties. I am particularly interested in the phenomenon of cutting in people with Borderline Personality Disorder, and how this is conceptualised in mentalization literature. I will use case material from a patient of mine to illustrate the argument that cutting, and then photographing the results, is used as a form of self-representation, or mirroring of self states.

The Concise Oxford Dictionary states that to represent is to "call up in the mind by description or portrayal or imagination, place likeness of before mind or senses, serve or be meant as likeness of" (1984, p.882); and that representation is "representing or being represented" (p.883). In the case of my patient, the representation is twofold. Her emotional or mental state is represented in her cutting, in that the cutting represents the emotional pain she is experiencing at the moment of cutting in a concrete manner. When she photographs the bleeding cut she is representing the representation, as a form of mirroring to herself the pain she has been experiencing. This is an alternative to thinking of or mentalizing about the pain directly. This study will explore the origins of this symptom in the patient's attachment history, and will also demonstrate the ways in which mentalization in the process of psychotherapy impacts on the frequency of cutting, as a form of affect regulation.

The ability to mentalize originates in an attachment relationship, and is developed through the primary intersubjective space (Fonagy & Target, 2006). If that attachment is disturbed, as in the case of a depressed mother who is unresponsive to her baby and neglectful of affect regulation, the infant does not develop a sense of his or her own mind; as the way that a child 'gets' a mind is by having it reflected in somebody else's (Bowlby, 1978).

This study explores the case of a young woman in whom the ability to mentalize has been compromised by an abusive and neglectful early attachment. My patient (called Medea, for the purposes of the study) is a young adult woman who is a student of the performing arts. She continues to live in the volatile home environment into which she was born. Medea began self-mutilation at the age of eleven, and continues to practise it today. Since fluoxitine was prescribed by her psychiatrist

she has shown some improvement; but when she is emotionally aroused she returns to self-mutilation, rather than turning to her mother or a friend for comfort.

This study uses a theoretical perspective that strives to explain the forms of representation of the self that are currently practised by Medea as a result of the ways in which early attachment difficulties led to an inability to mentalize. It will be argued that my patient, in an attempt to create a theory of mind that she can control, and which would reflect her mind, creates idealised fantasy images of herself. She portrays herself as a succession of fantasy creatures, and caricatures herself through cutting and then photographing her wounds.

In Medea's professional performances as a musician she refers to the audience by saying "they're just there" or "there is no real audience" – there is no real sense of connection with them in any way at all. She does not have a sense of connection with an audience other than herself. In the absence of a theory of mind, how has this patient constructed herself? What holds this construction in place, and why?

The significance of this study is that cutting is one of the most common features of Borderline Personality Disorder. The study therefore adds to the understanding of the functions of and reasons for cutting. This is done through addressing the questions in the title of my thesis:

No Audience: Mind Constructed Through Representation of Self.

> In cutting and photographing her cuts is the patient, a performing artist, expressing through this 'performance' the need for an audience?
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LITERATURE REVIEW

In the last decade, treatment of patients with Borderline Personality Disorder has undergone considerable change with the development of mentalization-based therapy and theory. These are rooted in attachment theory, which itself has developed since Bowlby first postulated his thoughts on infant development. Mentalization is a form of symbolic representation of the self and others in the mind of the mentalizing individual. Individuals with a poor attachment history (and the resultant pathology of the self) lack the ability to mentalize. The absence of a stable sense of self leads to an ongoing need for representation of the self. This results in the patient engaging in self-representative behaviours that antedate mentalization in the normal development of a child. These are non-mentalizing behaviours, and represent the feeling states of the patient. Mentalization is an advanced form of symbolic representation, as is language. Semiotics describes various forms of representational systems including the use of signs and symbols, and can be an aid in the therapeutic process.

I begin this chapter with an explanation of Borderline Personality Disorder (BPD), as I undertook this research for the purpose of understanding the behaviours of a patient with BPD. I demonstrate the link between BPD and mentalization-based therapy, which has been the mode of treatment for this patient. I follow on from there with a discussion of the early attachment relationship. When it works, the child develops a theory of mind. Failure in this relationship is linked to the development of mental illness, part of which may be a poor sense of self.

From there I go on to mentalization-based theory and therapy, including explanations of the behaviours that are considered non-mentalizing behaviours: psychic-equivalence, pretend mode and teleological stance. Although mentalization is a symbolic form of representation of mental states, current mentalization literature does not offer a full analysis of this form of representation, or of the forms of representation which replace mentalization when it fails.

I therefore follow with a discussion of representation as understood in signs and the study of signs, which is called semiotics. I describe three forms of signs (iconic, indexical and symbolic), the cultural and contextual nature of signs, and the use of signs as forms of communication in the behaviours of a patient with a BPD and others who practise body-modification behaviours.

The link between signs as representation, and expression in cases in which language has not been developed, takes the reader back to the attachment relationship in the mother-infant dyad where we began: because of a failure in the early attachment relationship, adequate symbolic representation in the form of language was not developed, and therefore more concrete or corporeal forms of representation are used. I then argue that in interpreting and understanding the semiotic self, the therapist and patient gain insight into the early construction of the self: functional, dysfunctional and behaviours.

Borderline Personality Disorder

Borderline personality disorder (in which failure of mentalization is often evident) is described in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV-TR) as "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (2000, p.710). There are nine criteria listed as indicators of the patterns described in the definition; in order for a diagnosis of BPD to be made, five or more of the criteria must be met (DSM-IV-TR, 2000).

The mentalization-based therapy model is based on the assumption that "individuals with BPD, while able to mentalize, are more likely to abandon this capacity under high emotional arousal because mentalization was not as well established during the first decade of life" (Fonagy & Bateman, 2007, p. 85).

Attachment and the Development of the Self

Historically, it was believed that infant attachment was the consequence of meeting the basic survival needs of the infant: food, warmth and protection. For example, early psychoanalytic and Hullian learning theory considered the emotional primary attachment bond to be secondary to the gratification of other needs (Fonagy, 2001; Sroufe, 1996). Bowlby's attachment theory marked a new understanding of the importance of attachment in the primary intersubjective experience of the child. He first proposed the notion that "disruption of the early mother-child relationship should be seen as a key precursor of mental disorder" (Fonagy, 2001, p. 6).

Bowlby (1978) argues that an infant enters the world predisposed to social interaction with its mother, and this serves to promote and protect the physiological well-being of the child, as well as achieving the psychological goal of feeling closeness to the caregiver. This activates attachment to the caregiver. Secure attachment facilitates exploration, whereas its absence inhibits exploration and triggers a fear response in the infant, who feels exposed and unprotected (Bowlby 1978; Fonagy, 2001; Sroufe, 1996). The attachment system keeps the attachment figure accessible and responsive – in Bowlby's term, "available" (Bowlby, 1978, p. 235). In a secure attachment system the caregiver is experienced as "available"; while in an anxious or insecure attachment system, the caregiver is perceived as unresponsive and unavailable, or inconsistent, resulting in the infant developing behaviour strategies for circumventing the unavailability and unresponsiveness of the caregiver.

This becomes the internal working model of the child, centred on the availability of the attachment figure (Bowlby, 1978). When the infant perceives a threat to the availability of the attachment figure, his or her fear of abandonment is aroused. Domestic violence is described as a particularly powerful

source of developmental difficulties, because the child anticipates a threat to the availability of the attachment figure through injury or conflict (Fonagy, 2000).

According to Fonagy & Target (2006), brain development itself is facilitated or inhibited by early psychosocial experience. Secure attachment ensures optimal development of brain processes that underpin social thinking patterns for collaboration and co-operation with others. Early childhood experiences lay down biological (brain) pathways, thereby "hard-wiring" patterns of social interaction later in life (Fonagy & Target, 2006).

Majava (2005) postulates that mirroring (discussed in more detail below) is neurobiologically programmed into the cells of the brain, facilitating (or inhibiting, by a lack of contingent mirroring) the development of a self-image and differentiation of the self from the other. In this way, the structure of the brain is physically changed, which impacts on the individual's ability to interact and form attachment relationships later in life. This means that when the primary care giver mirrors (copies) the behaviours of the child in such a way that it acknowledges the child, but also differentiates the parent from the child, this detail is "wired" into the brain as part of the brain development.

Bowlby argues that the "internal working model" (1978, p. 236) of the infant is a representational model of the self. He suggests that "each individual builds working models of the world, and of himself in it, with the aid of which he perceives events, forecasts the future, and constructs his plans" (Bowlby, 1978, p. 236). A key feature of this model is the identification of "who his attachment figures are, where they may be found, and how they may be expected to respond", and "how acceptable or unacceptable he himself is in the eyes of his attachment figures." (Bowlby, 1978, p.236). Therefore, in this model the child's feelings of acceptance or rejection by the attachment figure determine his or her working model of him- or herself.

Fonagy argues that this model is a transactional model, representative of "self-other" (2001, p. 13) relationships. It describes the intersubjective relationship between infant and child. In this relationship the child sees the parent thinking about his or her needs, and responds, modelling connections with thoughts, feelings, moods and desires. The child internalises this model and makes interpretations for him- or herself, and so develops a theory of mind – and the ability to mentalize. In the attachment relationship between the parent and child the parent responds to the child, and teaches the child about regulating his or her emotions by modelling them. The parent may do this either by soothing an over-stimulated or overwhelmed child, or by stimulating an un- or under-responsive child. The child internalises this pattern of affect regulation, and learns to regulate him- or herself.

Attachment and Affect Regulation

Fonagy states that Sroufe "reconceptualised attachment theory in terms of affect regulation" (2001, p. 14). Sroufe argues that the relationship between and infant and caregiver not only implies an "affective bond" but is in fact "the apex of dyadic emotional regulation, a culmination of all development in the first year and a harbinger of the self-regulation that is to come" (1996, p. 172). Fonagy emphasises Bowlby's suggested differential patterns of attachment, which result in the access an individual has to particular types of "thoughts, feelings and memories" (Fonagy, p. 15).

Those with secure attachment histories learn (in their attachment relationship) to regulate their emotions, and have good access to thoughts and feelings experienced in the attachment relationship. Those with insecure attachment histories either down-regulate, which means they avoid emotionally charged systems, or up-regulate and become increasingly emotionally disorganised when aroused, having limited access to attachment-related thoughts and feelings (Fonagy, 2001).

In order for affect regulation to develop in the infant, the primary attachment figure needs to match the infant's mental state accurately, so that his or her matching is congruent with what the infant is feeling. The attachment figure also needs to be able to express that affect clearly, indicating that it is not his or her own affect he or she is expressing. In making this indication the parent is 'marking' the difference. This marked expression of an emotion that is congruent with, and therefore mirrors, the emotional state of the infant is also known as contingent mirroring (Fonagy & Target, 2006).

Where the attachment figure does not accurately mirror the infant's mental state, a narcissistic structure may develop. Where mirroring does not clearly mark the attachment figure's affect as different from that of the infant, the parent's expression may be experienced by the infant as an externalisation of the infant's own mental state. Mirroring without marking can be overwhelming for the infant because it is seen as a display of the parent's own emotional state. It may seem as though the parent has been 'infected' with the child's unregulated affect, thereby escalating the emotional state rather than regulating it.

This experience may predispose the infant to experiencing emotions through others. Fonagy & Target (2006) suggest this is part of the borderline personality structure. In a secure attachment the parent or primary attachment figure soothes the child by mirroring the infant's feelings, while marking them as different from the parent's feelings. The parent manages the infant's feelings by conveying a sense that the feelings are contained.

Attachment and Alien Self

Fonagy & Target (2006) argue that in children with a disorganised attachment, the child is required to "look not for the representation of his own mental states in the mind of the other, but the mental states

of that other which threaten to undermine his agentive sense of self" (p. 562). When the child internalises these mental states of the other as representations of the self, they are alien to the self; and can also be so unbearable that they are then re-externalised in attachment relationships, rather than internalising a "capacity of containment of affects and other intentional states" (Fonagy & Target, 2006, p. 563). Fonagy & Target suggest that the result of this is that these "children whose attachment systems are disorganized become keen readers of the caregiver's mind under certain circumstances, but poor readers of their own mental states" (2006, p. 563).

Bateman & Fonagy (2004) argue that there will not be a stable core sense of self if the primary intersubjective attachment is one of early neglect or physical maltreatment, because the attachment will be disorganised. If the primary attachment figure does not respond to the infant's internal experience with sensitivity, attentiveness and availability, the feeling remains overwhelming, confusing and unlabelled, resulting in further affect dysregulation. Because there is no one to represent external states for the child, the child is under pressure to represent these states for him- or herself, and so internalises the external states of the mother or the environment as part of him- or herself.

What this means, for example, is that if the external world is violent and frightening, the child will internalise the feelings of rage and fear, and his or her experience, of him or herself as violent and frightening. This leaves the core self poorly structured, making the individual vulnerable to further trauma. Because this internalised self is incongruent and persecutory, it is foreign or alien, and must be expelled. Bateman & Fonagy (2004) argue that this need to externalise alien parts of the self may account for the frequency with which BPD patients find themselves in abusive relationships. The self is fragmented by the externalising of aspects of the self that are intolerable. They are externalised *because* they are intolerable, and they are not truly a part of the self; rather, they are the internalisation of a dysfunctional other or system (Bateman & Fonagy, 2004).

Mentalization, Mentalization-Based Treatment and Theory

Mentalizing happens most successfully in the intersubjective parent-child relationship in which thoughts, feelings, desires and beliefs are playfully experienced by the child as significant, and are respected by the parent or primary attachment figure. Simultaneously, they are marked as being different from physical reality. This integrates psychic equivalence and pretend mode in optimal mentalization. The ability to mentalize – to identify internal states *as* internal states, with symbolic representation – is necessary for self-regulation and self-organisation. This ability can only develop and become robust if there has been an opportunity to experience these patterns of functioning in the intersubjective experience between the primary attachment figure and the child. It is in the arena of a sensitive, attentive, available primary attachment that a child develops a sense of him- or herself as

having a sense of agency, of being 'intentional', and thereby developing a stable core self (Bateman & Fonagy, 2004).

