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Introduction to chapter 2

In this paper Peter Fonagy and Mary Target formulate the hypothesis that both self harm and violence against others are linked to failures in the capacity to mentalise: the lack of capacity to think about mental states in the self and others may lead individuals to deal with thoughts and desires primarily in the realms of body states and processes. If a characteristic of the human mind is the ability to relate to one's own as well as to others' mental states, the borderline patient presents a failure in such capacities. The authors suggest that the problem can be traced to a crucial stage of development of the self when the child searches the face of his primary object for a representation of his own states of mind. Failure to find this forces him into pathological solutions to achieve a containing organisation.

The authors explore the meaning of gender difference in the direction of aggression, and the way in which the child has a second chance to foster a secure psychological self through his relation to the father, even when the mother has been unable to support and to separate successfully. In this Fonagy and Target have been influenced by Donald Campbell's stress on the role of the father in the analysis of a young suicidal patient (in this volume, chapter 3). The chapter also explores issues of technique in the treatment of a violent young man.

Fonagy and Target's line of thinking can be traced to psychoanalytic writings which emphasise the relevance of the maternal environment in the containment of the child's anxieties, where the mother's capacity to reflect on her child's experiences becomes a representation for his own experience. Fonagy and Target believe that at the core of the self is the other, but this other represents the self. These ideas have had an impact on contemporary psychoanalytical thinking in Britain, as can be seen from some of the other papers in this collection.

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2

Towards understanding violence: the use of the body and the role of the father

PETER FONAGY AND MARY TARGET

Introduction

This chapter concerns the understanding of some violent patients. We aim to extend the thinking developed in previous papers (Fonagy, 1991; Fonagy *et al.*, 1993), which described the use of aggression in some cases as a defence of the psychological self, weakened by childhood experiences of abuse or neglect, and threatened in all subsequent relationships. In this chapter, we consider cases in which no such abusive experiences have occurred, but a similar pattern of apparently senseless violence develops, towards either the self or other people. We also attempt to identify one route to this form of pathology in the disruption of early triadic relationships (Britton, 1989). Finally, we hope to illustrate that violence, aggression directed against the body, may be closely linked to failures of mentalisation, as the lack of capacity to think about mental states may force individuals to manage thoughts, beliefs and desires in the physical domain, primarily in the realm of body states and processes.

Psychoanalytic thinking on aggression has been distracted by the controversy over the relative importance of innate destructiveness and environmental influences. As Mitchell (1993) has made clear, these polarised positions have important clinical implications. This is illustrated by the diametrically opposed views of Kernberg (1984) and Stolorow *et al.* (1987) on the technical handling of aggressive borderline patients, based on their differing views of the meaning of this behaviour. Mitchell himself adopts a position consistent with that put forward in our previous paper (Fonagy *et al.*, 1993), that aggression is biologically rooted, but arises in response to perceived threats to the psychological self. In this chapter, we have tried to explore what it is that is felt to be

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endangered, what environmental and constitutional circumstances are likely to lead to such a sense of threat, and hence when aggression is likely to develop as a habitual response.

We have offered a model (Fonagy, 1991; Fonagy *et al.*, 1993) of the way in which physical or emotional abuse in childhood may lead to aggression. In such cases, we suggested, four things happen: (i) the child's psychological self remains fragile, because the reflective process (capacity for mentalisation) underlying this part of the self is jeopardised. A child's 'theory of mind' (Premack and Woodruff, 1978; Morton and Frith, 1995), his appreciation of the mental foundations of human behaviour, crucially depends on his developing awareness of the psychological world of his attachment figures. Perhaps even more importantly, it depends on the capacity of the mother (or primary caregiver) to demonstrate to the child that she thinks of him as an intentional being whose behaviour is driven by thoughts, feelings, beliefs and desires (Fonagy *et al.*, 1991). This essential intersubjective process is compromised if the caregiver's thoughts about the child are often malevolent, and the child no longer feels safe to think about his object's thoughts about him or to see people as thinking. (ii) As a second step, aggression is brought in to defend the fragile psychological self from the assumed hostility of the object. (iii) A third stage is reached, when self-expression and aggression are associated so regularly that a pathological fusion can occur between the two (self-expression becomes isomorphic with aggression). (iv) Finally, the reduced capacity to mentalise, to picture the mental states of the other, reduces inhibition of aggression by representing the victim as devoid of thoughts, feelings and the capacity for real suffering.

It is relatively easy to discern this pathway to violence in patients whose background is part of the so-called cycle of abuse. There are, however, other patients with an apparently similar psychic structure, who also tend to respond with violence under little or no provocation, but whose environments appear to have been relatively benign (Weiss, *et al.*, 1960; Blackman, *et al.*, 1963). We suggest that in these cases also certain forms of violence have been done to the child's psychological self, but that these were more subtle, hard to pinpoint in external relationships, and usually only become clear in an intensive personal encounter, such as psychoanalysis. Nevertheless, they may be seen to have led to the same end-point, a fragile capacity for mentalisation, protected by aggression aimed at anything challenging this capacity.

