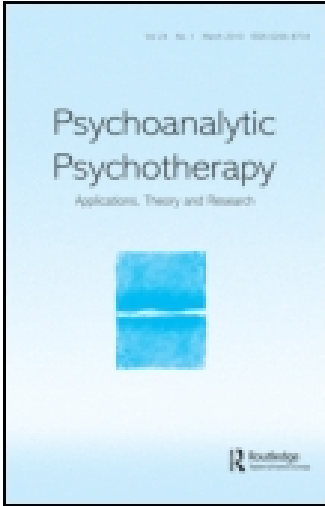


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Towards a Relational Affective Theory of personality disorder

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This paper introduces a Relational Affective Formulation of severe narcissistic and borderline disorders. The formulation is grounded in psychoanalytic and neuroscientific theory, clinical observation and therapeutic work with hospitalised patients. It provides a conceptual framework for psychodynamic psychiatrists, therapists and psychosocial practitioners working in teams. Paying particular attention to the central place of affect, projective and introjective processes, claustro-agoraphobic phenomena, regression and the place of both deficits and dynamic defences in the failure of symbolisation, the case is made that this framework is suited to therapeutic work with patients who are highly suicidal and complex. The application of this formulation to service design and treatment pathways is described along with a summary of the body of psychoanalytic thinking which contributed to its development. The formulation is the cornerstone of a practice guide currently under development.

Keywords: personality disorder; claustro-agoraphobia; neuroscience; psychoanalysis; regression

Introduction

The theoretical formulation outlined in this paper arose from personal observation in clinical psychodynamic work with people with severe narcissistic and borderline disorders, psychoanalytic theory and neuroscience reading over the past 25 years.¹ Although the formulation has broad applications, it was developed through working with people who, being persistently determined to kill themselves or having co-morbidities which fall outside local expertise, could not be contained in local psychiatric wards. People with such severe and complex difficulties, such as Miss A, may be detained under the Mental Health Act and placed in locked units.

Miss A was a young woman who hardly socialised, but worked relentlessly. After arguing with a colleague she took leave due to 'stress'. Once at home she remained in bed. She attempted to hang herself, without obvious reason, but refused help saying she wanted to be left alone. She described her family as emotionally remote and absolutely intolerant of disagreement. As a child, her

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speech developed late, and at times she stopped speaking and eating altogether. In young adulthood, she fell unconscious sometimes for hours at times of stress. Now all these symptoms re-emerged. Months of neurological investigation could not establish a cause. She would lose consciousness, become mute, stop eating and dramatically lose weight. She said she wanted nothing from others, but her actions ensured they must respond for her safety. Psychiatric admission under the Mental Health Act led to further escalation until finally she was sent to a locked unit where she remained for many months, whilst her symptoms persisted. She generated crises and removed any means of managing them, would not participate in therapy and seemed motivated by the need to remain one step ahead of the staff.

When I met her, she was withdrawn and hardly spoke, but then gave me an articulate but fabricated account of her childhood. At the second meeting, she offered a convincing history of a diagnosis which would prohibit therapy. When I pointed out she was ensuring she was neither discharged from services nor offered anything she could use to get better, she responded saying she was in 'my system' and must try and get out of it. I commented that she saw me as a spider from whose web she must extricate herself if I were not to consume her. She agreed, going on to say she always managed by maintaining minimal contact with others through incessant work. When work collapsed so did she. For her, therapy would result in complete collapse and permanent loss of her independence. She saw this dilemma as insoluble.

In the face of such difficulties what use is this formulation? First and foremost, its value is clinical. Insofar as it brings clarity to such complex difficulties, it can guide therapeutic practice in teams working with people who otherwise seem beyond help. However this paper is not a practice guide, this being reserved for a future publication. In this paper, I have reviewed a small part of the extensive psychoanalytic literature on this subject in the light of what I have learned from patients. I argue that much writing on this subject, albeit from incompatible theoretical perspectives, points to a common underlying psychological structure which is most apparent in those who suffer the most severe and complex difficulties. The formulation aims to describe this structure.

The Relational Affective Model

To put the clinical work in context, on the basis of a business case which proposed that local intensive psychotherapeutic work with severe and complex personality disorder (PD) was cheaper and more effective than locked placements, a new psychoanalytic psychotherapy service was commissioned. The design of the service and the therapeutic approach was based on the formulation outlined here. Essentially the model is based on the psychodynamic therapeutic community approach developed at the Cassel Hospital in London; in particular, the two-stage model, i.e. residential and community treatment model (Chiesa, Fonagy, Holmes, & Drahorad, 2004), adapted for work with people

detained under the Mental Health Act and those with co-morbid eating disorders, somatisation, substance misuse and autistic spectrum disorder.

The programme offers 3 years of therapy (Figure 1), the first 7 months attending a 4-day a week therapeutic day programme then outpatient work in 'The Combined Therapy Programme'. Both day and outpatient programmes offer a team approach which includes psychodynamic psychosocial practice, individual psychodynamic therapy, group analysis and family therapy. It is offered as an alternative to inpatient 'Tier 4' placements where possible or as a means of managing a prompt and therapeutically coherent discharge from inpatient units where admission is unavoidable.

A practice guide based on this formulation is being written for use in inpatient, day and outpatient services. This is in recognition of the difficulty working in a therapeutically consistent way when geographical distance and separate commissioning processes mitigate against doing so. The practice guide is written to facilitate outcome research. Finally, although founded firmly in psychoanalytic theory, the model takes neuroscience research into account. This particular integration of neuroscience and psychoanalysis has been set out as a falsifiable Relational Affective Hypothesis of narcissistic disorders (Mizen, 2014).