Mentalization is explained by Bateman & Fonagy as follows: "Mentalization entails making sense of the actions of oneself and others on the basis of intentional mental states, such as desires, feelings, and beliefs" (2004, p. 36) . It is recognition of what is in the mind of the individual and in the minds of others, and implies an understanding of one's own behaviours and the behaviours of others. In the case of my patient, she exhibits the capacity to mentalize when she says that although she is angry with a family member, she still loves them; or, that her teacher seeing her blood running after she had cut herself "freaked her teacher out", and that is what made the teacher cry. With these comments, Medea is indicating that she understands her state of mind and that of the teacher.

Bateman & Fonagy describe mentalization as: "the capacity to think about mental states of oneself and others as separate from, yet potentially causing actions" (2004, p. 36). It is the ability to recognise what one is thinking and that it is one's own thought that determines how we behave, as well as having the capacity to recognise and allow for others to have thoughts that may not be the same as one's own. In other words: thoughts, beliefs, feelings and goals determine one's behaviour.

The ability to see the person whose behaviour you want to understand or anticipate as a rational being, with thoughts, feelings and desires separate from one's own, is what Fonagy & Target call "Interpersonal Interpretive Functioning (IIF)" (2006, p. 546). They argue that understanding another is not possible if one has not had the experience of being understood. It is in the mirroring of the caregiver in the primary intersubjective interactions between infant and caregiver that the child first experiences that she or he is understood. Bateman & Fonagy argue that mentalization is what is developed in the first few years of life, through the infant's secure attachment relationship with his or her caregiver.

Non-Mentalizing Behaviours

Bateman & Fonagy (2004) describe the main concepts that inform Mentalization-Based Treatment Theory (MBT). They are mentalization and non-mentalization. Non-mentalization is represented by three mental states: psychic equivalence, pretend mode and teleological stance. These are the ways that Bateman & Fonagy (2004) suggest that children experience their mental states prior to developing mentalization skills.

Psychic equivalence describes a state in which a person experiences no difference between his or her internal and external worlds. There is a direct translation from the internal to the external. An example of this would be projection. For example, when Medea does not perform well, and is criticised for

that, she understands herself to be not good enough. If she does one thing wrong she believes everything is wrong, and she is of no value.

In pretend mode the mental state is separate from the external world, physical reality or the patient's own emotional state. Pretend mode is detached and isolating because it is rigidly underpinned by a fantasy illusion of stability, with meaning that is not based in reality. These rigid beliefs are so unreal that the patient is detached and isolated (Bateman & Fonagy, 2004). An example of pretend mode in Medea would be the occasion that she described hunger and tears as not being real. She said that they did not exist, and were just in her mind. She does not like them, so they do not exist. When pretend mode is used in the therapeutic setting, it is referred to as pseudo-mentalizing. Pseudo-mentalization is described by Twemlow, Fonagy and Sacco (2005) as the situation in therapy in which mentalizing terms or language are used by the patient, but the connection to the reality of the experience that is being discussed has been lost.

Teleological behaviours are representative of the failure of the infant-mother dyad in developing a theory of mind because it is by having a theory of mind that the child is able to "attribute mental states to others" (Gergely & Csibra, 2003, p. 1). The teleological understanding of action is outcomes-based, and predates the ability to draw inferences about the actions of others that are evident at around the age of one year in a secure attachment relationship (Gergely & Csibra, 2003). Teleological thinking therefore predates the acquisition of language (Fonagy, Target, Gergely, Allen & Bateman, 2003). When a mother responds contingently to the infant, the child develops a sense of agency as a separate being. However, when the mother is depressed and preoccupied with marital conflict (as in the case of Medea), she is unable to respond contingently to the child, and the child does not develop a sense of agency or a clear sense of the 'other' as an intentional being, and so understands others and behaves in a more goal directed manner (Csibra, 2003).

The care-giving environment of a child plays a key role in the social development of the child. In the first months of life the child learns that he or she is a "physical agent whose actions can bring about changes in bodies with which he has immediate physical contact." This is the teleological stance; but alongside that, the child in a secure attachment relationship also develops an "understanding of himself as a social agent" (Fonagy & Target, 2006, p. 550). Through interaction in the primary intersubjective relationship the child discovers that his or her behaviour affects that of his or her caregiver. When the caregiver's response is contingent to the behaviour of the child, he or she is able to differentiate between him- or herself and the carer. When the contingent "affective-reflective" reactions of the carer occur in relation to the affective states of the child, the child learns that his or her internal self states are differentiated from those of the carer (Fonagy & Target, 2006).

For example, when the carer sees that the child is distressed and crying, the carer contingently reflects the emotion by acknowledging it in a soothing manner; the affect is contingently marked, and the

soothing affirms the child's affective sense of agency to cause the carer to respond to his or her distress. Fonagy, Target, Gergely, Allen & Bateman argue that the reason for focusing on "understanding actions in terms of their physical as opposed to mental outcomes, which is characteristic of the teleological stance ... often seen in the violent acts of some individuals with BPD" (2003, p. 420) is as a result of early adverse experience, in which the individual deliberately discontinues mentalization "in order to avoid the trauma of having to conceive of malevolent intent in the other" (2003, p. 421).

Semiotics – Signs and Symbols

Mentalization is a symbolic form of representation of mental states of the self and others, and is a "representational system for mental states" (Fonagy & Target, 2006, p. 544). Although the mentalization literature describes this metacognition, it does not analyse the nature of this form of representation in full. However, semiotics does. Leiman describes the sign as a "material form and 'a depository' of meaning. The sign always points beyond itself" (2002, p. 226), meaning it represents or stands in the place of something else. Chandler (2000) argues that we want to make meaning, and that in order to do so we invest things with meaning; with the result that anything can be a sign, as long as it is interpreted by someone as signifying something. The sign represents the signifier.

Roelofse describes different forms of representation or signs. He describes "indexical signs" (1982, p. 47) as always being natural signs; for example, smoke is an index of fire because "fires cause smoke" (1982, p. 47). In an example closer to the case of Medea, blood is a natural sign of injury, because injury causes blood to flow. Although there is more than one cause for blood, it is usual to associate blood with injury. Roelofse (1982) describes artificial (non-natural) signs as signs randomly assigned; meaning, by the agreement (usually tacit) of a community.

Artificial signs are further divided into arbitrary signs and motivated signs. An arbitrary sign can be conventional, such as the letters of the alphabet. A word such as 'horse' has no resemblance to a horse at all, but for us it has come to represent a particular animal. Roelofse (1982) and Chandler (2000) divide motivated signs into three groups: iconic, indexes and symbolic. Although separated for the purpose of clarity in this discussion, these often overlap – a sign is rarely exclusively iconic, indexical or symbolic.

Iconic signs are directly related to the signifier in that they bear a resemblance to or imitate the signifier, thereby making a sign. The resemblance can be tenuous, as in onomatopoeia (Chandler, 2000), or as in a thin blue line on a map representing a river; or more absolute, such as a photograph of the same river. The sign possesses some aspects or qualities of the signifier. According to Chandler (2000) the object does not have to have a sensuous resemblance to the signifier, but may in fact be analogous to parts of the signifier in the same way that Medea uses fairies to represent herself. The

fairies (in the form of Medea's pictures and figurines) are iconical representations of Medea, analogous to aspects of her personality, manner and bearing, rather than to a visual representation of her physical appearance.

The designated or artificial indexical sign is different from the natural index because it is not causally related to the object or signifier; however, it is directly connected, and can therefore be "observed or inferred" as such (Chandler, 2000). According to Chandler (2000), medical symptoms, measuring instruments and personal trademarks are included in the category of sign called artificial indexical signs. It is as though a portion of the signifier has been taken away and used to represent it (the signifier), although it has no resemblance to the signifier (Chandler, 2000). The indexical sign is intrinsically related to the signifier through a "relationship where the signifier is part of the idea of the whole" (Roelofse, 1982, p. 49) in a particular cultural context. For example, the crown is a signifier of monarchy.

Roelofse (1982) therefore defines designated indexes as "signs of which the relationship between signifier and signified is based on uni-contextual metonymy" (p. 49). Metonymy and metaphor are described by Albin (2006) as central to semiotic concepts. Metaphor is the unfamiliar expressed in terms of what is familiar (Chandler, 2000), such as a person being described as 'shaking like a leaf'. Metonymy involves a substitution, in which one sign stands for another, as in the example "the head that wears the crown" (Albin, 2006, p. 24). Metaphor and metonymy are culturally significant in understanding and interpreting the nuanced and layered meanings of material bodies – as in the case of body modifications (including self-mutilation), because they speak at the level of the individual (or collective), culturally representing more than one meaning at the same time (Albin, 2006). It is therefore important to contextualise that which is being represented within the culture in which it arose.

The symbol is the last of the motivated signs, and has no resemblance to what is signified. There is no prior relationship between signifier and signified, and unlike the designated index, the symbol is not necessarily even from the same cultural context. The relationship between signifier and signified is that of metaphor – according to Chandler, it is "arbitrary or purely conventional – so that the relationship must be learned: e.g. language" (Chandler, 2000). Roelofse (1982) provides the example of a rose as a symbol of love, in which the relationship between the rose (which is from horticulture) and love (an affective state) is arbitrary, but representative nonetheless. Mentalization, therefore, is a symbolic form of signification, because it is constructed through language and metaphor that the mind, thoughts and feelings of the individual and others are represented or held in mind in order to understand the self and others.

From the discussion above it can be seen that there are three types of signs (indexical, iconic and symbolic), though Hawkes argues that "it is important to note here that the 'triad' involves, not

mutually exclusive kinds of signs, but three modes of relationship between signs and objects or signifiers and signified which co-exist" (1977, p.129). The relevance of this will become apparent when cutting behaviour (which is both indexical and iconic) is discussed in the analysis section. Chandler (2000) provides an example of the interconnectedness of signs in any situation by discussing a map in which the map is "indexical in pointing to the locations of things, iconic in its representation of the directional relations and distances between landmarks and symbolic in using conventional symbols the significance of which must be learnt".

Semiotic Communication, Representation and Culture

Roelofse argues that communication is always contextual, fitting into an ever-widening field of "concentric circles" (1982, p. 43) which contributes to meaning by constraining interpretation. He says that the outer edges of the concentric circles are societal, cultural, economic and political factors, while the inner circles include family, social, personal and individual factors. Chandler (2000) argues that signs are related to their signifiers by social conventions, meaning that because we are so inundated by them, they are so much a part of our reality that we do not see them for what they represent, but as an end in themselves. They are not seen as representing an ideology or the world around us but as objective reality, and these representations are manipulated by culture and media (Albin, 2006).

Albin, in his understanding of body modification, proposes the interception of three such communication fields, namely "culture, psychoanalysis, and semiotics" (2006, p. 20). In his paper on semiotics and body modification, he writes of the intersection of culture, psychoanalysis, and semiotics as representative of "exterior expression of interior currents" (2006, p. 20). In his understanding of body modification he includes body piercing, tattooing, cosmetic surgery, eating disorders and self-mutilation as modes of corporeal expression.

With each of these forms of body modification there is a following or cultural group that admires these modes of self-expression, and yet there is simultaneously a body of literature in which these behaviours are linked to underlying self pathology (Fonagy, Target, Gergely, Allen, & Bateman, 2003; Bateman & Fonagy 2003 & 2004). Albin (2006) argues that self-mutilation, starvation or bulimia, piercings, tattoos and related behaviours are narratives – both culturally bound and individually expressive – being told by a "body that does not articulate, but still speaks" (2006, p. 34). The expression of each narrative becomes a translinguistic aid to a psychoanalytic concept in the understanding of our patients.

In his article on celebrity carnality Redmond argues the case for "an unconscious, unthought, pre-semiotic sense-based revelation" that "has the ability to make intimate the relationship between celebrity confessor and the fans who receive it" (2008, p. 149). If this thinking is applied to Medea

(the performing artist who is something of a celebrity in her family, and who has received professional acknowledgement from local and internationally-acclaimed professionals), she can therefore be considered to have celebrity status. In her body modification behaviours that she 'inadvertently' displays to her fans (family, tutors, therapist) she conveys her distress; and in so doing, she obtains the intimacy that she feels she needs in order to survive because of the lack of a sense of self.

Semiotics – Representation, Symbiotics and Attachment

Albin (2006) suggests that the use of representation (signifying practice) resembles the symbiotic mother-infant dyad, and that it is in this dyad that semiotics enters into language. This occurs when the infant babbles and the mother responds, using words like "you're telling me all about it, aren't you?" and waiting for the child, who then responds, babbling in a rhythm that mimics sentence construction and dialogue. After a while he or she discontinues, and awaits the mother's response, again copying the format of a conversation. Similarly, the infant represents to the caregiver that it has a wind by screwing up its face, pulling up its legs and crying. The attuned mother lifts the child and (while patting it on the back) tells it that it has a wind, and that she knows it is a wind because the chid has pulled up his or her legs and cried. The child uses a sign (babbling, crying) to indicate to the mother that there is something going on; and mother translates these semiotics into language, making the link between representation and expression for the child.

Albin (2006) and Majava (2005) refer to the work of Julia Kristeva, who called the phase between two and ten months the semiotic phase, in which (according to Majava) semiotic "images are grouped according to the mother's body. The interaction is very physical and mediated by the elementary rhythms and rules of the child" (Majava, 2005, p. 110). Majava presents Kristeva's notion that in this symbiotic phase, mental images develop that are "pre-linguistic, pre-symbolic, semiotic, rhythmically repeated elements of affective communication" (2005, p. 110), and that in the therapy process they communicate "elements originating from... the semiotic phase" (2005, p. 110). In the dyad relationship, semiotics enters into language through rhythm, intonations and sounds at the pre-verbal level, releasing inner tensions for the infant such as pleasure or pain (e.g. hunger, or wind). This is in the early attachment relationship, at a stage where the infant does not have a sense of self separate from the mother.