The form of aggression which we are describing here can readily be differentiated, phenomenologically, from sadism, where a capacity to imagine the feelings of the other is probably essential to full enjoyment. Glasser has made a similar distinction, between what he calls self-preservative violence and sadism or malicious violence (Glasser, 1986). The most extreme form of the more sadistic type of aggression is the planned, purposeful and emotionless violence of the psychopathic character. However, it is possible that a similarly fragile capacity to envision the state of mind of the other may be involved. Sadistic

individuals may need an amplified experience of the other's thoughts and feelings to experience intersubjectivity; they are unable to love, as this represents an insufficiently dramatic experience of psychological closeness (Fonagy, 1993). Therefore they may need to create a stereotyped form of interaction in which the thoughts and feelings of both partners are intensely involved, in order to feel in contact. However, although such a character may share a blunting of the ability to mentalise, there is an essential difference from the aggression we consider here, in that sadistic behaviour is not an attempt to defend the self. In contrast, the violent individuals we consider here, having sought proximity, then feel trapped by a persecutory object (Meloy, 1988). The act of mindless aggression is characterised by an inexplicable build-up of uncontainable tension and rage just before the violence, the perception of the victim as a threat, and feelings of being out of control during the violent act. The act is aimed at reducing this threat and regaining intrapsychic equilibrium (Meloy, 1993). We wish to explore the nature of the phantasy enacted in this act of preservation of the psychological self through violence.

In many cases of violence, there is aggression towards both other people and the self. The central thesis of this chapter is that in both cases the underlying motive is the same, *a wish to attack thoughts, in oneself or in another.* As one of our patients shouted in a tirade: 'If I kill you, I won't have to think about what you think.' Similarly, attacks on one's own body, such as self-cutting, may be seen as an attempt to blot out intolerable thoughts or images in the patient's own mind. We hope the cases described below will illustrate this point.

A further issue we consider is that of analytic technique with aggressive patients, when because of the fragility of the psychological self, analysis may be the most threatening situation which such individuals can experience. How can a pathological organisation focused on the destruction of empathy and compassion be changed using a technique based on just these qualities?

Case illustration[1]

Mr T came to see me feeling depressed and empty, worried that his psychological difficulties were threatening his promising career. He had a congenital deformity of the spine that, despite several operations, gave him increasing pain and difficulty in walking. Mr T was of medium height but his unkempt hair, unshaven pale face, dirty clothes and piercing look give him a sinister appearance. He drank heavily to blot out physical and psychological pain, but when drunk became violent and had several criminal convictions for assault, the most serious of which was an unprovoked assault with a beer bottle, causing severe head injuries to a stranger in a bar. As he recounted the story, Mr T felt

1 The analyst was the first author.

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overwhelmed by rage, provoked by the thought that the stranger had been mocking his deformity. Subsequently, he realised that he simply had no idea what that person had been thinking or feeling. In this way, he gave me an early indication, demonstrated repeatedly in the transference, that his understanding of the mental states of others, as well as his own psychic functioning, was at best partial.

Whilst asking for my help, Mr T immediately showed contempt for what I might have to offer. His mother was a doctor, who knew lots of 'shrinks'. 'They cling on to their patients.' I suggested that he was frightened that analysis might bring his own need to cling closer to the surface, and that no one, including me, would be able to cope with that. Needless to say, he sneeringly rejected my interpretation.

Mr T gave me an immediate taste of the potent mix of self-punishment and cruelty which organised his life. He started his first analytic session by suddenly taking off his shirt to reveal his deformed back, leaving it exposed for the entire session. I felt revulsion, confusion and then shame, eventually commenting to Mr T about what might be his terror of rejection, and his perhaps habitual way of pre-empting this anxiety by trying to control the feelings of those around him. He reacted with derision: 'That's shit, and you know it.' I believed that what I had said was true, but I sensed that my understanding had no meaning for Mr T. It seemed that any further attempt at empathy with the sense of injustice and hurt which seemed to drive his bitter hatred would be futile. At this stage I simply added: 'It seems that you feel safer when someone is uncomfortable.' To this he readily agreed.

In this initial session, Mr T demonstrated a pattern of interaction between us which was to become familiar: a persecutory, cruel but damaged object (in this session represented by his back) and a figure seen as shamed, uncomfortable and weak (sometimes himself and sometimes me). Perhaps even more characteristically, I found myself the reluctant recipient of thoughts and feelings which his behaviour brutally forced upon me. I began to feel that for Mr T, language and symbolic communication could not adequately convey psychic experience. He was forced to resort to communication through his body to convey to me the most important aspects of his experience of himself, his sense of inadequacy and his experience of his mother's shame and revulsion.

Mr T was the only child of an unusual family. His mother, 25 years younger than his father, had had an affair throughout most of Mr T's childhood and adolescence. When Mr T was about 5, his mother embarked on medical training and he was looked after by a housekeeper. He was sent away to boarding schools from the age of 6. Mr T's father died of a chronic cardiac failure when his son was 17 years old. His dominant memory of him was as someone constantly ill, sometimes suicidally depressed, and in later years confined to a wheelchair.

Mr T did not mourn his father's death, but from that age suffered a series of major depressions with manic episodes, drank heavily and abused drugs. He

had his first breakdown whilst still at school. He withdrew and refused to work. At this stage he had two compulsive activities: reading computer magazines, and masturbation. He felt 'whole and *someone* when [his] penis was erect'. Mr T went on to music college, where he specialised in self-destructive performances, for example, in a well-attended leavers' concert, he played 'silent music', drumming his fingers on the side of his head.