What does this development add to existing models? Research into manualised treatments for borderline personality disorder (BPD) underlines the importance of a structured, coherent treatment approach (NICE, 2009). Dialectical behaviour therapy (DBT) (Linehan, 1993), mentalisation-based therapy (MBT) (Bateman & Fonagy, 2004) and transference focused psychotherapy (TFP) (Clarkin, Yeomans, & Kernberg, 2006) all have a growing body of research in support of their efficacy in the treatment of BPD. The evidence for their effectiveness in work with those with the most severe and complex disorders currently treated in locked setting is less well established. DBT is most commonly offered in specialist locked units. Our local experience is that, whilst patients returning from placements say they find it useful, even

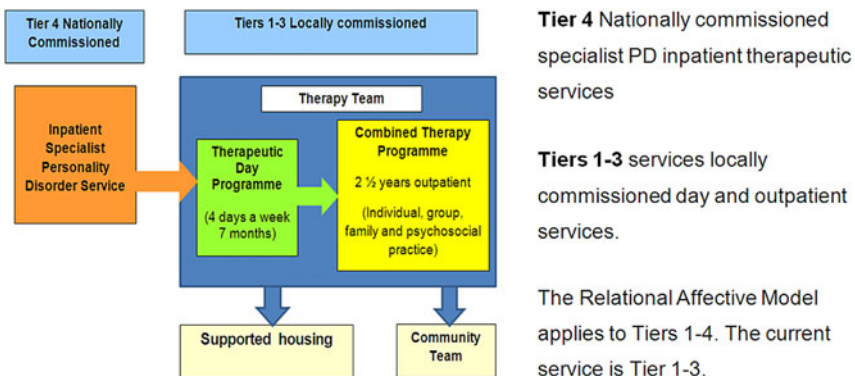


Figure 1. A Tier 1-4 personality disorder care pathway.

lengthy DBT placements of between 1 and 4 years do not prevent the re-emergence of symptoms and behaviour on discharge. On the basis of this local experience, it seems likely that DBT alone is not enough to equip people with such severe difficulties to live outside hospital.

MBT overlaps with the theory set out here. The differences lie in the focus in this model on psychoanalytic defences rather than mentalisation. I argue that focusing on those defences is essential with the most complex patients if progress is not to be sabotaged. TFP is a psychoanalytic model which emphasises the importance of aggression and lack of regulation termed 'effortful control'. TFP is designed for people with borderline difficulties in outpatient settings.

The Relational Affective Model is a team approach in the preliminary stages of development. It identifies the adaptations of technique required for work with the most serious suicide and self-harm risks (severity) and co-morbidities (complexity). This provides a theoretical framework which supports teams to meet patients' emotional and practical demands for containment. This paper sets out a psychoanalytic understanding of the defensive structure underlying these disorders.

Objects with boundaries: projection and introjection

Establishing the experience of a physical and psychic boundary separating internal from external spaces is a prerequisite if projective and introjective mechanisms are to perform their function in relieving the infant of anxiety. Stern (1985) observes the development of an 'emergent self' with awareness of self and non-self spaces in infants during the first 8 weeks of life. (Watson (1995)) proposes that infants possess a genetically endowed 'contingency detection module', which seeks out perfectly response contingent stimuli. In the first 3 months, this is directed towards preferring perfect contingency arising from self-actions, later switching to high but imperfect contingency of caregivers. This may be one mechanism through which infants develop a sense of agency and distinguish self from other. By 3–4 months, Stern observes infants to have an integrated sense of themselves as coherent bodies with control over their actions, experiencing affects as their own with a sense of others as distinct and separate. This must be distinguished from the apprehension of the mind of the other with its own desires and experiences (Fonagy, Gergely, Jurist, & Target, 2002), which emerges during the second year of life.

Such developmental observations are related to, but distinct from analytic observation with its emphasis on the internal world, phantasy life and defences. The relation between internal and external world developments is complex. As Britton (2003c) points out, mental life takes place in psychic space, which is experienced as having the qualities of, and is mistaken for, physical space. Rey (1994b) describes how a developing sense of internal and external space influences developing object relations, which in turn influence infants' experience of space in phantasy.

Bick (1968) describes preliminary infantile states of unintegration in which the baby is passively dependent on a sensual object, 'the nipple in the mouth, together with the holding and talking and familiar smelling mother'. This containing object, Bick argues, is experienced concretely as the skin being the first introject, setting the stage for later splitting and projective defences.

Failures in this development have important implications for the operation of projective identification (PI) as Bion (1962) describes. When the sense of psychic skin is established the emotional world of self and other are compartmentalised so that normal PI can be used to communicate psychosomatically undifferentiated affective states to the other where they are contained and transformed into feelings, which can be thought about. In that form, they are re-introjected by the infant. Where the introjection of the primary skin, container function fails, Bick describes catastrophic anxieties, which Meltzer (1992) considers characteristic of psychotic disorders. In borderline and narcissistic disorders, the sense of skin is present but experienced as leaky with consequent anxieties about failures of splitting defences. Alternatively, it disintegrates through the operation of PI.

Considering the origin of such failures, Bion's (1963) concept of the container and contained allows for the interplay between the holding containment provided by mother and the infant's ability to tolerate frustration. This relation between container and contained is the prerequisite for progression from somatic and concrete experience to symbolisation and the development of a capacity for thinking about feeling. Where frustration cannot be tolerated, the container is experienced only as a restriction or trap. A hallucinatory world persists in which all things remain possible, reality and its limitations are denied and one thing cannot come to represent another (Bion, 1970). In this way, accepting a limitation, as an early iteration of the depressive position, is essential to emotional development (Bion, 1967). The experience of the boundary between inside and outside, projection and introjection are therefore fundamentals of mental life and pathogenesis.