According to Vygotsky (1978), this is the stage prior to the convergence of practical activity and speech, which are developing completely independently. According to mentalization-based theory, this is the state of teleological thinking, which antedates mentalization (Csibra, 2003; Fonagy, Target, Gergely, Allen & Bateman, 2003 and Gergely & Csibra, 2003). Albin (2006) argues that at this time the *internal is externally represented,* which characterises psychic equivalence (another pre-

mentalizing behaviour). The infant releases the inner experience by making sounds which the mother (as a semiotic receptacle) partakes of and understands. This marks the beginning of the infant's awareness of a separate self, and the transition to verbal expression. Albin states that "the symbolic refers to the process of establishing a system of sign, syntax, grammatical constraints, and social codes of convention" (2006, p. 30), and the infant moves between the sign and symbolic in order to find expression. Vygotsky (1978) states that this is the point at which language and practical intelligence merge, and at which abstract intelligence emerges.

In the movement between the sign and the symbolic, there is a tension for the child. Albin (2006) argues that it is in the tension between the two (at the split) that the explanation for body modifications (including self-mutilation) can be found, because when the child must strive for control over the environment, there is a simultaneous need for control over the body. The particular mode in which the need for control is expressed is both culturally and individually determined, and contains traces of semiotic expression. In understanding that mode, the clinician gains insight into the patient (Albin, 2006). Language begins with sounds, followed by words as a child learns to speak, and the patterns of that speech begin in the early babbling of the child. As he or she moves towards autonomy through motor action and speech in the second year of life, "speech becomes a new, libidinally-cathected, communication of love" (Albin, 2006, p. 30), and contributes to the establishment of a sense of self, including a body image and self-identity.

In discovering the world, action is integrated with speech. In this phase of development, Albin argues that speech is used in preference to action, and is used for reality testing "when the level of anxiety is tolerable" (2006, p. 30). However, he argues that in pathological development the separation may only be partially achieved, so that there is some verbal or symbolic expression and some action (whether concrete, or an iconic or indexical representation thereof). He further postulates that anxiety may partially undo the capacity for symbolic (language) representation and result in regression to a phase in which "action becomes a wordless form of communication, thus signifying a more infantile reaction to affect" (Albin, 2006, p. 31). This is in agreement with Target, Gergely, Allen and Bateman's (2003) view that persistence in teleological thinking (practical intelligence) is a deliberate choice on the part of the child, in order to avoid accepting the idea of malevolence on the part of the primary caregiver.

The Semiotic Self and Psychotherapy

Barclay and Kee adapt Vygotsky's theory on egocentric speech to argue that the child uses speech in "the creation of a self" (2001, p. 682). According to Vygotsky (1978), eccentric speech begins in the social world (mother-infant dyad), then becomes internalised in an internal conversation; which, for him, is thought (or mentalization). He is describing the development of the self in the normal course

of events. Barclay and Kee (2001) argue that initially the meanings of and identifications with words that the child uses as they develop are unclear to them; and this lack of clarity allows for creative interpretation and imagination in the construction of the self "in the world, in language and gradually makes its way into the interior of the individual but not without its construction by the social structure and its incipient semiosis" (2001, p. 682). This supports Albin's (2006) notion of the social construction of the acquisition of language, and the semiotic move from concrete (corporeal) representation to abstract symbolic expression and representation in speech.

Barclay and Kee (2001) argue that in psychoanalysis, we can view the unconscious as semiotically constructed and everywhere present. In studying the semiosis of the individual patient we are able to make meaning with, of and for the patient. Furthermore, if we understand the construction of the semiotic self as made up of a number of malleable narratives, socially constructed – some false selves, some authentic aspects of the self – we can understand the very structure, function, dysfunction and behaviours of the self. Barclay and Kee argue that a sign not only can, but must be interpreted in the therapy process, and that in this, "meaning is transmitted, or perhaps more correctly we should say that meaning is constructed" (2110, p. 672). The patient with Borderline Personality Disorder has a reduced ability to make meaning, or to mentalize. Where the therapist is able to make and transmit meaning of behaviours through the use of semiotic interpretations of behaviour, it assists the patient in making meaning and gaining insight into his or her behaviour. This aids the therapy process, and in my concluding chapter I will argue that it also increases the patient's ability to develop the capacity to mentalize.

Similarly, Leiman argues that patients "come to therapy because they do not understand their symptoms" and that their "disowned experiences lie buried in these symptoms, which can be regarded as meaning-laden signs" that he describes as "encrypted messages" (2002, p. 228). He states further that in the therapy process it is possible to rediscover the meaning of these signs from a semiotic standpoint that can be presented by the patient, verbally or non-verbally. He argues that a sign which has a (cultural) history specific to the patient, and a context in which it arose and to which it is associated in a representative manner, may become a vehicle for change in the therapeutic process. As the sign emerges – represented contextually as it arose – it can be repositioned and mediated, in the context of the relationship between the therapist and the patient, "by utterances" (Leiman, 2002, p. 225). My understanding of this is that as these signs arise in the therapy, they represent the context of early childhood in which they arose; and as they are discussed or mediated through language by the therapist, a new understanding arises for the client, who is then able to understand both the sign and the context within which it arose as well as the implications thereof.

Chandler (2000) describes how Jacques Lacan adapted the Saussurian semiotic theories using a "quasi-algebraic sign" (2002) in which the 's' for the signifier (the form that the sign takes) is larger

and above a horizontal line over the smaller ‘s’ representing the signified. This makes the signifier more obvious, and thus more noticeable and more the focus of attention than that which it is representing (i.e. the signified). This is directly relevant to the case of Medea, whose forms of representation are much more noticeable and more the focus of attention than what she is signifying. Furthermore, in Medea the line that Lacan placed between one “s” and the other is parallel to the line between the representations (or signs) and what she is representing or signifying, unconsciously and without mentalizing.

Therefore, by using what Majava describes as a “psychosemiotic orientation” (2005, p. 113), we enrich our therapeutic attitudes and understanding of the patient; and in my experience, by sharing this with the patient, the patient learns to understand her own mind as well, because in the interpretation the hidden unconscious becomes exposed, and is brought to the surface.

RESEARCH METHOD

The purpose of this chapter is to outline the methodology that has been employed for this study, namely a single case study. An in-depth study of my patient will examine the case material in order to illustrate relevant literature (Hammersley & Gomm, 2000). The individual case study method refers to a body of research that investigates a single case in "considerable depth" (Hammersley & Gomm, 2000, p. 3). In this instance the aim is to understand the case in relation to mentalization literature in general, and issues of representation in particular.

Edwards (1996) argues that in-depth individual case studies are the cornerstone on which scientific knowledge in the field of psychotherapy has been built. It is the principal approach used by all "major analytic theorists" (Atwood & Stolorow, 1993, p. 27). Donmoyer presents three advantages of the case study method. Firstly, accessibility, in that the case study "can take us to places where most of us would not have an opportunity to go" (2000, p. 61). What this means is that with a rich description of the case, the reader has the opportunity to experience the content of the therapy vicariously through the patient. Secondly, he argues that the vicarious experience of the case "allows us to look at the world through the researcher's eyes and, in the process, to see things we otherwise might not have seen." (p. 63). In this instance it provides an opportunity to understand Medea's case through the 'eye' of mentalization-based and semiotic literature, thereby illustrating not only an individual case but also a particular theoretical viewpoint adding depth to theoretical understanding (Donmoyer, 2000). Thirdly, Donmoyer (2000) argues that vicarious experiences are less likely to produce "defensiveness and resistance to learning" than direct experience. This is likely to be true for some who shy away from working with a particular type of patient.

The two main issues that arise with regard to case study research are those concerning the subjective nature of case study research: validity, and limitations regarding generalizability. The case study method is intrinsically subjective in nature. In this, Stake (1995) agrees with Walker (1981) and Miles (1979) whom he references as critics of case study research, because they criticise its subjectivity). He argues that subjectivity is not a failing of case study research, but "an essential element of understanding" (Stake, 1995, p. 45). Atwood & Stolorow (1993) argue that the validity of the case study method is difficult to assess by any empirical method, and that validity can only be tentatively established. Criticism of case study research presupposes that it is possible; and furthermore, that the purpose of such research is to attain irrefutable truths. Donmoyer pointedly states that "the search for the correct interpretation may well be a search for a Holy Grail" (2000, p. 62).

Atwood & Stolorow argue that case study research presupposes that "personality research can be fully understood only if viewed in the context of the individual's personal world." (1993, pp. 27-28) and that it is rooted in the context of the history and development of the subject. This is in contrast to alternative personality research, which may attempt to isolate the personality variables from their

historical and phenomenological contexts, thereby becoming sources of random error (Atwood & Stolorow, 1993). Case study research does not test an hypothesis of personality against an independent basis, but rather returns to the "life-historical context" (Atwood & Stolorow, 1993, p. 28) of the subject in order to verify the veracity of an insight in terms of its coherence with the therapeutic process.

Poor generalizability is another limiting issue of case study research. According to Donmoyer (2000), all the research findings in certain disciplines – including education, social work and counselling or therapy – are tentative, because the focus is on individuals. Donmoyer (2000) argues that even statistically significant findings from large sample groups cannot be universally applied to all individuals, requiring rather the wisdom of the individual clinician in determining the applicability of any finding on any one individual in particular. Generalizability is not the aim of this research; the aim is rather to understand one particular, unique patient, and to illustrate relevant mentalization literature with case material.

The data for the study consists of material sourced from Medea, my patient, in her regular therapy sessions. It includes referral notes, the intake session, case notes, supervision notes, case presentation notes from the UCT Child Guidance Clinic, and the content of some emails. We have had 45 therapy sessions, which were recorded on a digital recording device. Hand-written summary notes were taken from the recordings. The recordings were retained so that I could refer back to them for clarification, or for word-for-word transcriptions if necessary. The case material was used in conjunction with mentalization-based literature specifically pertaining to issues of mental representations in people with Borderline Personality Disorder and issues of cutting.

Material arising from the analysis of the case has been used to illustrate a theoretical discussion within a mentalization-based therapy paradigm. Extracts from the 45 sessions recorded thus far provide enough material, for the scope of this thesis, to illustrate the relevant literature in order to examine cutting as it is represented across the sessions. The patient also presented photographs of the cutting, but I do not have copies of these. As a researcher I would find copies of those photographs useful, but in discussion with my supervisor it was decided that to request these would be inappropriate, as it could send an unhelpful message to the patient, who may misconstrue my interest in the photographs.

My patient came to me through a referral from the UCT Student Wellness Centre. She was referred to the UCT Child Guidance Clinic by the consultant psychologist, who had seen her on an ad hoc, crisis-intervention basis in 2008, and who felt that she needed more consistent long-term therapy. My patient is a 20-year-old performing artist who comes from a socio-economically-deprived background. In line with the mentalization literature, a case history and theoretical formulation of the patient have been be provided along the lines of attachment issues, mentalization, affect regulation and their relationship to the specific diagnosis of Borderline Personality Disorder (see appendix A).

Given that this research is subjective in nature, there is a risk of misrepresentation or misunderstanding. Stake (1995) argues that reliance on personal understanding in case study research may lead to misunderstanding on the part of the reader. This methodological weakness can be avoided by using a system of triangulation. Yin reports that "Most case study research has failed to establish an explicit chain (of evidence), and critics can rightfully question how specific conclusions were reached". He motivates for a "study built on a clear conceptual framework" (1981, p. 64).

In order to minimise such risks as those described above, Atwood & Stolorow (1993) argue that psychoanalytic case studies which are interpretive, and the insights extracted from them, should be evaluated in terms of hermeneutic criteria. These criteria consist of the coherence between the therapy and the history of the patient, with the analysis or psychological knowledge forming a cycle "in which the parts give rise to the whole and the whole provides a context for evaluation of the parts (Atwood & Stolorow, 1993, p. 28). The psychological knowledge against which insights from this case will be assessed is the knowledge expressed in the mentalization literature. The validity of the findings has also been evaluated with regard to their coherence with the therapy in progress, and their congruence within the individual history and phenomenological experience of the patient as the findings illustrate the mentalization literature.

Stake (1995) offers a similar and very structured approach to data analysis, using what he terms triangulation. The term triangulation is taken from the method used by mariners and other navigators, who navigate using the angle of elevation of the stars. Similarly, triangulation in research uses three points of convergence in order to provide a measure of validity for the findings of the research. This method of data analysis will be applied to this research. Stake argues that "we assume the meaning of an observation is one thing but additional observations give us grounds for revising our interpretation" (1995, p. 110). These grounds for revising are the triangulation protocols.

The three triangulation protocols identified by Stake (1995) are data, investigator and theory. Firstly, data provided needs to describe the issues under discussion as accurately as possible, so that the reader has the chance to triangulate him- or herself. In addition, the triangulation of data requires its comparison with, and consistency within, the entire data set. Secondly, Stake (1995) refers to investigator triangulation, in which another researcher looks at the same data in order to make his or her own interpretation of the material. Finally, theory triangulation looks at the data from a particular theoretical viewpoint, and considers its consistency with that theory.

In my analysis of the data it has been necessary to exclude a considerable amount of the case material in order to focus on the research question. The choice of what data to extract was made under the supervision of my clinical and research supervisors, providing the data triangulation protocol. For investigator triangulation, my work with the patient and the therapy process has served as the protocol. For the third protocol, that of theory, the material selected and the relation of that material to

the relevant mentalization literature must be tested against how accurately and clearly it illustrates that literature.