Early in the analysis Mr T frequently sat in the chair or on the couch saying very little, but these silences never felt totally isolating. He spoke just enough for me to know I was in the company of a torturing superego. He habitually denigrated his analyst and other patients, criticised my consulting room, kicked my books or the furniture. Although I made strenuous efforts not to deprive him of any analytic time, I would find myself blamed for obstructing his progress and for not giving him extra time when he was late. He mentioned no relationship which was not characterised by exploitation, hatred, envy or criticism. All experiences of understanding in the transference and outside it were seen as evidence of weakness and fear, and love was 'crap'.

Mr T would reject my attempts at making links, and used this to confirm my uselessness as an analyst. He was terrified of mental disintegration and was often confusing and almost incoherent. He controlled his anxiety between sessions by taking cocaine and ecstasy. In the session he physically intimidated me, rushing around the room wildly, standing in front of my chair or on the table, at other times curling up like a baby, locking himself in the lavatory, or leaving in the middle of the session kicking my chair as he went. Although frequently menacing and abusive, he never actually hit me and, after starting his analysis, reduced his tendency to violence outside, provoking no further arrests.

I tried to stand my ground, careful *not* to interpret his actions as attacks on me or the analysis, or to give them unconscious meaning, beyond that of an ordinary human gesture. I felt we were in a space without meaning. He acted impulsively, unable to put into words the feelings and ideas which made him behave this way. At this stage, my task was to offer him recognition, however tentative and however quickly rejected. For example, when he stood on the table, I said 'I know you are frightened that you look ridiculous, but doing things like this simply exaggerates your vulnerability.' At another time, when he lay on the floor in a foetal position, I walked over to him, sat down somewhat wearily, and said: 'Oh well, if you want to be like a baby in here that's fine, but let's carry on talking anyway.' My interventions restored contact with him at a human level, and usually some kind of analytic dialogue would resume. The challenge was to experience both what Mr T conveyed by talk and what he conveyed by projection (or perhaps by projective identification) while at the same time preventing him, through interpretation and confrontation, from living out his defensive phantasy in the transference. Unless I was alert, he used the analysis as a refuge from life, as opposed to a process which could regenerate life.

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My sense was that in Mr T's mind we needed one another, not as part of a mutually beneficial and satisfactory relationship, but because our dissatisfaction with one another kept a greater fear away, the terrifying mental void left by an absence of thoughts and reflectiveness. He recalled a dream of two hens pecking at one another. Behind the hens was a dangerous rabid dog but the hens took no notice – they were too busy fighting. I understood this as indicating that the constant conflict with me diverted attention from something far more frightening, which would confront and overwhelm us if we had space to reflect. The dream also suggested an anxiety connected with a third figure, an onlooker. This theme was to recur in many forms.

Mr T came half an hour late to a session, shortly before the Christmas break. He did not lie down on the couch, but limped painfully round in circles. When I tried to interpret his lateness and restlessness in terms of the approaching break, he dismissed this and said 'You know, being here with you makes me feel worse. I feel worse now than I have ever felt.' I replied 'I am not surprised you feel bad if you walk round in circles, hurting yourself and making yourself dizzy.' He sat down, with a smile, and told me a dream.

In this dream there was a big drum. He was on top of it, and by moving, he could make the drum roll around, yet stay on top. However, at the same time he pictured himself as terrified, trapped inside the drum, about to lose his balance and fall over as it moved. He was also aware of people on a balcony, who were apparently indifferent to his struggle to keep balance. I interpreted that he wanted to be on top and be in control of me and the analysis, but in so doing he threw himself off balance. He felt that I was not really part of what was happening, but just on the balcony, able to see him but not to rescue him. To this he responded by getting up, hobbling round the room and finally saying he wasn't sure where he was. I said: 'I think you know that you need me, because you feel that a part of you is supported and sustained by me thinking about your struggles. I think you are terrified that you will lose yourself completely over the Christmas break.' Although he looked thoughtful, he did not respond to this interpretation and eventually left the session early.

Mr T portrays himself accurately as terrified of being locked into an infantile dyadic relationship with his mother-analyst. He sees himself as trying to control his mother, but in fact at the mercy of the slightest changes in her position, and frightened of being trapped inside her. He might fantasise that he is on top and in control, but this barely disguises his sense of helplessness: where the drum goes, he goes. To be liberated from this horrific predicament, he would have to gain a third perspective – a lifeline from the outsider (father) on the balcony. However, the people on the balcony are indifferent and ineffectual.

In the second and third year of his analysis, Mr T's deadening form of defensive organisation was gradually replaced by something almost its opposite. He had panic attacks on the couch, his body visibly shaking. Underlying the panic was deep rage about the unfairness of our situation: nothing anybody could say

or do could give him the body that a person might be proud of rather than disgusted by. We began to talk more meaningfully of his anger about his disfigurement and his envy of me as able-bodied.