In summary, it is assumed here that infants are oriented towards making the distinction between self and other in the physical sense. They will do so unless there is a deficit either in this capacity itself, in the environment or defensive factors militate against doing so. In contrast, the emotional distinction between self and other arises from the experience of physical and emotional containment in the early months of life. Both interpersonal relational and internal psychodynamic factors contribute to this process. The development of this boundary allows the compartmentalisation of the emotional world into internal and external spaces. These spaces are then available to projective mechanisms for communication, relief from and regulation of anxiety, as well as introjection and identification as developmental processes.

The development of a capacity for symbolisation

Panksepp (1998) and Solms (2013) amongst many others find neuroscientific evidence of the embodied nature of affect as the basis of subjectivity. A question

remains as to how the raw material of visceral sensation and affect come to be transformed, first into emotional feeling (Craig, 2009) and then symbolised subserving symbolic play, language, abstract thinking and metaphor. There is no room here for a full account of a hypothesis as to how this transformation comes about (Mizen, 2014). In brief, I suggest the process requires involvement of both affective (vertical) and relational (horizontal) axes. I will outline some observations which underpin what I am, as a consequence calling the Relational Affective Model.

Observational studies indicate that infants start life with an egocentric perspective. This is not in fact a perspective at all being perceived as the way the world is (Fonagy & Target, 1996). The progression from an egocentric to an allocentric view, in which the child recognises their point of view is one amongst many, requires a process of de-centring in cognitive, relational and psycho-analytic domains.

Rey's understanding of how children construct their temporal and spatial world from experience calls upon Piaget's work, taking both internal analytic and external world perspectives into account (Rey, 1994b). Piaget, addressing himself to cognitive development, thought children developed spatial concepts through the action of subject on object (Battro, 1973). Through action upon objects, concepts of time, space and quantity develop as entities independent of the immediate perceptual experience of the child. For example, when a child develops a concept of quantity and so understands that, despite appearances a short wide glass contains the same amount of water as a tall thin one, Piaget describes this separation of concepts from immediate perception as de-centring. Hobson (2004) considers the relational context within which the capacity for abstract thinking emerges to be dependent on an inbuilt mechanism for interpersonal engagement, which he terms 'the child in relation to other'. This is missing in babies who go on to develop autism. Initially engagement between mother and baby is dyadic and face to face. Towards the end of the first year, the baby uses toys or objects to engage the attention of the other and becomes aware of another's sensitivity to that object, discovering that there are other points of view aside from his own. This is referred to as the stage of secondary intersubjectivity (Trevathan & Aitken, 2001). By the middle of the second year of life, three new developments occur: the capacity for symbolic play, a new awareness of self and others and the emergence of language. Hobson describes how this comes about through triangulation (Figure 2). The infant observes the object (world), the other and the other observing the object (world). The seed is sown for this development in the dyadic phase as the child is moved emotionally by mother and in turn moves her to feel differently about the object of their shared experience. In doing so s/he realises that the object has an existence independent of the point of view or state of mind from which it is observed. Attitudes and objects become separated. This too is a process of de-centring. It is a short step from this to the capacity for symbolic play where objects have their own properties but can become something else in the mind of the thinker. Words and

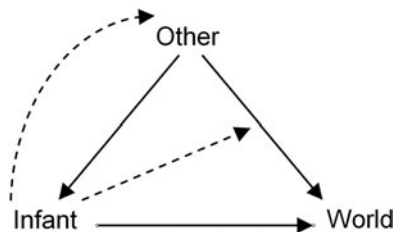


Figure 2. Hobson's triangle.

language then become possible as symbols with a shared meaning which can be used to represent experience for the purpose of communication. This is also the beginning of the capacity for abstract thinking in which that which is thought about is considered from different points of view.

Britton (1998) gives an account of related events in the internal object world. From the initially dyadic relationships with mother and father, if the earliest perception of the link between the parents can be tolerated, the child develops a third position from which the relationship between the parents is observed. From this, the capacity to move between subjective ('I') and objective ('third party'), points of view on internal or external objects develop. This provides a degree of mental freedom Britton describes as 'triangular space'. Without this, emotional space can only be achieved through increasing emotional or physical distance from the object.

To summarise then, in cognitive, relational and psychodynamic domains, by affectively engaging with and acting upon the object, triangulation and de-centring are achieved through which concepts and representation, (symbolisation) develop.

Regression and narcissism

Clinically, profound and sustained states of regression are amongst the most striking features of severe narcissistic disorders. These are of an altogether different order from those transient regressions in therapy and day-to-day life for neurotic patients (Sandler & Sandler, 1994). The pathogenic potential of regression was recognised early in the history of psychoanalysis and the question of whether regression is a therapeutic requirement or a destructive force to be resisted by the analyst has been a source of controversy. This is perhaps best summed up by Bion's comment: 'Winnicott says the patient must regress, Mrs Klein says the patient must not regress; I say the patient is regressed'. Miss B typifies the regression I am referring to in this paper.

In her mid-teens, she went to a hospital with a minor injury. She had a stiff shoulder and being unable to use her arm was admitted overnight. The following morning, she could move neither her arm nor the opposite leg. Medical investigations found no physical cause. She felt a sense of overwhelming panic

and secreted her tablets away planning an overdose. She became meticulous about the arrangement of possessions around her bedside and at times refused food and drink. She would not co-operate with rehabilitation but tried to control the nursing staff whilst remaining confined to bed. She did not recover, instead over time developing contractures and requiring long-term, full-time nursing care.