In analysing the data, initially I began by colour-coding the criteria (listed above) so that I could mark the case notes to identify the material that was relevant to each of the criteria. I then went on to listen to the recordings while following my case notes, and making additional notes where I had not filled in sufficient detail for the purpose of the research. In this way I immersed myself in the data and became more familiar with it. While working through the case notes I continually went back and forth between the data and my definitions in order to ensure that they were clear in my mind, before colour-coding the final notes. I then went through the written notes with my colour markers, highlighting aspects of the criteria that I would extract for discussion in my thesis. In simultaneously immersing myself in the data and in the definitions I was ensuring that the data that I used for illustrative purposes was true to the experience and history of the patient, while also representative of the literature. While I was listening to recordings, making notes and re-reading definitions I made notes to myself in a note book, clarifying for myself the definitions, the behaviours and my understanding of the meaning of these.

The definitions I used for the data analysis are as follows: “Mentalization entails making sense of the actions of oneself and others on the basis of intentional mental states, such as desires, feelings, and beliefs” (Bateman & Fonagy, 2004, p. 36). It includes a self-reflective component (i.e. metacognition) as well as an interpersonal component, in that one is able to consider the thoughts, feelings, attitudes, and motivations of others (Fonagy & Target, 2006).

Bateman & Fonagy (2004) describe psychic equivalence as a state in which the person experiences no difference between their internal and external worlds. There is a direct translation from the internal to the external. This is a very concrete understanding in which thoughts are experienced as compellingly real; which means that feelings of badness are felt with a level of intensity that is unbearable and overwhelming, because they cannot be symbolized or meaningfully represented in a secondary form (Fonagy, Target, Gergely, Allen & Bateman, 2003and Bateman & Fonagy, 2004).

Pretend mode is one in which the mental state is separate from the external world, physical reality or the patient’s own mental world. This means that fantasy is also cut off from the real world. It is a detached and isolating experience, because it is rigidly underpinned by an illusion of stability that has meaning that is not based in reality (Bateman & Fonagy, 2004; Fonagy & Target, 2006). The “internal state is thought to have no implications for the outside world” (Fonagy, Target, Gergely, Allen & Bateman, 2003, p. 427), and it is this mode of thinking that permits self-mutilation and states of mind in which continued existence of mind is not reliant on the existence of the physical self.

Pretend mode and pseudo-mentalization are closely linked. Pseudo-mentalization is described by Twemlow, Fonagy and Sacco (2005) as a situation in therapy in which mentalizing terms or language are used by the patient, but their connection to the reality of the experience that is being discussed has been lost. This occurs in therapy when the patient is in pretend mode (Twemlow, Fonagy & Sacco, 2005).

The teleological stance is described by Csibra (2003) as representing "an interpretational strategy that seeks to construe an event in terms of goals. It does not attribute mental states to the agents" (Csibra, 2003, p. 448). It is a tendency to construe events as goal-directed, "relating at least three different aspects of the observed event to each other: the behaviour, its physical context and the end state" (Csibra, 2003, pp. 448-449).

'Cutting' refers to occasions when the patient intentionally cut herself using a sharp razor blade or similarly sharp cutting tool, and the photographs discussed are those that the patient took of the bleeding wound after she cut herself.

For the purpose of the research The Concise Oxford Dictionary (1984) definition of representation quoted in the introduction was used to select data that illustrates representation of the self states of the patient. Aspects of the patient's developmental history were also looked for in the data.

Ethics

In the initial intake therapy session the patient was informed of the status of the UCT Child Guidance Clinic as a teaching institution. She was also informed that the material from sessions would be recorded, and that any information used for research or further psychological knowledge purposes would be divested of identifying data. After discussion, the patient gave consent for the above. In this instance the discussion was more than a mere formality, because the patient was anxious about the purpose of the recording and was not prepared to sign consent until she had understood clearly that every session would be recorded and that any of the information from the recordings to be used for research would be disguised so that it could not be connected with her.

Whether to richly disguise clinical material instead of obtaining patient consent for research, or to inform the patient about the research and obtain informed consent, is an ongoing ethical debate that continues in psychotherapy today (Bollas & Sundelson, 1995 and Gabbard, 2000). Each researcher therapist must make an individual decision in this regard.

For the purposes of the research, identifying data have been excluded. My patient has been named Medea, after the mythological princess associated both with fantasy and with very violent imagery. Medea, after setting a charm to cause the dragon guarding the Golden Fleece to fall asleep, assisted Jason to steal the Golden Fleece and escape. In order to prevent her father Aeetes from capturing them

and recovering the Golden Fleece, she slew her brother and scattered his limbs on the sea in order to delay her father, who she know would stop to pick them up (Mavromataki, 1997). The name Medea and the imagery conjured up by it represent my patient's pretend mode fairy representations of herself alongside the very violent images of her cutting and photographing the wounds.

Malan (1999, p. 13) states that one of our primary tasks as therapists is to "rescue our patients from the self-destructive consequences of what they are doing, by tracing these mechanisms to their origin and uncovering the feelings that are being expressed." In undertaking this study I have undertaken the most ethical course of therapy with this patient that I can, by attempting to understand deeply the mechanisms and origins of her self-destructive behaviours, and thereby also the path that will lead her out of that place. The research work has fed directly back into the patient's therapy, with good results.

Challenges and Limitations of the Research

The strength of this research is that it provides a very rich embodied illustration of the literature, providing both insight into and explanation of the client and literature in a way that offers the reader sufficient depth of information to enable him or her to enter into a vicarious experience of the client (Donmoyer, 2000). Using a single patient in order to illustrate the literature provides a limited range of behaviour and experience to illustrate the aspects of the literature that I have illustrated. In part, this has been addressed by selecting the more common behaviour of cutting in people with Borderline Personality Disorder, but future study with more than one patient's therapy material would provide a wider range and richer illustration of the current mentalization literature.

CASE ANALYSIS

The purpose of this thesis is to illustrate the ways in which mentalization and semiotics literature conceptualises cutting and the representation of affective states, beliefs, thoughts and intentions in the current behaviour of a patient with Borderline Personality Disorder. The inability to mentalize in people with Borderline Personality Disorder may stem from a constitutional vulnerability, sometimes secondary to the failure of the early attachment relationship with the primary caregiver in early development, and this (combined with traumatic experiences within that attachment context) results in hyper-responsiveness of the attachment system. This impacts negatively on the ability to mentalize (Fonagy, Target, Gergely, Allen & Bateman, 2003) or to represent self states and the mental states of others symbolically. Fonagy, Target, Gergely, Allen & Bateman (2009) state that the result of this "fragile" ability to mentalize leads to a return of earlier, infant psychological modes of function. These modes are teleological stance, psychic equivalence and pretend mode, and represent semiotic forms of representation rooted in the cultural context of the individual (Albin, 2006).

The argument in the analysis that follows suggests that the failure to mentalize and its connection to early attachment relationships is linked to the unfulfilled need for representation to occur in order for a stable core self to be developed. The data was analysed using mentalization theory definitions to establish examples of mentalization, psychic equivalence, pretend mode and teleological stance in relation to self-representation. Discussion about cutting, photographs of cutting, and instances of bingeing with purging were also looked for in the data, in order to answer the research question about the link between the failure of the early mother-infant dyad and the ongoing need for representation. The forms of representation were then looked at in terms of their semiotic nature.

Effective mentalization attests to the success of both the mother-infant attachment and the representation of the infant self in the contingent mirroring of the mother as a representing, affirming audience of the emerging infant self. In infancy, psychic equivalence, pretend mode and teleological thinking predate mentalization, and are indicative of non-symbolic semiotic representation. As they become integrated into the infant's sense of self through representation by the mother, these infant states mature into mentalizing (Fonagy, Target, Gergely, Allen & Bateman, 2003) and into more abstract forms of representation in the form of metaphor or symbol (Albin, 2006).

In this chapter I will begin discussion of each of the aspects of non-mentalization. I will describe examples of psychic equivalence, pretend mode and teleological stance, ending with an example that brings all three of these non-mentalizing behaviours together. From there I will discuss self-harm in the form of cutting as an example of representation that is illustrative of all the forms of non-mentalization coming together in a single act. This brings together the aspects of non-mentalizing behaviour used by Medea to represent her self-states to herself.

This discussion will argue that this resulted from the lack of a stable core sense of self, and an ongoing need to construct and maintain an audience. The audience constructed in this way maintained a precarious sense of selfhood and self-representation. I will then go on to provide illustrations from case material of examples of mentalization in Medea, illustrating her potential to mentalize. The aim of therapy was to develop this reflective space.

The chapter will close with a discussion of mentalization as a form of symbolic representation that is absent in Medea, and how Medea's non-mentalizing behaviours are indicative of iconic and indexical representation that are culturally congruent for her, while simultaneously expressing what is inexpressible in words for her because of a language deficit that is symptomatic of failure in the early attachment relationship.

Psychic equivalence

In a discussion about crying, Medea stated that "control is really important", and that when she is not in control "then I'm weak, and weak is bad". I asked her what a sign would be that she is weak, and she replied "um, crying and, like, if you feel bad and you can't make yourself feel better". I asked her what happens when a tear sneaks out. "I will cut some more", because when she cuts, she feels better. She must physically take out the "bad" in order to make herself feel better. There is no distinction between mental reality and outer reality, and the internal has power over the external (Bateman & Fonagy, 2004).

In cutting herself, Medea is physically representing the internal pain on her body. In sessions she has said that the emotional pain she feels is felt on her wrists, abdomen and thighs, particularly the anger and the feelings of being "bad". Typically, these are the places that she cuts herself; so in cutting, she is externalizing and physically representing to herself the pain that she is feeling inside herself. She is mirroring the pain to herself and making it very real for herself – too real (Bateman & Fonagy, 2004). And this is instead of mentally or verbally representing it to herself and instead of thinking or mentalizing about her mental state at the time of cutting. She is acting out in direct translation what she cannot mentalize, because she does not have an intact theory of mind.

Medea hates having to take piano lessons. She says she does not want to play the piano because she cannot play it. There are too many things to think of at one time because she has two rhythms to play and must use her feet at the same time. Her teacher has criticised her for writing the names of the notes on the page to make it easier for her to read the sheet music; so she does not do it now, because she says it shows that she cannot play the piano. She said she'd like to break all the pianos at college. She'd like to "pour blood over the keyboards and they won't work anymore – the keys would get stuck because the blood would dry and make them stick." She said she'd use her blood, and that the blood makes her feel better because she thinks "there shouldn't be such a thing as a piano". Then she

said, “maybe I’d cut the strings too.” When Medea represents to me the image of the blood on the keyboards and cutting the keys she is projecting her internal pain of feeling inadequate as a pianist onto the piano, and showing the violence and destructiveness of those critical thoughts inside herself by representing her “murderous” feelings in relation to the piano, rather than representing them mentally, and thinking in the abstract about what her destructive wishes represent.

In this way she is illustrating mental world (internal experience of thoughts and feelings) and physical world (piano keys and strings) isomorphism (Fonagy, Target, Gergely, Allen & Bateman, 2003). In her experience there is no difference between inner and outer reality, which is a reversion back to the early infant world relationship in which the infant is not aware that he or she is separate from the mother, and the mother is experienced as an extension of the self. Fonagy, Target, Gergely, Allen & Bateman argue that in psychic equivalence “the projection of fantasy to the outside world is felt to be compellingly real” (2003, p. 427) and comes from a time when there is no clear sense of self or ability to mentalize.

Medea often describes how her mother and father argue and fight. Physical fights between various family members occur on an ongoing basis. This, together with the violence of the community in which she lives and in which she has observed violent murders, and the lack of a benevolent primary intersubjective experience with her mother, has meant that as an infant, instead of internalising contingently marked self states, she internalised her mother’s state and the state of the relationships within her family and community as part of her self structure. The primary intersubjective attachment relationship was disorganised for many reasons, but primarily because of her mother’s depression, her acrimonious and violent relationship with Medea’s father, and her own disorganised attachment with Medea’s grandmother.

This meant that in the primary intersubjective relationship with Medea, her mother did not act as a buffer between Medea and the outside world. Medea was born and has lived all her life in a township on the notoriously violent Cape Flats. She has witnessed multiple murders through stabbing and shooting, as well as many fatal pedestrian accidents. Within her family, Medea’s parents had physically violent fights with each other and with two of their children. Medea’s mother’s behaviour therefore mirrored the state of violence in the community and family around her, rather than protecting her from it.

Because Medea’s own self-states were not being adequately mirrored to her by her mother (by contingently marking and mirroring Medea’s own self-states back to her as congruent with Medea’s state, while contingently marked as different from the mother) Medea could not develop a stable sense of herself that was consistent with her own experience of herself. This meant that she developed a fragmented self-structure, which included aspects of herself that were congruent with herself and internalised as such, but was incomplete, therefore requiring an ongoing need for mirroring. Ongoing

mirroring is required because Medea's sense of self is fragmented, and therefore is not clearly differentiated from others, particularly that of her mother (Fonagy & Target, 2006 and Majava, 2005). It was necessary for Medea to monitor and be responsive to the mental states of her mother, because these threatened to undermine her sense of agency as an infant.

When Medea's mother did not respond to Medea's mental states Medea could not see herself as having the capacity to impact on the behaviour of her caregiver or environment, which threatened her sense of agency (Fonagy & Target, 2006). What Medea's mother did mirror was a violent state, reflective of the environment external to the attachment relationship. Medea was left with no alternative but to internalise an alien state. Because the attachment with her mother was disorganised and misattuned, Medea could not look for her own mental state reflected in the mind of her mother. She had to look for the mental state of her mother and internalise that as a self-state. This resulted in the internalisation of a self-structure that was alien to her, as it was not representative of her self state. Fonagy & Target (2006) refer to this as the "alien self" (pp 562-563). Because it is alien, but has been internalised as a part of the fragmented self-structure, it is projected out onto others in a complex form of psychic equivalence played out in violent relationships. It is psychic equivalence because the internalised violence is projected onto the external world via the medium of other people in such a way that her external world (i.e. the relationship) is no different to that aspect of her internal world (Bateman & Fonagy, 2004). These relationships clearly illustrate the absence of a stable core self and the need for concrete rather than mental representation of a self-state.