Mr T's sense of his mother's disgust with his body began to emerge, and overtly entered the transference. There was a screen memory of the mother looking away from him with revulsion, as he was trying to show off how straight he could stand. This material emerged as Mr T began to discuss his girlfriend's distaste about his sexuality. There were also memories of his childhood exhibitionism, for example, at age 6 or 7, standing at the window exposing his penis to passers by. It seemed that, in the incident with his mother, his back was also a displacement from his erect penis. His experience was that his entire body including his sexual excitement was unacceptable to her.

I had the impression that Mr T did not possess a maternal 'good object' in his mind who saw him as a whole and could love him in spite of his imperfections, and who could mourn the loss of a perfect child. In part, he seems to have retreated from the rejection through identification with a paternal object whom he perceived as similarly damaged and rejected. At the same time, he withdrew from the world of other people, and became very isolated. He remembers, as a child, filling his time with carving, particularly making very sharp, elaborately decorated knives from wood, and with breaking old musical instruments, which he then burned.

Mr T's own damaged body and the infirmity of his father appeared to have left a legacy of hatred and intense guilt, which made it unbearable for him to be aware of any concern. This was illustrated when he assumed that a session cancelled by me was due to a hospital appointment. His familiar attacks took on a renewed viciousness and hatred; his panics increased in the sessions and outside. Repeated interpretations of his anxiety about feeling concern, which might overwhelm him, brought the memory of his father's heart attack into the material. One night his father, near collapse, had stumbled into Mr T's room and said he could not breathe. My patient had replied: 'So what, I don't care!' and had gone back to sleep. My immediate reaction was of horror at his callousness. My counter-transference together with his reaction to my supposed illness made me appreciate the depth and reality of his need to destroy his paternal object.

As these matters became the dominating themes in Mr T's material, his external situation improved. He has become increasingly productive and successful, and rekindled a relationship with an old girlfriend who admired and supported him, although he has remained frequently contemptuous of her. He uses the analysis more positively; he has turned into a prolific dreamer and talks coherently in most of his sessions. His testing of the analytic boundaries has lessened, but he sometimes comes late or leaves a few minutes early. He can see the analysis as helpful in containing his impulsivity, and his attacks on the relationship are outweighed by periods of genuine contact.

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A further session might help to illustrate this. Mr T was on time. He was evidently filled with excitement and he actually ran into me. He lay down and talked very rapidly. He said that he had to talk fast because he had three dreams to tell me about. In the first dream a boy was feeding ducks at the riverside he stayed at on holiday. He remembered the ducks stretching their necks to be the first to reach the food. He associated to this dream a holiday incident when he was feeding swans, and a memory of being a small boy and going to feed the ducks with Ruth, the housekeeper who looked after him. He remembered being afraid of offering food to them in case they bit his finger.

In the second dream he was on a trampoline kicking against the elastic surface, soaring into the sky. In the third and most disturbing of the dreams he had an image of a house which falls down because the roots of an adjacent tree undermine the foundations. He had an image of the roots growing into the bricks and mortar.

He was silent for a while. I said: 'You feel torn in two directions. There is some part of you that is so excited to see me that you almost want to jump into me. But for another part of you, wanting to be so close is terrifying because you feel that it would undermine the foundations of the analysis.' He gave something like a 'hmm' of agreement but he continued in a less manic way to talk about his holiday. He gave many details about where he had been, how they drove around and where they stayed. I noticed how he became increasingly anxious and critical as he touched on the subject of how eager and greedy people were to get into a concert in one of the places he stayed at, reaching across each other's shoulders to get at the cashier who was giving out the tickets. I said he was frightened to be seen to be wanting to reach out to people, and went on 'I think your way of dealing with this is to attack first, but I think you want me to know that there is a little boy inside you with a yearning hunger for the analysis, but it is very frightening in case the excitement and demandingness get out of hand and you feel overwhelmed by the wish to push others out of the way.' Mr T did not reply directly but his anxiety seemed again to subside.

Mr T said he supposed he was quite complicated to understand. He talked of his mother and how she at times implicitly understood him. When he got into a tantrum she would take him into her bed to soothe him. Then he said how he and Andrew, an older boy who seduced him when he was 10, used to play out fantasies, pretending to each other they were dreams. If something is a dream you don't have to feel guilty about it. Despite the double-edged nature of this communication Mr T sounded sincere. I felt he was both trying to twist the real contact he felt at the beginning of the session (when he felt like jumping right into me) and at the same time telling me about an aspect of himself. I said that I thought he was feeling that he was being quite complicated at the moment because he wanted to do two quite opposite things: he was trying to get us twisted together but was frightened in case the tangle would become a destructive one, that his wish for affection would be mistaken for a homosexual overture. But at the same time he wanted to tell me how the realness and power of his fantasies could frighten him.

Mr T surprised me by responding in quite a warm and natural tone that he thought that was true. He went on to say that as a child, on family walks, he used to run ahead of the family and hide. When the rest of the family passed him he would jump out and frighten them. He now realised that he had hoped that he would be looked for and found. When they showed no sign of this he would frighten them to cope with his disappointment. I said: 'I think you know it's near the end of the session and you are frightened that I will not look for you and find you tomorrow. I think you feel that you almost have to frighten me in some way, like jumping off the couch and leaving early, so you can be sure that I won't overlook you and will keep you in mind until tomorrow. By manipulating me and getting tangled within me you could be sure that I would not leave you and walk past you when I returned.' He considered what I said and added that it seemed to him that for him the analysis was 'for real'.