Balint (1968) first uses the term 'malignant regression' in analytic work with narcissistic patients. When regression occurs to the level of the 'basic fault', the meaning of words is lost. He considers this regression in the service of recognition, contrasting it with malignant regression. He defines malignant regression as:

A state of addictive dependence and orgiastic satisfaction occurring in patients with marked hysterical tendencies. (p. 145)

He considers malignant regression a state to be avoided by adapting technique.

For Britton (2003b) narcissism originates in excessive activity of the death instinct manifest as intolerance of otherness or a 'xenocidal impulse'. This intolerance may arise in the baby who cannot bear the extent to which mother's understanding is only approximate, or from mother's difficulty internalising the baby's emotional states accurately enough. Britton draws on Rosenfeld's (1987) idea of thin-skinned and thick-skinned narcissistic states in which the separate qualities of the object are denied. Thin-skinned narcissism is understood here to be a defence against adverse object relations, the purpose of which is to preserve love rather than being primarily destructive. In this state, there is no space for separate thought or independent action and an objective point of view is experienced as intolerable. This Britton also describes as adherent narcissistic disorder or the 'borderline syndrome'. The dominant form of PI is 'acquisitive' in which the mind, body and mental attributes of the other are acquired and experienced as a part of the subject, 'I am you'. In contrast, Britton describes thick-skinned narcissism as a basic hostility to object relations, essentially destructive and a manifestation of the death instinct. This he terms 'detached narcissistic disorder' or 'schizoid personality'. In these states, there is no access to the psychic life of the other. Difficulties with otherness are resolving by identification with the objective position, renouncing subjectivity. The dominant form of PI is 'attributive' through which something of the self is repudiated, disavowed and attributed to the other, characterised as 'you are me'. In this way, the patient appears absent, but requires a place from which to be absent, retaining contact with the disavowed part of the self.

Miss C's difficulties typify an unstable thick-skinned state. In an analytic group, as in other relationships, she attended only to other patients at the cost of talking about herself. Whilst doing this she was articulate, thoughtful and could function fairly effectively. When alone, however, she became immobile, sometimes literally unable to move and could only think of wanting to die. In the analytic group, she sat close to the door panicking if the exit was blocked in just

the way that she always had her suicide plan close at hand. Other patients felt that she might leave at any moment never to return. Over a few weeks, she approached a crisis. Falling silent at the end of a group, she remained immobile and unresponsive for 20 minutes after the others had left. This recurred thereafter at the point of separation.

In thin- and thick-skinned states the problems sharing space manifest as claustrophobia or agoraphobia. In both, moving between subjective and objective points of view is compromised.

Although Britton does not talk about these two states in terms of regression, clinical observation in severe narcissistic disorders indicates a marked regression in thin-skinned states in which the person is intolerant of separateness. These states alternate with and are managed through a type of pseudo-independence which is achieved by denying dependence, disavowing and attributing dependent parts of the personality to the other in thick-skinned states. The movement back and forth between thin- and thick-skinned, regressed and pseudo-independent states is the dominant feature of the transference and psychiatric presentation of this patient group.

Destructive narcissism

Fairbairn (1954) addresses the issue of regression in narcissism in his conceptualisation of the tri-partite ego. The central ego struggles to keep in touch with life whilst another withdrawn part splits, forming a libidinal and anti-libidinal ego. The anti-libidinal ego or internal saboteur stands in opposition to relations with the external world. Guntrip (1962) developing this theory describes the phenomenology of regression and defences against such states including eating disorders and manic states which, on their inevitable collapse, lead to states of devitalisation.

Where Fairbairn's anti-libidinal ego, in rejecting libidinal need is essentially a defensive structure, Rosenfeld (1971), considers destructive narcissism a consequence of de-fusion of the instincts, fusion of the life and death instincts being the object of analysis. In libidinal narcissism, overvaluation of the self arises through introjective identification with the good object. Destructive narcissism arises through idealisation of omnipotent destructive parts of the self, directed against positive libidinal involvement including need of, or desire for the object. In some instances, this takes the form of a pathological organisation or internal gang. Progress towards separation in this case can be followed by increased self-destructiveness or negative therapeutic reaction.

Steiner (1993a) expands upon this idea in his work on 'psychic retreats'. The retreat is a psychological position, cut off, isolated and out of reach, more often idealised than terrifying. It offers either occasional respite or permanent refuge from depressive and paranoid schizoid anxieties arising from contact with external reality. Steiner (1993b) adds that, in borderline and narcissistic patients, the psychic retreat conforms to the characteristic way in which mental space is

structured in this patient group, as outlined by Rey, Fairbairn and Guntrip. The retreat and the patient's relationship with it are equated at a primitive level with phantasies about mother's body and the dynamics of Rey's (1986) claustro-agoraphobic dilemma. From the outside it may seem a place of safety, however from within it feels like a trap.

Britton (2003a), in his work on the ego-destructive superego, similarly refers to 'that aspect of the patient which is in opposition to any form of creative contact with the world', which could only be modified by the introjection of a loving mother and father.

Whilst not underestimating the differences between their theoretical positions, Fairbairn's anti-libidinal ego, Rosenfeld's destructive narcissism and Britton's ego-destructive superego refer to psychological structures, which oppose relations to the external world, to vulnerability, infantile feeling and desire. The activity of this part escalates when the patient progresses towards libidinal and dependent relating. In the patients I am describing, these psychological structures commonly take the form of auditory hallucinations, which become active in three circumstances: when the patient moves towards resumption of a pseudo-independent state, when there is a danger of regression in the transference or when there is a move towards greater integration and separation. In this way, such hallucinations represent pathological organisations which police the maintenance of the defensive structure and may constitute an unrepresented form of the patient's aggression.