In Medea's case the clearest examples of the projection of the violent alien self is made onto "Johnny", who raped her, and other men who attempted to rape her as a young adolescent. "Johnny" was the owner of a studio in which Media used to dance at the age of 14. When he found her crying at the school bus stop after being humiliated by her class teacher for not having paid her school fees, he offered to pay her school fees; in exchange, she had sex with him. As Media was a minor this constitutes statutory rape. Media's niece's grandfather also attempted to rape her when she was 14 years old and was babysitting her two-year-old niece at his home.

These are relationships, into which Medea enters, in which there is evidence of the alien self representing and mirroring the violence that she experiences within herself – the internalised violence from her primary intersubjective relationship. The violence in these relationships is contingent to the violence she experiences internally, so there is isomorphism between internal and external. In the same way that when she was a child she internalised the violence in the primary attachment relationship, now she projects the violence into new attachment relationships.

Pretend Mode

Medea is fascinated by fairies and butterflies. She says that her whole bedroom at home is decorated with them. She has a butterfly duvet cover and pyjamas, and she collects little fairy figurines. She also sketches fairies. Initially Medea came into therapy and presented herself in a very 'fairytale' manner – very demure and quiet, walking lightly and speaking softly. Later she described a "crazy" vibrant version of herself who was popular at school, always a prefect, always at parties that went on for the whole weekend.

The fairy aspect and the vibrant party girl aspect are part of her fragmented self-states; and examples of pretend mode, when she uses them in these circumstances. These are situations in which Medea is the representation of herself, and there is no link between her inner reality of her true felt experience at that time and the outward presentation of herself. She is pretending she is somebody she is not. More than that, she is pretending that she is an idealised aspect of herself. What she is doing is representing an aspect of herself as if it were a whole self; and this is what happens in pretend mode (Fonagy, Target, Gergely, Allen & Bateman, 2003, Bateman & Fonagy, 2004; Fonagy & Target, 2006). When Medea uses pretend mode she displays the fragmented nature of her self-structure and the need for concrete representation of herself to herself, so that she can mirror to herself what was not contingently mirrored to her as an infant, and so was never internalised into part of a cohesive self-structure.

In our third therapy session Medea produced pictures of fairies that she had drawn. They were beautiful, delicate, ethereal creatures. One picture was of a pregnant fairy, and it was dated. I asked if she had been pregnant at the time she drew the picture, and she said that she had had a pregnancy scare at the time, and that she had hoped she was pregnant. In this picture the fairy is looking down at her pregnant belly and holding it protectively with her hands. There was another picture of a fairy in a tutu, a dancing fairy that she drew in dance class and that will be discussed further below. She also drew a picture of a rebel fairy. It had short spiky hair and stood with hands on hips. The words beside the picture are "Make me sick", with a great gaping mouth beside them. She drew this in a lecture in which she was annoyed by the lecturer.

Later in the therapy, Medea mentioned a fairy figurine that she has. It is a fairy sitting with her legs tucked up against her chest and her arms round her legs. She says that people often comment that it 'is' her. Although Medea denies that any of these are 'her' she has acknowledged that they are representations of herself. These fairytale representations of Medea are illustrations of the pretend mode that exists where there is no bridge between her inner world and her external reality (Fonagy, Target, Gergely, Allen & Bateman, 2003). The fairies are split-off aspects of herself, but not representative of her true self, because they lack the full reality of her internal experience and are incongruent with her current experience. They are very seductive illusions of stability, but with

meaning that is not based in reality; and the beliefs that they represent are so unreal that the patient is detached and isolated from her inner world (Bateman & Fonagy, 2004).

Medea's tummy often rumbles in our sessions because they start during or shortly after lunchtime which is a meal she often skips. When her stomach rumbles she sometimes tells it to "shush", or giggles. On one occasion I asked her if perhaps her tummy was trying to tell her that she needs food. She said she was not hungry "It's in my mind – there's no such thing as hunger." Similarly she says that "there's no such thing as tears – they're not real". These comments of Medea's, so clearly not grounded in the reality of her physical or emotional reality, are examples of pretend mode in which her belief about hunger and tears is separate from the physical reality of the stomach rumbles, which are evidence of the hunger, and the wet eyes, the evidence of the tears. In this state the sense of self becomes rigid and detached from reality, making it isolating and meaningless (Bateman & Fonagy, 2004).

Medea reported with detachment one day that she was thinking about what she will study when she has finished with university. She does not think she will earn a living through her performances. This very detached discussion continued with a brief mention of the area in which she lives. She says it is very rough, and that she has witnessed many murders. She calmly went on to tell me about a drive-by shooting at the traffic lights that she witnessed at the weekend. The man in the car next to the one she was travelling in was shot dead. She said she got out of her car and opened his car door and he slumped onto the passenger seat with blood gushing from his head. He had been shot in the head. She wanted to take a photograph because it was "cool", but the police came and chased her away.

Similarly she describes how in this year she has witnessed three people being knocked down and killed by motor cars. She always refers to the blood, and always says, "it's no big deal – I must be used to it by now." She describes these incidents in a calm detached manner. When she tells me about these incidents Medea paints for me a graphic and violent representation of traumatic events that she has witnessed, but her thoughts and comments about the incidents are detached from the reality of what she experienced. This is pretend mode, and the rigidity of her thoughts and comments mark the firm boundary between mental state and physical reality (Bateman & Fonagy, 2004). The detachment is pretend mode, but there is an aspect of psychic equivalence in the retelling of these events, because the violence that she describes so graphically is congruent with the violence that she has internalised as an "alien self" in her early childhood.

Although the "fairies" or the "party girl" are aspects of herself, they are not all of who she is. They are aspects that she idealises when representing them to herself. When she represents these aspects of herself to herself they are not nuanced and textured with the emotions of her current experience. Usually she draws fairies when she is emotionally overwhelmed by distressing circumstances, and becomes the vibrant self when she is underwhelmed. These states are therefore also not congruent

with the experience of that moment, and so are pretend mode. When she says that seeing someone executed is cool, or when she draws a fairy because she is overwhelmed, it is pretend mode, because it is not representing her emotional state at the time. However, although she is detached from her emotional state, what has occurred is representative of a self-state; so, for example, the fairies are representative of a part of her, a fragment of her which is calm and peaceful and serene – and that aspect of the fairies is congruent, and not pretend.

It is my hypothesis that this aspect of her is most evident and congruent when she is teaching. In the therapy sessions, when she has described some of her teaching sessions, and her understanding and patience with her students, she has been serene, and almost magical. This is not pretend mode, because the manner in which she is representing herself is congruent with her mood state at the time. Similarly, there are times when Medea genuinely is a party girl, having fun socialising, dancing and relaxing. In circumstances when these representations are incongruent with her self-state at the time, this is pretend mode – and, I would argue, also a deeply unconscious connection with an aspect of herself that sooths her current state. The fairy self is soothing when she is distressed by violence, and the party girl is enlivening when she is depressed.

In these examples of pretend mode, Medea represents aspects of herself that are unreal. The reason that she does this is based in the unfulfilled need for representation of mental states in the primary intersubjective relationship. In psychic equivalence the internal world of emotions is experienced as too real, and not separate from the external world; and is therefore overwhelming, and unbearably real. Her pretend mode behaviours counterbalance the overwhelming psychic equivalence isomorphism by being "decoupled from external or physical reality", and the "internal state is thought to have no implications for the outside world" (Fonagy, Target, Gergely, Allen & Bateman, 2003, p. 427) and is therefore underwhelming. In pretend mode, she represents for herself fragments of images of herself that are not true to her lived experience. For example, the calm, demure, fairytale figure that she presents in therapy in no way acknowledges the real lived experience of the violent murder she is describing. The emotional tone of the conversation is decoupled from the content of the conversation, and is therefore unreal.

These fragments – split off from one another, but combined with internalised violent aspects from her infant world that are experienced as her alien self – Medea projects onto the world in order to see herself. She needs to see herself external to herself, because she does not have a stable core self. Medea does not have a strong and cohesive sense of herself as an individual, separate from others and with a sense of agency, or ability to act and impact on the world around her. She does not have a sense of who she is in her own mind; and therefore has an ongoing need to see aspects of herself outside of herself, so that they can be represented to her in the same way that a mother represents aspects of the infant to the infant in the primary attachment relationship.

Medea needs to see aspects of herself that are congruent with how she is feeling in order to be able to hold on to her sense of self, and she needs this to be outside of herself, to be both concrete and physical. She did not have a contingently mirroring mother – therefore, she represents to herself representations of herself, thereby mirroring for herself what is not mirrored. In the therapy she brings these representations to me in order to see, reflected in my 'gaze', the mirror that she needs. In the therapy, by linking the emotional aspects of psychic equivalence with pretend mode externalised aspects of herself, she is able to integrate a more whole self (Fonagy, Target, Gergely, Allen & Bateman, 2003).

Teleological stance

During therapy, Medea describes her concerns about her weight. She says that she usually weighs 53kg, but would like to weigh 20kg less. She has bulimia that is largely in remission at the moment. At times she restricts her eating to near-starvation, but for days rather than weeks at a time. In her last few years at high school and her first year at university, when she continued to be what she describes as "obsessed" with her weight, she would drink alcohol to make herself feel lighter. She says that when she drinks it just makes her feel light-headed and that "takes the edge off". She feels less fat, and her mind is soothed by the biochemical reaction to the alcohol that makes her feel lighter. Though the fat is still there, she doesn't feel it, so she feels lighter. This illustrates teleological thinking: the patient does not feel any sense of agency to actually change her weight through a proper diet and exercise plan, but rather chooses a direct and immediate action that physically impacts on her mental state, and is felt to change the situation (Fonagy, Target, Gergely, Allen & Bateman, 2003).

In a time of heightened stress (during her mid-year examinations) Medea became very tense because she is sensitive to the atmosphere in her department, and to the build-up of exam pressure among the students and staff. In addition, she was anxious about her own exams and about the upcoming break in therapy. Medea was able to understand that these were the things that were distressing for her, and was able to talk about them. Therapy was a place where she felt held and contained. She had previously spoken about feeling as though she would "fall apart" if she were not held together, and for a while she felt sufficiently held in the therapy; although there were some relapses to self-destructive behaviours. However, as the tension built up around exams, she needed to take physical action to relieve her self-state of the feeling that she would fall apart.

Medea says that she has a tendency to sit with her arms around her legs, holding them together. On this occasion she arrived at the session and sat perched on the edge of the chair. She was uncomfortable, looking like a bird that would take flight at a moment's notice. After a minute or two she asked to sit on the floor. She sat with her legs up against her chest and her arms around her legs. I asked her to tell me about her need to sit in that position. Her response was that sitting on the floor is

"not like sitting in the middle of nowhere", whereas when she was sitting in the chair, it was "just like floating". She agreed that she had become unhooked from the therapeutic process, and also from being grounded by the sessions. She needed to take actual physical action in order to alter the mental state that she was experiencing (Fonagy, Target, Gergely, Allen & Bateman, 2003).

Because Medea cannot represent her mental and emotional states in an abstract form to herself and work with these using language, when she is in a state of emotional arousal she reverts to very concrete and physical action. These behaviours act out, demonstrating her emotional state, and representing themselves to me in a very concrete manner. They reveal her unarticulated state to me. Through physical action she is representing a mental state that she is unable express verbally. She is also acting out her distress, because she does not have a sense of her own ability to impact on me without demonstrating how she feels. In the same way that she represents internal pain by cutting, she represents her need to feel emotionally grounded by sitting on the floor. Her inability to mentalize and her ongoing need for self-representation and mirroring result in these teleological behaviours.

Medea's earliest example of teleological thinking was brought to me in our very first meeting, in which she told a story about an argument that her parents had one day when she was about seven years old. Her parents had a very violent relationship, which often turned physical. On this occasion Medea's mother had found a note that Medea had written (her grandmother had taught her to read and write early) in which she had said that she was going to kill herself, detailing how she would do it and that her cat should be given to a friend who was at school with her. Medea said she often wrote notes of this nature at that age, but always threw them away or hid them. Her mother found this one, which put her (the mother) in a bad mood. Medea blamed herself for the subsequent fight between her parents, because she had caused her mother's fighting mood by means of the note. Medea said that she was hurt in the fight, and later threw herself down the stairs and cut her head open.

In this instance, she was taking physical action in order to alter the behaviour of her parents. She was in a "crisis of her agentive self" (Fonagy & Target, 2006, p.550), using the physical action of throwing herself down the stairs and injuring herself in order to stop her parents from fighting. On a subsequent occasion she took an overdose, which landed her in hospital and again stopped her parents from fighting for a few days, as they were worried about her recovery. The incident of throwing herself down the stairs after her parents had injured her in their physical fight is very closely illustrative of Medea's need to discontinue mentalization in order to avoid the trauma of facing the thought that her parents may have "malevolent intent" (Fonagy, Target, Gergely, Allen & Bateman, 2003, p. 421).

Medea's teleologically-driven behaviours (i.e. her self-harming behaviours, and physically holding herself together) represent her understanding of behaviour of herself and others as being restricted to the physical (as opposed to the mental) realm. They occur because she cannot conceptualise the

mental shift in thinking needed in order to relieve her sense of trauma and pain, or her sense of being fragmented. Similarly, she cannot conceive of her mother mentally holding her (Medea's) pain or reflecting congruent aspects of herself back to her, all of which leads to the physical action that she expresses by acting out her need for intervention. In therapy, when Medea relates the story of what action she has taken, or demonstrates to me her need to sit on the floor because she feels as though she's floating, I can see in this physical action that she needs to be mentally and emotionally held and soothed. Because she does not have a well-developed theory of mind, she needs to represent to me her need for a change in the status quo, and her sense of powerlessness (Fonagy, Target, Gergely, Allen & Bateman, 2003). In the absence of a stable core agentive self, Medea needs teleological action to alter mental states when she is unable to mentalize.