Discussion

Inevitably, there are many ways of understanding Mr T's material. His deformity, and his experience with a seductive yet rejecting mother may have created a deep uncertainty about his self-worth, and undermined his sense of identity. His ability to negotiate Oedipal experiences adequately is likely to have been jeopardised by his father's vulnerability and his own disfigurement, together with his mother's overt neglect of both men in the family. Damaging oneself may be a displacement from the other to the self, part of a desperate attempt at achieving control over murderous rage and guilt. For example, Mr T's primitive guilt about the damage he might have done to his objects may have led him to attack and degrade himself, the murderous act condensed into self-destruction and self-abasement. The need to hurt himself may also have been a response to a sense of emptiness and deadness. Mr T's alcohol and drug abuse, his desperate searching for sensation and excitement, may have counteracted the experience of internal, emotional vacuum.

Without questioning the importance of these and other perspectives on the case we have described, we would like to explore three particular lines of thought, for their contribution to understanding Mr T and others who readily resort to violence. We suggest first of all that a dysfunction of mentalisation is a central feature of such disorders. A second, related aspect of Mr T's complex disturbance may have been his tendency unconsciously to represent his own mental states in bodily terms, and consequently to feel that the minds of others were accessible via their bodies. The third theme that we address is the role of the father in the psychic development of violent individuals. In a final section, we

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point to some technical issues in the management of such individuals in a psychoanalytic setting.

The root of violence in the fragile psychological self

We suggest that Mr T's difficulties began with a failure to integrate his mother's perception of him into his self-image. Her perception was likely to have been of a freak whom she had created. This painful, shaming image could not be assimilated, probably by either of them, and the formation of Mr T's self structure was disrupted. The dialectical theory of self-development (first stated by Hegel)[2] assumes that the psychological self develops through perception of oneself, in another person's mind, as thinking and feeling (Davidson, 1983). We speculate that the narcissistic injury to the mother of having her only child born deformed was so catastrophic that she could not think about him, particularly about his true experience of himself. There was no physical abuse, but where in his mother's mind there should have been a child with thoughts and feelings, there was too often emptiness, a space, nothing on which he could build a viable sense of himself as thinking, believing or desiring.

Habitual violence towards either the self or another may reflect a failure to meet the fundamental need of every infant to find his mind, his intentional state, in the mind of the object (see Fairbairn, 1952). For the infant, internalisation of this image performs the function of 'containment' (Bion, 1962), which Winnicott has written of as 'giving back to the baby the baby's own self' (Winnicott, 1967, p. 33). Failure of this function leads to a desperate search for alternative ways of containing thoughts and the intense feelings they engender.

The search for alternative ways of mental containment may, we suggest, give rise to many pathological solutions, including taking the mind of the other, with its distorted, absent or malign picture of the child, as part of the child's own sense of identity. This picture then becomes the germ of a potentially persecutory object which is lodged in the self, but is alien and unassimilable. There will be a desperate wish for separation in the hope of establishing an autonomous identity or existence. However, tragically, this identity is centred around a mental state which cannot reflect the changing emotional and cognitive states of the individual, because it is based on an archaic representation of

2 'Self consciousness exists in and for itself when, and by the fact that, it so exists for another; that is, it exists only in being acknowledged. This has a two-fold significance: first, it (the self) has lost itself for it finds itself as an other being, secondly, in doing so, it has superseded the other for it does not see the other as an essential being, but in the other sees its own self. First it must proceed to supersede the *other* independent being in order thereby to become certain of *itself* as the essential being; secondly, in so doing it proceeds to supersede its own self, for this other is itself' (Hegel, 1807, p. 111).

the other, rather than the thinking and feeling self as seen by the other. Winnicott (1967) wrote:

> What does the baby see when he or she looks at the mother's face? … ordinarily, the mother is looking at the baby and *what she looks like is related to what she sees there* … [but what of] the baby whose mother reflects her own mood or, worse still, the rigidity of her own defences. … They look and they do not see themselves … what is seen is the mother's face.
> (p. 27)

Paradoxically, where the child's search for mirroring or containment has failed, the later striving for separation will only produce a movement towards fusion. The more the person attempts to become himself, the closer he moves towards becoming his object, because the latter is part of the self-structure. This is illustrated in Mr T's dream of the drum, in which his mental movements and the mother's were bound together; the most he could hope for was the illusion of mastery, quickly dashed by the sense of being trapped inside. This in our view accounts for the familiar oscillation of borderline patients, between the struggle for independence and the terrifying wish for extreme closeness and fantasised union. Developmentally, a crisis arises when the external demand for separateness becomes irresistible, in late adolescence and early adulthood. At this time, self-destructive and (in the extreme) suicidal behaviour is perceived as the only feasible solution to an insoluble dilemma: the freeing of the self from the other through the destruction of the other within the self.