This was the case for Mr D, a young man whose family was indeed a criminal gang. Despite spending his teenage years in care, his family recruited him to acts of violence towards disloyal gang members. He participated under duress, seeking therapy ostensibly because he wanted to cut ties with the family. When we met he was mute, watching me warily whilst attending to a conversation with hallucinatory voices. He muttered, turned away and thumped the chair as though engaged in a violent exchange about whether to talk to me. I said, I thought he was afraid if he spoke to me the family, both internal and external, would punish him for his disloyalty. He might not escape with his life, either at his own hand or theirs and so must at all costs avoid talking to me. He remained wordless but drew a picture confirming that talking would end in death. Such severe negative therapeutic reactions can be an insurmountable obstacle to therapeutic work under any circumstance but particularly when undertaken outside a containing team setting.

Claustro-agoraphobic phenomenology

Rey in his account of the claustro-agoraphobic dilemma describes what he terms schizoid states:

They complain of inability to make contact with others . . . if they manage to enter a relationship it becomes intensely dependent. They rapidly and transiently form identifications with their objects, and experience a loss of their sense of identity

with the self. They seldom establish a firm sexual identity, vacillating in their experience of maleness and femaleness . . . their choice of love objects is just as vacillating. They are demanding, controlling and threatening . . . and are easily persecuted. This may be associated with grandiose ideas about themselves. In fact they are dominated by feelings of relative smallness and bigness. (Rey 1994b, p. 8)

In such states, the patient feels trapped in or outside his or her object and so finds ways of never truly identifying with or becoming attached to any category, whether internal or external as a means of negotiating the problems of proximity and distance.

Rey emphasises the role of identification with the father as a bridge between inner and outer spaces in the development of symbol and language formation and intercourse. In borderline states, as a result of absent or defective communication between inner and outer spaces, displacement of any object from self to non-self space, including the subject himself, is experienced in keeping with its significance with regard to PI. The experience of proximity and distance can be understood as the need to remain in proximity with projected aspects to maintain a sense of continuity of the self. 'Coming out' from inside to outside is accompanied by panic and bodily sensations in accordance with the prevailing phantasy. He considers the perception of small versus large, close versus distant and male versus female were all understandable in these terms.

For Rey the claustro-agoraphobic dilemma results from, rather than causes the absence of symbolisation, resulting in over-reliance upon projective mechanisms, difficulties in introjection and the absence of reparation in a concrete emotional world which impedes progress towards the depressive position.

It is perhaps self-evident that claustro-agoraphobic dynamics are expressed in relation to the mind and body of the patient and therapist, although the implications of this for therapeutic technique and the meaning of patient's communications are easily underestimated. The implication of this extending to the physical environment of the consulting room, department, service or ward are perhaps less obvious. The more severe the narcissistic disorder, the more marked the claustro-agoraphobic dynamics. Ultimately, patients become stranded in inpatient beds or locked units from which they cannot be discharged, providing a trap in the place of containment. In this circumstance, it is too easy to arrive at a psychological dead end with little prospect of emotional development.

Problems of internalisation, introjection and identification

The tendency in narcissistic disorders towards states of identity as opposed to identification with others and the dominance of projective over introjective mechanisms are well recognised in the analytic literature. A loving relationship with the breast, which is accepted as both good and other, is required if feeding and introjection is to take place. However, this is exactly the relationship the person with narcissistic disorder cannot have (Britton, 2003d). I will attempt a classification as understanding the level at which the difficulty in taking things

in arises is likely to have significant implications for therapeutic technique (Alvarez, 2010).

Bion (1967) and Rey (1994b) illustrate the problems with introjection arising from failures of symbolisation, where psychotic parts of the personality are dominant. Where the object world is concrete the act of internalisation is experienced as a loss of identity. In other instances as described above, problems with introjection and identification may lie primarily with the infant's narcissism or result from mother's own narcissistic difficulties. An infant unable to tolerate anything less than a perfect 'fit' between their need and mother's response may only develop a feeding relationship with an exceptionally accommodating mother. A narcissistic mother relating acquisitively may, during feeding, evoke in her infant the experience of incorporation within the same skin and loss of identity. Glasser (1986) sets out the consequences of this form of maternal narcissism in his concept of the 'core complex', describing a situation in which the only way the child can gain mother's love is to permanently and irreversibly lose their identity. Where mother's difficulty leads to her attributing her own unwanted mental states to the baby (thick-skinned states), the baby in the feeding relationship may be required to contain mother's anxieties. This Williams (1999) terms Omega function. Finally, problems with introjection may arise from failures of splitting as Meltzer (1992) describes anxiety about evacuated aggression and bad objects contaminating the good feeding experience.

Failures of introjection may arise in any of these circumstances, limiting the establishment of good internal objects. The infant then relies on projective processes to manage internal anxieties and affects.

Manic and 'depressive' states in narcissistic disorders

Klein (1935) set out the progression from paranoid to depressive to manic states and subsequent shifts between these states towards a resolution of the depressive position, the capacity to love being dependent upon working through the nodal position represented by the depressive stage of development. Where persecutory anxiety is too great, or the ego cannot endure both the persecution anxiety and the anxiety for the object as the depressive position is approached, retreat from concern for the object results or projection of the good object and so failure to identify with it. In short, the depressive position may never be reached or may be reached and retreated from. Klein considers mania a refuge from both depression and paranoia. Where mania is primarily a defence against paranoid anxieties, this takes the form of identification with the breast as all-providing, idealising power and denying dependence. Where mania is a defence against depression, the identification is phallic, reparative and primarily paternal (Rey, 1994a).