'Bleeding mind': Non-mentalization – a sketch

The fairy rebel that Medea drew is representative of a typically complex mixture of pretend mode, psychic equivalence and teleological stance. Medea drew the fairy halfway through a dance class. She was feeling upset because she was not dancing as well as some of the other dancers, and her teacher was not giving her the praise that the others were receiving; more accurately, she believed the attention she was receiving was not as positive as that which she believed the other students were receiving. Medea felt bad in this situation and wanted to cut herself, but could not until after the class, when she did.

During the remainder of the class she drew a picture. At the top of the picture was a ceiling with blood dripping from it, and below that a fairy in a tutu. The fairy had blood dripping from cuts on her wings, her stomach and round the side of her face and neck. Medea said that it was raining blood on the fairy. Above the ceiling of blood is the word 'Audience' and alongside the fairy are the words 'Bleeding Mind', and the date. When I queried this, Medea said that her mind is bleeding. "I can feel the blood dripping, dripping, dripping, and dripping." She says that she often has the feeling of blood dripping inside. She agreed with my interpretation that her head is hurting and that is why it is bleeding. She says that it hurts because she doesn't do things as well as everyone else. Her thoughts hurt her and cut her, almost like the blade does.

This sketch straddles the non-mentalizing stances of psychic equivalence, pretend mode and teleological stance, and so is representative of the experience that Medea often has of herself – and that I have of her as a patient. The psychic equivalence is represented by mind-world isomorphism in which the internal has the power of the external, so that her thoughts actually feel like a blade and cut her mind. The experience of the mind is so powerful and painful that it is traumatic, and the feelings of badness are experienced with overwhelming and unbearable intensity (Fonagy, Target, Gergely, Allen & Bateman, 2003).

On this occasion, the intensity was so bad that after the dance class in which she drew this picture, she cut herself, and also binged and purged, in order to make herself feel better. In this picture the pretend mode is represented by the lack of bridge between the inner and outer reality; the bleeding mind results in the bleeding ceiling and the bleeding fantasy creature that is reminiscent of a Brothers Grimm fairytale creature. There is dissociation from the trauma of the criticism in the dance class, in her drawing the fairytale creature that is detached and isolated from the true experience (Bateman & Fonagy, 2004). The teleological stance is represented by the need for an actual physical activity of withdrawing from the class and drawing her pain in this fantasy mode, so that she is able to alter the way she felt in the moment. Whereas another person may have been able to use self-talk or distraction in order to get through the class, Medea had to discontinue the class in order to stop the teacher from making any further critical comment on her dancing; and she had to take physical action, in the form of a drawing, in order to alter the mental state of both the teacher and herself.

This was evidently a crisis of the agentive self, in which the only action that is able to alter the mental state of the patient is direct physical action (Fonagy, Target, Gergely, Allen & Bateman, 2003). The drawing provided the physical relief by illustrating the trauma in the picture. In drawing this sketch Medea illustrates her inability to mentalize in a high state of arousal, and the need for representation of the fragmented self to an audience self, because there was no stable core for her to hold onto in the face of unbearable emotional distress. In this instance the absence of a stable core self also means that there was no ability to practise self-soothing through mentalizing about the event.

Concrete representation from failed mentalization

Self-harm, and particularly cutting, is a complex example of a failure of the ability to mentalize, because it is representative of all the aspects of modes of thinking that antedate mentalizing. In other words, psychic equivalence, pretend mode and teleological stance need to be present in order for us to conclude that mentalizing ability has failed (Fonagy & Target, 2006). When the patient cuts herself, psychic equivalence is operational, because the feelings of "badness" are experienced with such unbearable intensity that she literally needs to cut them out. Pretend mode is operational because the constitutional self is absent and decoupled from the thought process, and feelings are not accompanied by thoughts. It is pretend mode that allows self-mutilation, because the ongoing existence of the mind is not reliant on the ongoing existence of the physical self. (It is also this mode of thinking that allows certain kinds of suicide attempts.) Teleological thinking at the time of cutting means that in order for the overwhelming feelings to be relieved, something must be altered in the physical realm of the patient. It is therefore only through cutting that there is any sense of relief for the patient. Cutting and similar acts of self-harm can therefore be seen as a clear indication of a failure to mentalize, and the ongoing need for representation in the absence of a stable core self (Fonagy, Target, Gergely, Allen & Bateman, 2003; Fonagy & Target, 2006).

Mentalizing and non-mentalizing are states that are indicative of the quality of the patient's early attachment relationship with her mother. In the absence of any means by which to measure, I am extrapolating the quality of the attachment relationship from Medea's current functioning, including her non-mentalizing and mentalizing behaviours. In the therapy the patient has developed an attachment relationship with me, as the therapist. When Medea is mentalizing she represents to me the potential that she has for mentalizing, and also a state of calm reflection that we can develop in the therapy. The non-mentalizing behaviours (psychic equivalence, pretend mode and teleological stance) are indicative of her thinking as a pre-mentalizing infant (Bateman & Fonagy, 2004). These current behaviours are indicative of Medea's ongoing need for representation and a mirroring audience, in the absence of the sense of a stable core self.

Medea's ongoing use of and need for psychic equivalence is indicative of her unsatisfied need for contingent mirroring in the primary intersubjective relationship. In projecting these violent feelings onto her body, the 'body' of the piano, and in the relationships with 'the violent other' she mirrors (for herself) her emotional state, which must be externalised because it is experienced with such overwhelming intensity (Fonagy & Target, 2006). In these instances Medea is the 'audience', the replacement for an absent mother. The visual representation to herself of her inner pain acts as a mirror of her internal experience of pain. These acts are substitutes for meaningful secondary representation that would be indicative of mentalization (Fonagy, Target, Gergely, Allen & Bateman, 2003). When she shares these experiences with me, I am the audience. Being separate from Medea and her experience, I am able to contingently mirror the intensity of the feelings she was experiencing for her; and in discussion, I can bring her to begin mentalizing about these self states.

When Medea is operating in psychic equivalence she is experiencing no difference between her internal and external worlds, which means that for her, her "experience is too real and therefore overwhelming" (Bateman & Fonagy, 2004, p. 38). In psychic equivalence she cuts herself or projects violent abusive behaviour into a relationship, conjures up images of cutting piano strings and pouring her blood over them, or draws pictures of bloodied fairies. She is representing her affective state for herself, mirroring for herself the way she is feeling. On the other hand, when Medea draws pictures of fairies and collects fairies; denies the existence of tears, feelings and hunger; or looks unmoved on the violent death of another and tells herself it is "cool", she is representing to herself a rigid and fixed illusion of self-stability that is without meaning and connection to the reality of her lived experience (Bateman & Fonagy, 2004).

When Medea brings evidence of unregulated affect or rigid self-representation in telling me about the childhood sexual abuse that has become adult prostitution, in cutting herself, or in any of the other actions described above, she represents to me both the intensity of emotion she is experiencing and the rigidity with which she has to cling to an illusory sense of self. These representations that she

brings to me are representations of the initial representations to herself. This mirroring to herself is Medea's way of representing for herself her lived experience in the absence of a contingently mirroring mother. She needs this mirroring because when she is upset or emotionally aroused, mentally she is in an infant state.

However, the mirroring she does merely marks her experience – the marking is not contingent, and therefore is ineffective in producing affect regulation or mentalization. When Medea represents to me the initial representation that she made for herself she is seeking contingent marking that will acknowledge her experience, regulate her unregulated feelings and provide a sense of congruence with her lived experience, thereby linking the psychic equivalence and pretend mode for her. They can then be experienced as representations in which "inner and outer reality are seen as linked, but separate, and are no longer either equated or dissociated from each other" (Bateman & Fonagy, 2004, p. 38) and thereby become mentalizing. The mentalizing then modulates and alters affect regulation (Bateman & Fonagy, 2004).

When, in her teleological stance, Medea physically brings about change in her experience because it is either overwhelming or underwhelming, she is expressing a sense of impotence and a lack of agency brought about by a lack of representation through mirroring in her early attachment relationship with her mother. This lack of a sense of agency dates back to her early experience, in which she did not receive contingent mirroring. When the mirroring was not consistent with her own emotional state, it was incongruent; and therefore she did not experience herself as having an ability to impact on her environment in a non-physical manner, including on her caregivers.

Similarly, when her mental states were not mirrored, and thereby not marked as being different from those of her mother's, Medea did not have a sense of herself as separate from her mother. Therefore, she did not internalise a sense of herself as clearly separate from others, making her vulnerable to experiencing (as her own mental state) the mental states of others. When she saw that her mother was not attuned to her emotionally ,Medea had to demonstrate physically by crying or smiling, or by taking some physical action to make her desires or mental state clear to her mother. Her mother did not hold her in mind, and therefore, for example, could not anticipate that the impact of a violent physical fight with her father in front of her would be emotionally distressing. Because Medea does not have a strong sense of self she is particularly vulnerable on these occasions, experiencing the violence and aggression of her parents as her own violence and aggression. She therefore had to act out her distress, for example by throwing herself down the stairs in order to make them stop. This became part of her pattern of non-mentalization. This teleological thinking that results in manipulating the physical world by physical means highlights the need for representation in the form of contingent mirroring and the integration of psychic equivalence and pretend mode, because it is linked with a sense of agency and of the self. Fonagy & Target state that "affect regulation, the

capacity to modulate emotional states, is closely related to mentalization, which plays a fundamental role in the unfolding of a sense of self and agency. In this account, affect regulation is a prelude to mentalization; yet, once mentalization occurs, the nature of affect regulation is transformed: not only does it allow adjustment of affect states but more fundamentally it is used to regulate the self" (2000, p. 554). This illustrates the principle that in order for the subject to have a mind, the attachment figure must perceive the subject as a mind.

When Medea represents her internal pain through cutting (or alternative psychic-equivalent behaviours) she represents the internal pain, which is about the trauma of criticism or feelings of inadequacy, and this represents the mental pain. She does not feel the physical pain, but symbolises the pain for herself in the initial representation to herself. When she photographs the pain (i.e. her wounds from cutting) or illustrates the pain or a rigid aspect of the self (e.g. a fairy) she represents her representation in order to meet her need for contingent marking. In the therapy I take the role of the attachment figure. I meet her where she is, I match her mood state, and then contingently mirror it, thereby regulating her affective state. In this way I teach her how to regulate her own affect, and mentalize, by integrating psychic-equivalence and pretend mode, so that she gains a sense of self and of agency, and no longer has a need for non-mentalizing behaviours.

Mentalizing

Mentalizing is an ability that Medea struggles to employ. She uses it in her relationships, but it tends to fail when she is emotionally aroused or upset. What follows are examples Medea has used in the therapy to illustrate her ability to mentalize.

In a discussion with Medea about her relationship with a man (whom for the purpose of the therapy we have decided to call "Johnny"), Medea tells of an exchange in which she provides sexual services for money. This relationship began when Medea was 14 years old and needed help to pay her school fees. The relationship continued from then until the first three months of therapy, with a year's break in between. On one occasion, when Medea was in her final year at high school, she was at home because she was ill. Johnny called her to find out how she was, and offered to buy her some medication at the pharmacy. Medea accepted, and went to his house afterwards, where she worked on a project for school for a while before the drowsiness from the drugs made her need to lie down. She woke up to find he was having unprotected intercourse with her. After that she was afraid she might be pregnant, and was very angry with him for putting her in such a predicament. He responded by getting her the morning-after pill, and she was in two minds as to whether she should take it or not. On the one hand she wanted to punish him by being pregnant, and letting him be found out for what he was doing (i.e. having sex with a child), but she mentalized instead, realising that the consequences for herself would be greater. She would be stuck with the child.

In this situation the risk for non-mentalization was high because she was angry, but the thought of her reputation, what her parents would say, and the burden of mothering the child caused her to reflect on her decision and take the morning-after pill. That she could consider all these consequences shows clearly how she had not only her mind but the minds of her parents 'in mind' when she eventually made her decision. By symbolically representing to herself the states of mind of herself and of others simultaneously, she was able to hold her wish for retribution in mind while simultaneously reflecting on the implications of a decision to 'expose' Johnny in this way (Fonagy & Target, 2006).

On one occasion Medea discussed with me how, after she had been cutting herself, the blood had run down her arm during a music lesson. As will be discussed below, her self-mutilation was non-mentalizing, but on this occasion there was a very clear example of mentalization that followed immediately. The music lesson was with a tutor with whom Medea had a very close and friendly relationship. Medea recalls how, unbeknown to her, the blood ran down her arm and dripped down as she rehearsed with her tutor. The tutor noticed the blood and began to cry. Medea was able to understand that this experience "freaked her teacher out", and that it was because the tutor cared about Medea that she was upset, that she cried and then scolded Medea for hurting herself. Medea could clearly see that her tutor could not understand why she (Medea) would harm herself in this way. This example illustrates Fonagy & Target's (2006) notion of the interpersonal aspect of mentalizing. Medea understood the thoughts and feelings of her tutor, and so had insight into why it was that she was so distressed by Medea's behaviour. In order to do this, Medea needed to represent to herself symbolically the states of mind of the 'other' (Fonagy & Target, 2006).

In a later interaction, Medea once again demonstrated the ability to mentalize one aspect of the transaction but not another. On this occasion the precipitating agent for the cutting was an accompanist, once Medea's tutor but now a friend. The tutor had been called upon to assist another student in a performance. By chance, Medea and the tutor met on the stairs outside the venue, and had only just begun an exchange when the student the tutor was assisting arrived, and they had to depart in order to be on time to perform. My patient felt very hurt and rejected because she and her former tutor had met on this occasion only by accident, whereas previously the tutor would have notified her in advance that she would be on campus. Medea cut herself following this encounter; and yet at the same time, once again she was able to mentalize what her tutor may have been thinking: she imagined that her tutor rushing off to perform had not been intended as a personal slight, but rather that the tutor had a professional responsibility and commitment to leave and perform that was in no way connected with Medea. The interpersonal mentalizing (Fonagy & Target, 2006) aspect of this interchange again illustrates Medea's ability to understand another person – in this case, by understanding her tutor's motive for leaving suddenly. In other words, she understood the hurt was unintentional.