Consistent with this, a number of writers have described a central fantasy common to states of mind preceding suicide attempts (Maltsberger and Buie, 1980; Campbell, 1995 and chapter 3 in this book). 'By projecting the hated, engulfing or abandoning primal mother on to the body and then killing it, the surviving self is free to fuse with the split-off idealised, desexualised, omnipotently gratifying mother' (Campbell, 1995, p. 13). Here, we see the desperate bid to break free of a mother felt to have invaded the child's mind, rather than having given the child a sense of his own mind, first perceived in hers. We suggest that the absence of the experience of having been recognised in this way left a deep longing, in Mr T, for a mother who could have made the child feel loved, as a separate person with separate experience which could be tolerated within her mind; instead, his overtures to the mother may have faced a shrinking rebuff.

The use of the body

Where a patient cannot easily conceive of an object at a psychological level, he may seek identifications or create representations of mental states via the body, and this can predispose to acts of physical violence directed at himself or others.

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Mr T's attacks on his own body were in part, we believe, attacks on the mother's mental state (whether of revulsion or of emptiness), a desperate attempt to clarify the distinction between his own sense of himself and his mother's sense of him. The patient's unconscious fantasy may be that ideas reside in the body – they can be held together by holding the penis, driven out by drumming on the head, fended off by attacking another person's head, or his books.

Mr T's disturbance is perhaps echoed by many individuals who harm themselves. A 23-year-old woman, suffering from intense panics, with a history of anorexia nervosa and serious self-mutilation, brought a dream in the first months of her psychotherapeutic treatment. In the dream, she was aware of a feeling of terrible tension which she could only relieve by opening up her veins and watching her blood flow. The blood ran in tributaries which joined up and made a river. The river became wider and wider and flowed into an ocean. Her associations quickly led to the waterways of her mother's country of origin, which her mother had often talked to her about in her early years. Making the link between her lines of thinking about her mother over past sessions and her experience of relief in 'bloodletting' led her immediately to share the fantasy that her mother somehow resided within her own body. As this image was elaborated over subsequent sessions, both patient and analyst became aware that she experienced her mother as living within her skin, that starving herself or self-cutting were both aimed at attacking this other being, and relieving her of the fantasy of a shared existence.

We suggest that patients such as Mr T experience the bodily self as a refuge (Steiner, 1993) in which they have some sense of safety and understanding. If objects cannot be properly represented as thinking and feeling, they may to some extent be controlled, distanced or brought into proximity through bodily experiences. As self-cohesion is limited by inhibition of the capacity to reflect on and integrate mental experiences, these patients call upon bodily experiences to provide a sense of consolidation.

The incomplete structuralisation of the self also enables patients such as Mr T partially to disavow ownership of their bodies. This is of primary importance in patients who control their thinking by harming themselves, since the pain and discomfort (as when Mr T walked round and round in my office) is probably only bearable because of a pathological separation of the psychological self-representation from the representation of the physical state. Maltsberger and Buie (1980) in their study of states of mind preceding suicide attempts, demonstrate that this separation is starkly evident in the thinking of many people intending suicide. As bodily states are to a certain extent represented outside the psychological self, the former are available as a stage upon which the nature and functioning of the mental world can be actualised and enacted (McDougall, 1986).

A pernicious problem faces those who try to use this defensive manoeuvre to by-pass the mind, but whose bodies are actually damaged. This was the case with

Mr T, who fell back on his body as the theatre of his mental experience, but was confronted with a denigrated, defective object. This is also the case for individuals with chronic physical illnesses (e.g. diabetes), whose use of the body to represent psychological states frequently leads to self-damaging acts with irreversible long-term consequences (Fonagy and Moran, 1993). Naturally, such individuals may always have been more vulnerable to inhibition of the psychological self because, as was the case for Mr T, their early relationships have often been profoundly distorted by their parents' feelings about their physical disabilities. It is interesting, in this context, that Mr T had in fact exaggerated his disability, so that his posture and gait had become more abnormal over the years, and more than could be explained by his physical condition. This may have represented partly an increasing identification with the handicapped father, and partly the accumulation of mental suffering expressed through his physical state.

The role of the father

Loewald wrote in 1951 of the castration threat as the danger of engulfment of the emerging ego by the mother–infant unity, and he pointed to the crucial way in which the father could help the child: 'Against this threat of maternal engulfment, the paternal position is not another threat or danger, but a support of a powerful force' (Loewald, 1951, p. 15). Greenacre (1960) and Mahler (Mahler and Gosliner, 1955; Mahler *et al.*, 1975) both note the importance of the father to the pre-Oedipal child as a figure 'less contaminated' by the ambivalence which affects the maternal image, or a 'breath of fresh air' in the separation-individuation process. Stoller (1979) sees the father as a shield to protect the child against the mother's wish to prolong symbiosis, and thus a facilitator of the separation-individuation process. Abelin (1971, 1975) postulated an 'early triangulation' in the second year, an essential precursor to the Oedipal triangle, which is seen as ensuring the transition from mirroring one-to-one interactions to symbolic representation of more than one object, including the self.

We suggest that Mr T's father might have performed two important roles in mitigating the effects of the deformity on both mother and child. Had he been able to share mother's burden and grief in the face of his son's handicap, she might have been freed to think of Mr T in ways other than as a cripple. Equally important, we suggest, is father's role in the development of the child's mental self: the child needs to experience the father as somebody looking at his relationship with the mother, and at his attempt to find a viable image of himself in her mind.