Klein considers depressive and manic positions part of normal development, each step of unification being followed by splitting and then reparation, where for Rey manic reactions are deviations from normal development in which the

destruction of the object is denied until after the manic phase when depression returns (Rey, 1994a).

Regarding the quality of this depression Rey states:

Borderlines suffer from a form of depersonalised depression, characterised by boredom and lack of interest, not marked by the pain of usual depression, and the search for stimulants. (Rey 1994b, p. 9)

In short, manic states in narcissistic disorders may either arise from persecutory anxieties, in which case they are characterised by an identification with the breast, omnipotent denial of dependence and idealisation of power. Alternatively, they are a retreat from the depressive position in which case the identification is more phallic and reparative in nature. Depressive states in these disorders are commonly indicative of devitalised regression rather than arrival at the depressive position.

The Relational Affective Formulation

The formulation brings together clinical observation and theory. It clarifies the connection between PI, the experience in phantasy of being inside or outside 'the object' and regression, underlining the importance of spatial experience in narcissistic disorders. It depicts two defensive states which are evoked when the object is recognised as both needed and other.

State 1: Inside the object

The patient, through PI, feels as though he or she is merged with or resides inside a good maternal object. In this state, anxiety about separateness is abolished.

State 2: Outside the object

The patient occupies a position outside the object on which they would otherwise feel dependant, feeling no need for anything outside their power or possession. Feelings of dependence are disavowed and located externally in others.

Splitting originates in anxiety about aggression; however, once this schizoid world is established, aggression and desire are equally problematic. Projected desire amplifies the consuming quality of the object world, threatening entombment inside the object from which the only escape is flight into self-sufficiency. The patient is in a state of identity, with mother (inside the object), or father (outside the object). These states of identity cannot be brought together.

The emotional world inside the object: the agoraphobic state

In this state, the patient feels 'only love' towards the other. Aggressive feelings are projected into the external world, which is felt to be full of bad objects and equated with separateness. The aggression remaining in the ego is directed at

eradicating everything, which reminds the patient of the reality of their separateness from the object. Through acquisitive PI, the inside of the mind and body of the other are experienced as belonging to the patient. As Britton (1998) put it 'I am you' in phantasy, mother and baby existing within the same skin (Figure 3). This state is associated with progressive or malignant transference regression which does not promote development, but progresses towards a state of total infantile dependence (Khan, 1972). All desire for life, responsibility and adult functioning, being connected with the possibility of separation, are projected. Suicidal phantasies and actions offer both escape from the claustrophobic world and unconscious union with object (Bell, 2001; Hale, 2010). The means of committing suicide is kept close at hand, just as patients in this state sit by the window or door of the consulting room.

Such patients are at risk of suicidal enactments and when admitted to psychiatric wards, nurses are unconsciously pressed to be constantly present providing concrete physical and emotional care. Regression may then progress further, the patient being fed by nursing staff, sometimes losing bladder and bowel control. In some instances, verbal communication is lost altogether and movements slowed, ultimately reaching a standstill. At the furthest extreme a kinetic mute states arise similar to catatonic states in schizophrenia. Regressed states can abruptly occur following physical illness or injury requiring bed rest following which a breakdown of a pre-existing pseudo-adult defence takes place.

After a psychotic episode and near completed suicide, Mr E came to the Cassel Hospital. In individual sessions, he was intellectually engaging and emotionally distant. I stuck with my counter transference, interpreting his anxieties about dependence. His behaviour conveyed his increasing but scarcely recognised attachment to me, alongside rising anxiety. He walked up and down

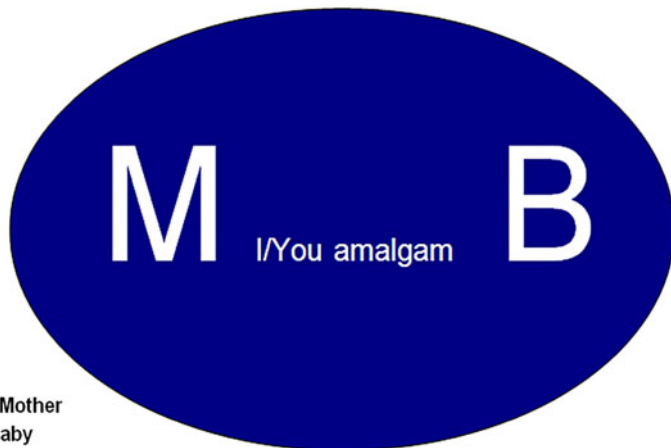


Figure 3. The person's phantasy of their relation to other in acquisitive projective identification.

stairs rehearsing a plan to jump off a tall building, mastering his fear so that when the time came he could see the plan through. Three months passed before Mr E recognised I had become important to him. He was extremely angry and anxious behaving as though I was now very dangerous. 'What are you doing to me?', he asked, 'My body is flabby when I used to be fit'. I said I thought he was anxious about losing his sense of himself as an adult man with me, feeling that physically, he was now a baby. He left the room, went to his bed and became mute. The nurses were unaccountably anxious he was going to jump out of a window. Thinking he would become dehydrated, an experienced senior nurse tried to spoon feed him. After an interlude in an acute psychiatric hospital he returned. Now he treated me with extreme caution. The more accurately I tried to describe his state of mind the further he withdrew being unreachable for a time. Finally, I said I thought he was like Odysseus and saw me as a siren luring him onto the rocks; all he could do to save himself was stop up his ears, strap himself to the mast. Through this, we found a way of resolving the impasse.