Later in the therapy Medea displayed remarkable insight into her own thinking. As a break in the therapy was coming up, we were discussing the ways in which she would cope during the break. She gave a number of examples of ways in which she would distract herself, but said she did not know what else she could do. I asked her what the benefit of the therapy was for her. Her response to this was “I can’t do things that normal people do”. When I asked what she cannot do that other people do, she said “think on their own, and... like, eat properly, and not cut, and, like, sleep without stuff.” In making these comments Medea clearly shows herself standing ‘outside’ of herself and thinking about how her thinking looks from the outside of her mind. She is thinking about how she thinks when she says that she cannot think on her own; in this exchange, she is acknowledging for the first time that she sees that her eating and cutting and sleeping patterns are outside the realm of what would be considered ‘normal’ or typical for the average person.

These examples of mentalization (and partial failure to mentalize) illustrate what Bateman & Fonagy discuss as a tendency for people with Borderline Personality Disorder. These patients, although capable of mentalizing “are more likely to abandon this capacity under high emotional arousal because mentalization was not as well established during the first decade of life” (2007, p. 87).

MENTALIZATION AND REPRESENTATION THROUGH SEMIOTICS: THE BODY BECOMES THE TEXT

Fonagy & Target state that "in order to conceive of others as having a mind, the individual needs a symbolic representational system for mental states" (2006, p. 544). Mentalization is that symbolic representational system; it is abstract, and reflects our ability to think about thinking (i.e. metacognition). Although the mentalization literature alludes to this symbolic representational system, there is no detailed discussion of the system itself.

In the therapy with Medea, in which the need for representation has been so clear, the absence of a more detailed understanding in the literature has driven me to look at the literature on semiotics. I need to understand the nature of representation in this patient, for whom representation is not abstract but takes a concrete form. In the absence of higher order or symbolic representation, Medea uses iconic and indexical signs to represent her self-states (Roelofse, 1982). Albin (2006) describes how the mother (as the semiotic receptacle) makes the signs given by the infant intelligible, and so the infant begins to develop an awareness of the self as a separate being. There is a connection to the attachment relationship, and in terms of the mentalization literature (see literature review) is reminiscent of the primary intersubjective attachment relationship between the infant and the mother, in which the mother (through marked mirroring) facilitates the development of a sense of self in the infant. In Medea's case, the behaviours described as antecedent to mentalizing (pretend mode, psychic equivalence and teleological stance) are represented using signs, which the semiotics literature ascribes to pre-verbal behaviour of the child and which pre-dates verbal language (which is symbolic, abstract and metaphorical – the language of mentalization).

Chandler (2000) describes metaphor and metonymy as central to semiotic theory, where metaphor expresses what is unfamiliar in terms of what is familiar, and metenomy is substitution, where one example stands for another. In her body modifications, which are expressions of underlying pathology, Medea is simultaneously modifying herself in line with all the cultures from which she has formed her identity: those within her family (in which she is described as the most beautiful of all the children) and those within her chosen profession, as well as those of her age ('youth culture'). For Medea, family has more than one 'cultural' component. Her brother belongs to a cultural group known as 'Goth' and he has many piercings and tattoos which belongs to that particular culture. Her sister has had cosmetic surgery and is in the beauty industry, so her focus is on making the body beautiful. Medea is also part of a performance culture, and for a time she worked as a model – part of an industry in which the body is very much a product that is advertised and sold. She is a young adult, part of a group represented by the media as only successful if slim and physically beautiful. Therefore her acts of self mutilation and bulimia, though representative of her pathology, also represent the violence of her home and Cape Flats culture, and she performs them in a manner that is culturally

congruent with the beauty and performance industries and the Goth culture, aspects of all of which resonate with her.

In body-modification activities Medea is expressing what is inexpressible in words and may predate verbal expression (Albin, 2006). Medea may well also be expressing the feelings that were internalised as the "alien self" spoken of by Fonagy & Target (2006). This alien self is part of a fragmented self, and the body itself is objectified and treated as a fragment in these forms of representation (Haiken, 2000). In Medea's case, her cutting/bulimia/piercing behaviours are representations of her fragmented self on her body – a self that has, by means of the choice of representation, become an objectified fragment rather than a whole. In this way she externalizes for herself the very nature of the fragmentation that she experiences.

On one occasion Medea showed me how she had cut herself in a neat, wavy, symmetrically semicircular pattern. This was curious to me, because previously she had cut in parallel lines, but there was an explanation. She has said a number of times that she has been thinking of getting tattoos on her arms where she cuts. She also spoke of getting a piercing, which she did for her birthday. Shortly thereafter she reported to me about how she had found a group of fairy figurines that had symmetrical patterns on their arms. She was surprised when she saw them because "why would they make fairies that cut?" but on closer examination she realised that the fairies were tattooed. She thought that was really "cool".

Cutting is a complex form of representation, expressing in semiotics what Medea does not express verbally. It represents in an indexical way the intense feelings and emotions that Medea cannot hold because they are so overwhelming. It is also metonymic, because the external cut represents the internal pain at the same time as it represents the violent culture that she comes from. Cutting is also metaphoric, because the wound is a metaphor for her internal pain, and the cut itself is iconic, because it bears an analogous resemblance to the signifier, the inner wound.

When Medea represents these cuts to herself and to me in the form of fairy figurines or photographs it is a multifaceted representation, being both iconic and indexical. Iconic, because it bears a physical resemblance to what it depicts, and indexical because of the "point to point" (Chandler, 2000) physical connection to the event making it optically connected to the event. The photograph expresses the pain she has felt in a concrete way, though one step removed from the actual physical pain. When Medea does this she uses pictures because she cannot put her experience in words, which would be more abstract and symbolically representative. She needs to see her experience visually. In her use of indexical and iconic signs she becomes a picture of suffering. The blood is indexical and metonymic, because it is adjacent to the pain inside herself. Blood is also a metaphor for psychic pain, and iconically representative of the internal pain.

Often when we discuss her cutting Medea says that she wants to cut the fat away, and that she is not what people want her to be, so she cuts. She says that when she cuts, she cuts away the "bad" parts that people don't like. She also binges and purges and is restrictive in her eating, sometimes to the point of fasting for periods of time in order to be thin "like everyone wants me to be". In selecting the forms of representation that Medea does, she is expressing from her preverbal psyche the internalised images that are symbols and not words in her unconscious. The images are mediated by her cultural experience, and therefore mask for her the very violence of the representation or the root of the pathology from which they stem. This is why she can see a fantasy representation of herself (a picture of a fairy) as '"cool" when it is marked with representations of cutting, or self-mutilation in the form of tattoos. She has become unconscious of the social construct of her choice of representation, and the manner in which it further isolates and alienates her from herself and her enactments or representations of the internal trauma and chaos of her psyche.

If signs are representations of the self and self-expression that pre-dates verbal language or extends beyond the language of the subject, then in her earliest behaviours Medea represented to her parents – by the gash on her forehead for which she needed stitches – that she was suffering, and in pain. She did so using indexical and iconic signs (Roelofse, 1982) because she had not developed an abstract or symbolic form of representation for communicating her distress to her family. Nor has she yet. In this family, in which action abounds and words are few, she used this teleological behaviour to express to her parents the need for them to stop fighting and take care of the neglected child. Simultaneously, she was representing for them the violence that they were doing to her and their relationship when they fought in her presence.

In this instance Medea's communication to her parents was both indexical and iconic: indexical because her distress was as a result of their neglect and violence, and iconic because of her violent self-abuse, which represents their violence towards each other and the violence that is done to her emotionally when they fight and are violent. Currently she represents her internal pain (that is beyond verbal expression) though cutting, piercing, bulimia and starvation, which simultaneously represent cultural norms of expression for a person in her situation, again using iconic and indexical rather than symbolic forms of representation.

For Medea, expression through the medium of language became 'dangerous' at an early age, when her mother found her note about how she would like to kill herself. It was after that incident that her mother was in a bad mood, and so fought with her father, and Medea threw herself down the stairs in order to signal to her parents that she could not cope with the violence in their relationship. It would seem that her parents could not cope with her symbolic expression of her distress and her wish to die, but they were more able to respond to her more indexical and iconic representation of these emotions

when she threw herself down the stairs. This then became her customary pattern of expression, so that by the age of 11 she was cutting, by 14 bulimic, and at 20, piercing and deciding on tattoos.

If we view these actions as metonymic practices, in which one example substitutes for another, that have (due to the experience of life in the culture of this family) become so closely related as to be interchangeable without causing confusion, we understand Medea contextually. For the therapist, as one who is outside of the cultural context, the role is to understand the behaviours metaphorically, relating the familiar to the unfamiliar (where the cutting, piercing, tattoos and fairy self-representations are the unfamiliar, and her body or sketching is the familiar). Then, we access the covert or unconscious meaning or intention in her actions, and thereby access the psychoanalytic component of the behaviours (Albin, 2006).

CONCLUSION

In this, my concluding chapter, I first discuss the argument of my thesis – that failure in the early attachment relationship results in the absence of a stable core sense of self, which results in an ongoing need for concrete representation of mental states. The ongoing need for representation results in non-mentalizing behaviour as explained by the mentalizing literature, which has been helpful in understanding Medea in her therapy. I discuss how I have used mentalization-based therapy with Medea in order to model for her how I mentalize, how I identify how she mentalizes, and to make explicit how I contingently mirror her self-states.

Although useful, the mentalization literature has not provided sufficiently detailed insight into Medea's forms of representation. I go on to discuss how the semiotic literature and therapy have been useful in providing a deeper and more detailed insight into the forms of representation that non-mentalizing behaviours take in Medea. I discuss the need for an explanation of the absence of mentalizing, and the link with language acquisition in the context of the primary attachment relationship, particularly in the language of feelings. I discuss the questions that this absence in the mentalization literature leaves, and how I believe the semiotic literature helps to bridge the gap. I put forward the hypothesis that attachment is connected with a sense of agency as a social being, and is also connected with language acquisition. I discuss the implications of this for therapy, providing examples that have been used in Medea's therapy. I conclude the chapter with a comment on the use of language as a symbol that can be used to link with fantasy in connecting the fragmented self-states of those with Borderline Personality Disorder.

In this thesis I have argued that a lack of a stable core sense of self results in a need to represent aspects of the fragmented self to the self as an audience, in order to maintain a sense of self and of self-representation. Although the mentalization literature indicates that mentalization is 'thinking about thinking', it does not make it clear that mentalization is an abstract symbolic or metaphoric way of thinking that is developed in a healthy primary attachment relationship. Semiotics literature has helped to explain that Medea's need to cut and photograph her cuts (as well as other non-mentalizing behaviours that she uses) is indicative of her ongoing need for representation and mirroring, because of the absence of a stable core self as a result of a failure in the primary intersubjective experience.

With Medea, I have used mentalization-based therapy to mirror for her the self-states of which she is not always aware. An example of this was an occasion in which she considered the workload of one of her students, who is an engineering student. She factored this in when planning lessons and setting homework tasks as well as when evaluating the student's level of progress. She had not realised how she was holding him in mind, so I 'held a mirror up to her' so that she could see how she was thinking of him, and how that meant that she was holding him in mind. As I asked her to examine how she was automatically and unconsciously considering him, I told her that when I did that I was holding a

mirror up to her so that she could see how she had been holding him in mind. I connected that with the way in which I hold her in mind and the way she can hold the therapy space in mind when she is outside of sessions and distressed by events that occur.

Similarly, when Medea represented herself as unmoved by a violent scene she had witnessed, I could tell her that it was pretend mode, that she was pretending that she was calm and unmoved; but her distress was evident in the detachment she needed to activate in order to cope with the distress. I also linked the violence of cutting with violent relationships in her life, and the internalisation of an alien self in the context of her childhood. Using the mentalization approach I was able to translate for her that when she cuts she is showing herself and acknowledging to herself that she is hurting; and that when she shows me, I mirror it for her, acknowledging both the pain and the need to have it confirmed, as well as holding it. In doing this I am contingently marking her pain for her, so that she could see her distress would not overwhelm or destroy me, and explicitly stating that I am doing as I do it. When she brings her success stories to therapy she tells me what someone else has said and watches my response, as I express – verbally and physically, through smiles and other physical gestures – my pleasure in her happiness and success. I then discuss with her what the exchange has been about so that she can accept and own her own experience of pleasure as congruent with her experience, and my response to her as mirroring what she feels.

The need for representation is very clearly evident in Medea's ongoing self-representative behaviours, and although the mentalization literature explains this need, it does not provide as detailed an insight into the forms of representation evidenced as is offered by the semiotic literature. The forms of representation that Medea uses are largely indexical and iconic; they are concrete representations, which in the language of mentalization-based theory may be classified as pretend mode, psychic equivalence and teleological stance. These forms of representation predate the more advanced and abstract forms of representation of the symbol or metaphor, and are reminiscent of the child who, when learning number concepts, first represents numbers using beads on an abacus, and then moves to the more advanced symbols of the algorithms we all use.

To extend the analogy further, Medea has never advanced to the algorithm stage developmentally. This impacts on the therapy, and also has implications for further research in the mentalization-based therapy approach in dealing with patients with Borderline Personality Disorder. This is particularly so since in the literature, the acquisition is linked to the early attachment relationship (Majav, 2005).

In therapy with a patient with BPD, the mentalization-based therapy approach (Bateman & Fonagy, 2003) has been helpful in increasing mentalization behaviour of the patient, and in making a beginning for labelling feelings and connecting them to precipitants. This form of therapy has also been useful in understanding the need to meet the patient where she is emotionally, to sooth her and help her to make the shift from simply acting impulsively on overwhelming feelings to using the

therapy space to think about the context of the feelings. The literature has not, however provided a useful language for discussing with the patient the connection with and need for fairies, cutting, tattoos, piercings, or bulimia.