In favourable circumstances, the father enters the mental world of the child in the first year of life (Burlingham, 1973; Stern, 1994). A secondary caregiver, his role goes beyond that of developing his own dialectical relationship with the child, it has an extra dimension. The child sees in the father not only a perception

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of himself as a psychological entity, but also the father's perception of the child *in relation to* the mother. Thus, even should the mother–infant relation be seriously flawed, the child can enter into an intersubjective relationship with somebody who sees him as interacting; this extends the psychological self.

Abelin argues, along lines very similar to the current formulation, that in the loving interaction of one attachment object (the mother) with the other (the father), the toddler perceives and recognises for the first time his own frustrated wish for the object. Abelin (1971, 1975) basing his thinking on the work of Piaget, assumes that triangulation arises out of the conflict between two ways of interacting, between two 'sensorimotor schemata' representing patterns of interaction between the child and each caregiver. Seeing the possibility of two ways of interaction breaks up the symbiotic unity with the mother. Contrary to Abelin, we see the essential difference between the mother–infant and father–infant relationship not in terms of contrasting sensorimotor patterns, but of contrasting perceptions of the child's mind, and, even more importantly in the case of the father, an external perspective on the child's primary object relationship. It is this latter aspect which may be necessary in some cases to release the child from a pathological symbiotic unity. However, this crucial safety net may also be absent.

Mr T, with his elderly, sick father, rejected by the mother, was not offered a way out through his father's image of him and of his relationship with the mother. Instead, he was confronted by another mental absence, or at best the equally painful perception of his father's recognition that the mother–child relationship was riddled with disappointments. He was left to struggle with the diffuse and confusing primary dyadic relationship, unable to differentiate what was him and what was her.

There is much evidence of the adverse impact of the absent father (see for example, Neubauer, 1960; Herzog, 1980, 1982; Burgner, 1985; Stoller, 1985; Wallerstein and Blakeslee, 1989), and some of this points to a link with attacks on the self or others. Herzog (1980, 1982) in particular highlights how absence or loss of the father during the first years can undermine the infant's capacity to modulate aggression. Campbell (1995 and in this volume) has also highlighted the damaging effect of a father's absence when the mother–child relationship is unsatisfactory, through examination of fantasies in suicidal patients.

> The patients' suicide fantasies articulated in the present represented internalised early pathological relationships between mother and child and father. The pre-Oedipal father's role was often obscured by the patient's relationship with the mother which dominated the suicide fantasy and by the father's absence or ineffectiveness. However, it was during the pre-suicide state that the internalised father's failure to intervene in the pathological mother–child relationship became most critical.
>
> (Campbell, 1995 and in this book, p. 82)

In classical psychoanalytic theory, the paradigmatic violent act is the Oedipal murder of the father. Ron Britton (1989) has given a compelling account of the importance of the father in the child's developing thinking, and his description in many ways overlaps with ours. He describes the way in which the child needs to be able to accommodate the perspective of a third person, the father, opening up the Oedipal situation into a triangle, allowing space to think. He relates the profound difficulties of certain patients in analysis to the lack of this third dimension. Britton sees the wish to obliterate the third position as the child's attempt to avoid thinking of the reality of parental intercourse, that the thinking of the analyst is similarly thought of as representing this intercourse, and therefore as a threat which has to be annihilated. We follow Britton in seeing violence, and specifically destructiveness towards the analyst and analysis, as expressing a wish to obliterate unbearable thoughts, to destroy reality and to restore omnipotence. However, at least in some cases, such as that of Mr T, we feel that the notion of destroying the image of parental intercourse seems not to be the most important basis of the pathology. In this case, and we would suggest in others, it is necessary to consider another aspect of the role of the father, which gives the child an additional perspective on himself, and (crucially) enables him to think about himself in relation to another.

We suggest that this patient, in wanting to let his father die, wanted to destroy his father's awareness that Mr T, too, was ignored and discarded by mother. Mr T could relieve himself of the burden of this view if he did not allow the perspective of a third. So, the Oedipal situation in a sense is turned on its head: we may see a wish to murder father, to eliminate *not a rival but a witness*. To kill the crushing confirmation, by the father, of the failure and unreality of the child's omnipotent Oedipal fantasy. This formulation may be seen as an extension of Grunberger's (1979) exploration of the narcissistic repercussions of Oedipal experiences.

The child's capacity to withstand the stresses and strains of normal development requires that he has someone whose capacity to reflect upon his relationship experiences he can internalise and identify with. Sometimes, the mother herself will be able to communicate to the child not only a perception of his psychological self, but also of the child in relationships with herself and others. However, at other times the mother cannot supply this independent perspective, perhaps because of a persistence of primary maternal preoccupation (Winnicott, 1956), or, more pathologically, because of entanglement in her own past (Main, 1991), or because of current preoccupations (as in maternal depression, Green, 1983). The father's capacity to present the child with a reflection of his place in relationships then becomes essential to the child's developing capacity to perceive himself in relation to the object.

This leads us to a related problem: why do aggressive men more often direct their hostility towards others, while self-mutilation is more common in women?