Once in the regression, the patient is trapped in an infantile state from which they are unable to escape. What had, when looked at from the outside, offered relief from the anxiety of separation turns out to be filled with claustrophobic terrors. In this state, the amalgamation of self and other may be experienced as a colonisation or obliteration of the self by either party. Despite the patient's apparent helplessness, internal or external acts of violence upon the adult part of the self and all mental life mediating the experience of other as separate are required to maintain this state of affairs. The affect associated with this state is a depersonalised empty depression.

The emotional world outside the object: the claustrophobic state

The patient in this state in phantasy exists outside the object. Contact, dependence and infantile feelings are attacked. In this emotional world, love brings with it the threat of destruction, so the destruction of love is a prerequisite for life. In this state, attributive PI is uppermost (Britton, 1998). Those dependent parts of the self which engender the anxiety of being trapped are repudiated, disavowed and attributed to the other to whom they are felt to belong, no longer belonging to the self. As Britton puts it, 'you are me'. To maintain this state the self requires a place from which to be absent, in this way the tie to the object is retained. [Figure 4](#) depicts the phantasy that all that is infantile is attributed to the other who is treated as though they are the baby who needs the pseudo-adult patient.

Being unable to make a separation through aggression towards the 'only loved' object, in the agoraphobic state (inside the object), the ego resorts to identification with an all providing or powerful object as a means of escape. This is not the true independence arising from the establishment of a good internal object and working through of the depressive position, but pseudo-independence founded on omnipotence, denial of need and an attack upon the infantile parts of the self. This position is manic, being a flight from depressive or paranoid anxieties.

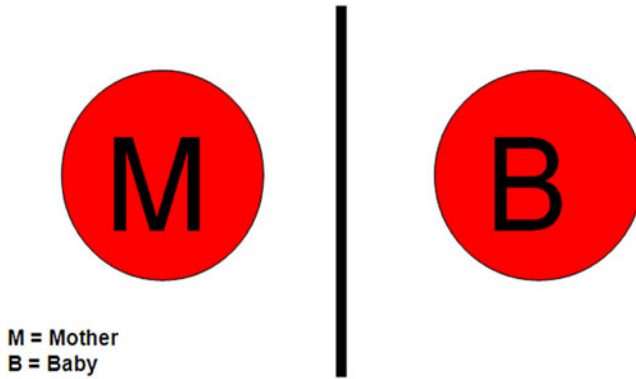


Figure 4. The person's phantasy of their relation to other in attributive projective identification.

The body and its functions, including the need for food, drink and sleep, represent dependence upon the external world and threaten this defence. So bodily functions and appetite are denied (scotomatised) or subjugated (controlled), strength being demonstrated through exertion. Patients in this state may compulsively care for sick or debilitated others at the cost of attending to themselves. So, they are difficult to engage in therapy and inclined to leave. The identification with the powerful object can reach a psychotic, grandiose state of elation.

At the point of flight, this state is claustrophobic although once established another set of terrors take over. Because containment is experienced as a trap threatening malignant regression and the danger of making contact with the disavowed infantile part, anything containing in the internal or external world is attacked leaving an emotional world in which there is no possibility of being held. The dominant anxiety at this point is therefore the 'fear of falling forever' (Winnicott, 1974).

Aggression is used to maintain defences and the split emotional world, being directed at all that represents the patient's loving, dependent relations with internal or external objects. The elevated affective tone engenders a state of excited energised activity. Appetite is either denied or must be satisfied immediately regardless of cost. The grandiosity of the subject (patient) contrasts with perceived infantile state of the object. The acceleration of thought and action required to evade attachment means this state of mind has all the hallmarks of a manic state in the psychiatric as well as the psychoanalytic sense. Mr F first broke down at 18 on the brink of leaving home. He jumped from a window breaking both legs. He then spent 12 years in psychiatric hospital attempting suicide if plans were made for discharge. He was offered three times weekly psychoanalytic therapy. After 18 months, he wanted to leave the hospital, which he tried to achieve through a fantasy that he needed nothing at all. He asserted that he did not

need food or sleep and was in an elated and triumphant state. On one of my weekly consultant visits to the ward to see him we had this conversation.

He had eaten 200 calories a day the previous week.

F – ‘My body does not need food; all I have to do is train it to manage without’.

SM – ‘I supposed that if I told you, as a doctor I knew that cells needed sugar to make energy to survive, this would not convince you at all’.

F – Smiling ‘Yes that’s right’.

SM – ‘How do you explain this?’

F – ‘Well If my body were to die, I would continue’.

SM – ‘In another body?’

F – ‘Maybe, I’m not sure’.

He was unconcerned, the nuts and bolts of how it worked seemed immaterial.

SM – ‘So you feel you are infinite, not held back by ordinary things like hunger or tiredness. These tie you to other people and remind you can’t live in isolation, you have limitations. Then I suppose you must hate your body for imposing limits on you, it feels like a restriction. Perhaps that’s why you attack it. Feeling hungry to you isn’t part of having a relationship or a life, but feels like a trap. Maybe you feel the same way about your body as you do about the nurses when you attack them for restricting your freedom’.

F – ‘Oh yes that’s it’.

A Relational Affective Formulation

In [Figure 5](#), these two states are depicted, summarising their characteristics and representing their spatial relationship with one another. The left-hand column lists aspects of mental life in the two states. The middle column represents the state of mind inside the object or ‘agoraphobic state’. The right-hand column describes the state outside the object or ‘claustrophobic state’. The line between the two represents the boundary between inside and outside.

Some implications

The agoraphobic state is a state of subjectivity without objectivity and the claustrophobic state one of objectivity without subjectivity (Britton, 1998). The difficulty bringing together subjective and objective and moving between subjective and objective points of view interferes with the development of triangular space and the capacity to symbolise, resulting in a collapse into concrete functioning and psychotic states.