On the other hand, semiotics literature does explain and integrate very well. Semiotics literature is useful because it explains the difference between indexical, iconic and symbolic representation, and connects with the notion of mentalization being symbolic representation. In the therapy it is useful to have the language to explain to the patient that her forms of representation are concrete, like pictures; but that in the therapy we use words, and the words symbolically represent the thoughts and feelings of the self and others. When this is successful, the patient is able to make the shift from seeing things visually (with their connection to pretend mode, psychic equivalence and teleological thinking) to being able to believe that her experience can be and is adequately expressed symbolically in words, in the same way that as a musician, Medea expresses herself through the music she makes.

The mentalization literature does not provide deep or rich explanations of what is meant by mentalizing, or the relationship of mentalizing to the acquisition of language. If it is linked to attachment, as is done in the semiotics literature (Albin, 2006), that link needs to be explored and explicitly included in the mentalization literature. There needs to be a language of feeling that is linked to mentalization-based therapy. Bateman & Fonagy (2003) do refer to the need for labelling affective states, and the relationship of this inability to the lack of a stable core self (with the reason for this attributed to failure in the primary intersubjective experience), but this is not closely connected in the literature to language development in the primary intersubjective experience (Bateman & Fonagy, 2003 & 2004).

In therapy, the questions that remain unanswered by the mentalization-based treatment approach are: When a patient is expressing things in pictures or acts rather than using words, how does the therapist bridge that gap? How do you make a language that is actually experienced as representative of the very powerful experience of the patient, when that has been missing in the attachment relationship in the primary intersubjective experience? And can pictures and actions regulate affect, or is that the job of language?

My sense and my experience are that in response to the first question, the gap is bridged in the therapeutic attachment relationship, when the well-attuned therapist – having soothed the patient to the point that mentalization is possible – then discusses the pictures or actions. First the discussion needs to clarify the context or situation in which the picture or action occurred in detail. Having understood the feeling states of the patient at the time, the therapist must interpret the action in terms of a semiotic understanding of the behaviours, and offer this to the patient as an insight into his or her behaviour.

In response to the second question I would argue that when language has not been representative in the early attachment, it needs to be linked over time in the therapeutic attachment to the behaviours of the patient, alongside explanations of how the therapist soothed the distressed patient using words. It has been my experience that, having soothed my distressed patient, I have been able to explain how our conversation has been helpful to her and can ask her to compare it with her non-mentalizing behaviour, in order for her to decide what has soothed her most. The attachment relationship is primary, as it should have been in infancy; and it is in the new therapeutic relationship that the representative nature of language can be established in a well-attuned therapeutic alliance.

This also answers the third and last question, as to whether or not language can regulate affect, or if actions are necessary. I believe that over time (as has been the case with Medea) the need for actions diminishes as a language of feeling grows in a secure attachment relationship. Initially the two happen alongside each other, but as the sense of self becomes more established and is more mentally represented, the capacity for language to regulate affect increases.

If we accept the hypothesis put forward by Csibra (2003), Gergely and Csibra (2003) and Fonagy, Target, Gergely, Allen & Bateman (2003), that teleological behaviours predate language development in a secure attachment, then it follows that actions are increasingly replaced by verbal expression and gestures as the child develops a sense of agency as a social being. Then there is a clear link with the ongoing need for teleological and other forms of representation through behaviours that are non-verbal. The need for the semiotic is found in the type of attachment relationship in which the child has developed neither a secure sense of self, nor a sense of agency; and therefore does not believe, or have a sufficiently satisfying or soothing experience of symbolic or metaphoric representation, in the form of language or being held in mind. The infant is not held in mind by the primary attachment figure, and as a result the infant is not able to hold him- or herself in mind either. The ability to trust language or symbolic representation as an adequate form of holding and conveying feeling states is never developed. Although language continues to develop, it is limited as a means of expression, regulation and soothing. The patient therefore knows unwaveringly that ‘actions speak louder than words’.

In the therapy relationship, through the development of a secure attachment with the therapist the patient has the opportunity of developing a sense of agency, and the ability to use the symbolic (metaphor or language) to adequately express, contain, regulate and sooth emotions in and between sessions. This develops as the patient learns in the practice of mentalization-based therapy what the mental outcomes of their behaviours are, rather than focusing on the physical. In my experience, using the semiotic understanding and interpretation of the behaviour helps the patient to connect the action or representation with his or her mental state at the time, and facilitates growth.

Chandler (2000) argues that language is a symbolic sign system. At the start of the therapy, Medea had not developed this system. When discussing forms of representation in the therapy it has been

helpful to use the terms offered by the semiotics literature, to explain and to help Medea understand that there are different types of signs, and that language is the most advanced because it is symbolic. In Medea's therapy I explained how this is seen in the development of the child, and in the acquisition of language in children. I have used her family's patterns of interaction to illustrate my point. This means that I was able to explain that the cutting violently represents the emotional upset she experiences when her parents physically act out their anger toward each other by hitting, and that they are representing their anger in an indexical way. Similarly, her cutting is representing her anger in an indexical way.

I began making this connection for Medea in a therapy session in which she was unable to put into words what she was feeling, because it was too overwhelming. She sat in her chair, digging her nails into her hands, and spoke of nobody loving her because her former tutor did not respond to her online greeting. Even when I helped her with the words by labelling feelings she could not articulate her pain. This was a hindrance to the process. She was able to look sad and hurt, and to acknowledge the pain with nods in response to my comments on the situation, but she had an ongoing need to represent the pain by clawing at her arm. I began discussing with her how she was physically representing her pain, explaining about iconic and indexical signs, and the difference between that and symbolically representing her experience in words. In this way I brought the symbolic, iconic and indexical together in the language I was using and linked them for her.

Later I could compare the above forms of representation with an incident in which she had been reduced to tears of frustration and anger in a music lesson; but on that occasion, the tears signalled appropriately to her teacher that she was upset, and a conversation followed in which she could express, using language, what was upsetting her and how it was upsetting her. I also linked that experience with symbolic representation systems, and with the fact that she had found the conversation and ensuing shared understanding and closeness with her teacher both soothing and containing. She could see that the language had adequately represented her mental state, and that other forms of representation that she has previously used have also represented her mental state, but she has not found them as soothing or therapeutic. In this way, the use of the semiotic understanding of representation has added a level of insight that the mentalization literature and practice has not offered. In Medea's case the additional layer of the semiotic psychotherapy has been therapeutically helpful.

Barclay and Kee argue that in psychotherapy, making meaning is achieved predominantly through the use of language (symbols) which can be used in mixing reality with fantasy, because language can facilitate the "production of the unreal world of imagination and fantasy" (2001, p. 673). With Medea this facility has been used to link her fantasy representations of herself in pretend mode behaviours with the reality that they are not representing, and with the split-off aspects of herself, helping her to

understand the connection between her pretend mode behaviours and her fragmented, detached self. This is consistent with Barclay and Kee's argument that "in constructing this new incorporating narrative, the person in therapy thereby constructs a new and more comprehensive (less fragmented) concept of the self" (2001, p. 673). Although the use of the technique they describe is in the context of dissociative identity disorder, I believe it has been equally applicable in Medea's treatment – and will be in the treatment of other people with Borderline Personality Disorder, because this is also a disorder in the structure of the self.

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APPENDIX A

Aetiological Formulation

Predisposing Factors

This formulation needs to account for why Medea, a 20-year-old performing artist who was referred to the clinic by Student Wellness with a history of bulimia and self-injurious behaviour beginning at age 5, and why she has presented with a Borderline Personality Disorder at the clinic at this time. Medea's vulnerability is possibly linked to her mother's depression, and an enlarged gland that may have had a hormonal effect that could have impacted on Medea's prenatal brain development. Furthermore, we know from the literature that depression affects the mother's ability to parent, and the attachment relationship with the infant.

Medea's mother was neglectful and inattentive, resulting in Medea's primary intersubjective attachment being disorganised. The continuously violent and conflictual parental relationship during Medea's early years taught her an ineffective way of dealing with emotional stressors and interpersonal relationships, and made her vulnerable to trauma. The conflict also resulted in her mother being absent through distraction, at the same time as triggering a fear response because of the threat of loss of the attachment figure through injury. The socio-economic situation meant that her mother could not afford adequate treatment, and her father's attitude that her mother 'makes her own problems' exacerbated the situation for her mother, which in turn aggravated the disorganised attachment.

Furthermore, the poor attachment relationship resulted in poor language development and symbolic representation in the form of mentalization. This, together with the family's tendency to use nonverbal and non-symbolic, but rather culturally-bound concrete or corporeal forms of representation, modelled for Medea the nonverbal pattern of behaviour and expression that she has internalised.

Precipitating Factors

Medea was attending counselling on an ad-hoc basis at Student Wellness, was seeing a psychiatrist, and had begun to develop an attachment to her counsellor when she had a pregnancy scare. There seemed to be a sense of hope around this pregnancy, and the subsequent arrival of her menstrual period was experienced as a loss of the baby. Medea herself says she wanted to take care of the inner baby Medea. The combination of these factors and the added stress of increased difficulty with coping with her academic work caused Medea to be willing to enter into a new, more consistent therapy relationship.

All of Medea's symptoms were (and are) ongoing without significant change in the two years prior to entering the clinic, except for the area of socialisation, which seems to have changed since the loss experienced as a result of the pregnancy scare last year. Medea seems to have withdrawn from social interaction, as well as simultaneously experiencing possible interpersonal difficulty. Medea used to have friends in the music department, but is now on the periphery. It is unclear as to whether this is part of her social withdrawal or a specific interpersonal difficulty.

Maintaining Factors

Although Medea lives in a university residence, she remains part of the dysfunctional family system that she was born into, and her parents continue to fight daily. She is unable to extract herself from involvement in this because her mother continues to phone her and complain to her about her father's behaviour, and Medea has not yet developed sufficient internal resources to indicate to her mother that she is not prepared to listen any longer. Because her inability to cope is part of a fragmented core self, Medea has not yet internalised a sufficiently well-integrated self-structure to regulate her feelings and think clearly about situations. Difficulties with interpersonal relationships sustain the cycle of violence and emotional neglect, thereby perpetuating many of the presenting problems. The ongoing physical violence between her parents, her brother's identification with the 'Goth' culture, with his tattoos and piercings, and her sister's involvement in the beauty industry – reinforce these types of behaviours as ongoing forms of self-representation and self-expression. Furthermore, her own experience of the attention and caring responses that her distress expressed through semiotic representation reinforced the usefulness of these behaviours.

Protective Factors

Counterbalancing these factors are the protective threads or patterns that run through Medea's life. These include a thread of reparative relationships with siblings and relatives. In seeking therapy, Medea illustrates a desire for repair. Medea has a pattern of eliciting nurturing emotional responses from people in her world, beginning with her maternal grandmother's sister and following through to my caring response to her in the therapy.

More recently, a sense of self has begun to emerge in the therapy that bodes well for treatment. With this emerging sense of self there are also the beginnings of an ability to use words to express her mental states symbolically. Medea's intellectual functioning and ability is also a protective factor, as she is able to engage in mentalization based therapy. She has a capacity to think, and a level of intelligence that enables her to grasp and make sense of abstract concepts.

<u>Therapeutic Formulation</u>

This formulation will use mentalization-based theory and semiotics to account for Medea's development of a Borderline Personality Disorder, with a need for ongoing self-representation, as a result of failure in the early attachment relationship.

Medea presents as a detached ethereal figure with a poor sense of self and an inability to interface with the world. She shows a reluctance to develop attachments, is prone to interpersonal difficulties, and when emotionally aroused expresses her feelings in inappropriate ways such as cutting, abusing alcohol and analgesics, and threatening suicide. Her defences against attachment and the threat of being emotionally overwhelmed or underwhelmed are to remain detached, and to use non-mentalizing behaviours of pretend mode, psychic equivalence and teleological stance as iconic and indexical signs of self-states.

Medea's deprived early primary attachment relationship gave rise to a fragmented and symbolically (in terms of language and mentalization) inarticulate self, in the following way. It is likely that Medea's depressed mother, living in the context of a violent marriage and a violent community, was unavailable to form a secure attuned attachment with the infant Medea. She did not model holding Medea in mind, symbolically representing her for herself, and did not respond to her uniqueness and

contingently mirror her feeling states. This meant that she was unable to match, contingently mirror and sooth Medea's infant self-states in order for Medea to internalise a congruent self-structure.

In opposition to this, mother's mis-attunement and unavailability, while simultaneously mirroring rather than forming a barrier between Medea and the violence of the outside world, caused Medea to internalise a violent and alien self-structure. This alien self-structure continues to feel alien, and Medea tries to expel it through violent behaviours against herself. Sometimes this has been acted out in historically violent relationships such as that of child prostitution and attempted rape and sexual abuse at age 14.

The absence of attunement and associated contingently congruent mirroring in the primary attachment resulted in a lack of appropriate hard-wiring for self-regulation and internal and symbolic self-representation using language or mentalization, with the result that Medea has an ongoing need for self-representation. This ongoing need is most evident when she is emotionally aroused, and she turns to more corporeal forms of representation of self-states. She does this using either pretend mode, in which she represents parts of herself as herself (for example iconically, as an ethereal fairy or a party animal), or she uses psychic equivalence indexically to mirror her emotional pain or numbness by cutting. The blood physically represents to her the internal pain providing the sense of congruent mirroring that was absent in her early infant attachment.

Similarly, on some occasions Medea's behaviour forces action on the part of those around her, such as when she threw herself down the stairs, cutting her head open; or more recently, attempted suicide, with the result that her parents had to physically stop fighting and take care of her. This is evidence of teleological thinking, in which Medea has a crisis of her agentive self and understands actions in terms of their physical outcomes rather than their mentalization outcomes. In these contexts this is also self-expression, using the signs her parents understand to convey what she does not have words to express, and in a way that they understand because it is culturally congruent for them.

Medea has within her the capacity to elicit caring emotional responses from others; but she distances herself from them in a repetition compulsion, repeating the pattern of attachment that she is likely to have had with a depressed and unavailable mother.