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We believe that both forms of violence suggest an attempt to be rid of an intolerable phantasy of the thoughts in somebody's mind, originally the thoughts of a parent. The gender imbalance may then reflect a wish to attack the thinking of the same-sex parent (with whom identification is potentially more painful and inescapable). For both girls and boys, the mother's thoughts about the child have generally been intersubjectively experienced earlier, and are represented as within the child's mind. The father's thinking is represented in both sexes as external. The intolerable mental presence of the same-sex parent is then felt to be inside the woman's mind, but outside the man, in other people or objects which represent the father. In contrast, as we have said above, for the man (as for the woman) trapped in a sense of engulfment by mother, escape may be sought in suicide.

A predisposition to mindless violence is a probable outcome in cases, such as Mr T, where the child's identity remains diffuse, poorly separated from that of the mother, and the primary relationship cannot be reflected on. The sense of self is fragile and readily threatened, and the pathological amplification of the intentional stance, aggression, may become the only way in which the individual can see himself existing in relation to others. The girl is more likely to try to resolve this confusion, and rid herself of the mother in her mind, by attacks on herself; the boy more often directs his aggression at the father's thinking, represented by others. In the transference, both may be expressed in attacks on the analyst.

Technique with violent patients

We suggest that the interpretation of aggression towards the analyst as attacks on the analysis is futile in cases such as this, and frequently actually counterproductive. Patients such as Mr T try to exert total control over the analyst's mind and use it as a vehicle for their projections in order to deny the separateness of the fragile psychological self and the object which has become incorporated in it, and thus to deny the possibility of the object's loss. True progress may only be made when the bondage of the analyst's independent mental functioning is abandoned by the patient. This may be achieved by facilitation of the process of mourning of the illusory omnipotence which merger with the object provides.

Interpretations need to address the confusion from which violence emanates, and the illusory clarity that it brings. The obstacle is the patient's terror of a mind which offers understanding, which in the transference is the one which so disastrously failed him in the past. Steiner (1993) has described patients who wish to understand, and others who wish only to be understood. Furthermore:

> a few patients appear to hate the whole idea of being understood and try to disavow it and get rid of all meaningful contact. Even this kind of patient, however, needs the analyst to register what is happening and to have his situation and his predicament recognised.
>
> (Steiner, 1993, p. 132)

For a considerable time, Mr T was certainly a patient of this kind, and the analyst was only allowed to offer recognition rather than understanding.

How does this 'recognition' help an individual dedicated to the avoidance of reflection? Interpretations may remain helpful, but their function is certainly no longer limited to the lifting of repression and the addressing of distorted perceptions and beliefs. As Winnicott put it: 'Psychotherapy is not making clever and apt interpretations. ... It is a complex derivative of the face that reflects what is there to be seen' (Winnicott, 1967, p. 32). We believe that the *developmental help* offered by the active involvement of the analyst in the mental functioning of the patient, and the reciprocal process of the patient becoming actively involved in the analyst's mental state, has the potential to establish this reflection and gradually to allow the patient to do this within his own mind. The route to this involves brief, accurate and simple statements of the analyst's perception of the patient's current mental state vis-a-vis the analyst or the patient's own self. Superficially such interventions may seem less than full analytic interpretations because mostly they stop short of the interpretation of conflict or unconscious mental contents. Their goal is the reactivation of the patient's concern with mental states, in himself and in his object; a revitalisation of a dormant mental capacity or mental process (Fonagy and Moran, 1991). The importance of this developmental stance is critical at times when the patient has moved to a psychological position of expression through a physical stance (enactment), when full interpretations of unconscious anxieties and conflicts are unlikely to be heard. If the analyst finds himself insisting on providing such understanding, the most likely outcome is a deep therapeutic impasse where the patient comes to rely on the analyst to reflect on his mental states, but these are neither genuinely understood nor experienced as of concern or relevance to the patient's core self.

The critical step may be the establishment of the patient's sense of identity through the clarification of the patient's perception of the analyst's mental state (Steiner's 'analyst-centred interpretations'; Steiner, 1994). It seems that gradually this can offer a third perspective, opening up a space for thinking between and about the patient and the analyst. In this way it has been possible for Mr T to perceive and experience his humiliation, and mourn the absence which was his actual relationship with his father. We suggest that the experience of sustained mental involvement with another human being, without the threat of overwhelming mental pain and destructiveness, ultimately helped to free the inhibition of Mr T's mental functioning, liberating him from using his body to represent his mental states.

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Summary

We offer some thoughts about the roots of habitual violence in patients who are not part of the 'cycle of abuse'. We suggest that both self-harm and mindless assaults on others may reflect inadequate capacity to mentalise. Poor functioning of this capacity tends to lead to mental states being experienced as physical, in both the self and others, and the violence is seen as an attempt to obliterate intolerable psychic experience. This experience is felt to belong to somebody else, originally to mother or father. The problem can be traced back to a crucial stage of the development of the self when the child searches the face of his primary object for a representation of his own states of mind. Failure to find this forces him into pathological solutions to achieve containing organisation.

We explore the meaning of the gender difference in the direction of aggression, and the way in which the child has a second chance to foster a secure psychological self through his relation to the father, even when the mother has been unable to support this and to separate successfully. These issues and others of technique are explored in the treatment of a violent young man.

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