Ego and superego function are related to as objects with significance like any other, being subject to attack or recruited for defensive purposes depending on the meaning of those functions in relation to the dominant anxieties of the moment. Where ego function is well established, the severity of underlying anxieties determines the extent to which ego function is preserved or appropriated for more primitive defensive functions. Where ego function is

	Agoraphobic State	Claustrophobic State
Libidinal vs. aggressive Re separation	Only Love (libidinal)	Hatred of love (aggressive)
	Only wanting to be with	Only wanting to be apart
Position re object	Inside the object	Outside the object
Relation to dependence Catastrophic Anxiety	Malignant regression	Pseudo-independence
	Trapped	Dropped 'Fear of falling forever'
Use of aggression	Attack on the possibility of separation	Attack on the possibility of connection
Affect	Schizoid state mimicking depression	Elevated mood.

Figure 5. The Relational Affective Formulation.

weak, a hierarchical promotion of primitive object relationships overtakes the ego to support the development of an ego, which performs an anti-libidinal function as a pathological substitute for more developmentally mature ego function. Likewise, the superego can be recruited to either cause, punishing dependence as weakness or using regression to inflict punishment.

Defences against the anxieties of the split emotional world

This emotional world is fraught with terrors, closeness and distance being equally problematic. In order to function a further layer of defences are brought to bear (Figure 6). For ease of reference, these are termed 'oscillation', 'sitting on the fence', 'one foot in each camp' and 'substance misuse'. They are shown at the boundary between 'inside' and 'outside' as they maintain the middle ground between the agoraphobic and claustrophobic state.

'Oscillation' refers to patients who are largely undefended against the split in their internal world. They fit the definition of BPD described in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5; APA, 2013). This may be an exaggeration of a developmental stage seen in adolescence and early adulthood, before stable defences and relationships have developed. Alternatively, this presentation may emerge later when the 'sitting on the fence' defence has broken down. At worst, stable functioning may never be achieved as shifts from one state to another allow little room for development.

'Sitting on the fence' refers to stable defences sometimes sustained for decades. A compromise is reached in which there is neither intimacy nor solitude. When circumstances change, the underlying claustro-agoraphobic difficulty comes to the fore. Apparent ego function may not really be ego function at all,

	Agoraphobic State	Claustrophobic State
Libidinal vs. aggressive Re separation	Only Love (libidinal)	Hatred of love (aggressive)
	Oscillation	
	Only wanting to be with	Only wanting to be apart
Position re object	Inside the object	Outside the object
	Sitting on the fence	
Relation to dependence Catastrophic Anxiety	Malignant regression	Pseudo-independence
	Trapped	of falling
	One foot in each camp	
Use of aggression	Attack on the possibility of separation	Attack on the possibility of connection
Affect	Schizoid state re depression	Elevated mood.
	Substance misuse	

Figure 6. Defences against claustro-agoraphobic anxieties.

but a defence or ‘stale mate’, placing profound limitations on intimacy and development. Such stability may be achieved through chronic states of attribution or acquisition in long-term relationships.

The term ‘One foot in each camp’ refers to the defences found in eating disorders. Patients who restrict their food intake consciously adopt a position of needing nothing, whilst their physical presentation demonstrates their requirement for total care. This represents a split in the self between the mind, which occupies a claustrophobic position and the body’s agoraphobic behaviour. In contrast for those with bulimia or binge eating the object is split. There is a requirement for the constant availability of food so that everything which represents separation or limitation is repudiated.

Some manage their claustro-agoraphobic difficulties through substance misuse. Stimulants and opiates have particular relevance to these two states of mind. Neurobiologically speaking, these substances directly affect the basic emotion command systems (Panksepp, 1998). I hope to say more about this in a future paper on the neuroscientific basis for this model. For now, in brief, opiate use saturates opiate receptors in the PANIC system obviating the need for proximity with others by alleviating separation distress. Stimulants are dopamine agonists and activate the SEEKING system. They are sometimes used by narcissistic patients as a means of escaping motivational, regressed states in order to function.

Conclusion

This formulation offers a synthesis of analytic theory much of which psychoanalytic psychotherapists are already familiar with. It is a framework for

thinking beyond diagnostic categories to understand the common factor in presentations, which otherwise seem un-related to one another. Where services specialise in symptom presentations such as 'PD', 'eating disorder', 'medically unexplained symptoms', 'substance misuse' or 'autistic spectrum disorder' they lack a means of linking the symptom presentation with personality structure as a whole. Those with the most severe narcissistic disorders may present with three or four of these co-morbidities at once. Where the design of services unknowingly replicates the claustro-agoraphobic nature of the patient's internal world, the iatrogenic consequences are likely to outweigh the effectiveness of any model of therapy provided within them. Where nationally commissioned locked services are disunited from impoverished, locally commissioned psychotherapy services patients are at risk of being either trapped or dropped. The model proposed here informs the design of an integrated PD therapeutic pathway from Tier 4 to Tier 3, taking into account the nature of the disorder and allowing a developmental progression. We have been running the service for 3 years and should soon be in a position to demonstrate the economic case for investment in such a pathway. We are also undertaking a preliminary study of its clinical effectiveness with such highly complex patients at which point we can hope to make assertions based on evidence and clinical experience. In the process, we are learning a great deal about the nature of the difficulties we are working with and continue to develop our therapeutic thinking.

Note

1. To protect confidentiality, patient information has been disguised and the vignettes in this article represent a 'typical patient' rather than any particular individual.

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