Using the Framework of Mentalization within Psychotherapy

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Caring for young minds

Anna Freud Centre

Acknowledgments

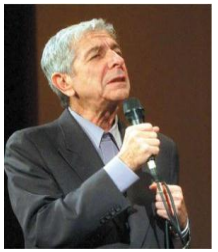
Especially to
Prof Peter Fonagy

And to some absent friends -







Outline

- Mentalization as a common factor across psychotherapies
- The models which can be relevant for increasing mentalizing include intensive analytic work
- How is such work understood through the lens of mentalization?
  - Risks and benefits
  - Stages, focus and stance

Why common factors?

- Evidence that a very wide variety of talking therapies are comparably helpful
  - From CBT to psychodynamic treatments
  - From infancy to old age
  - Therapist factors are very, arguably more, important
    - Some therapists far more effective than others
  - What are the good ones doing right?
    - And the less good ones doing less well?
- Can we improve all therapies via mechanisms?

  But maintain diversity?

Why also worry how therapy helps?

- 100s of therapies supported by outcome evidence BUT probably few mechanisms explain this
- Focus on strategies that trigger change processes
- Optimize generalizability from research to practice (mediators which must not be diluted)
- Also identify moderators
- Demonstrating outcome evidence builds the evidence base
  - But does not explain it
  - Mechanisms not deducible from labels

Kinds of focus

- More neurotic problems – representational change in what can be thought about
- Developmental deficits – examples:
  - Struggles with affect regulation
  - narcissistic personality disorders

Neurosis: partly failed integration?

- Intense conflict → partial failure of integration
- Aspects of the pretend mode of functioning (fantasy) experienced in psychic equivalence
  - May become encapsulated
- Intensity and conviction of feeling, psychic reality experienced as fixed, physical/external reality
- ? parent's difficulty in "playing with" this aspect of the child's thoughts

Personality disorders: pervasively failed integration?

- Developmental deficits + irresolvable conflict → structuralised failure of integration
- Aspects of the pretend mode of functioning (fantasy) insulated from reality checks
  - Fantasies of self and other dominate
- Inflexibility of views of world (psychic equivalence)
- Teleological mode leads to physical solutions
  - Cutting, violence, changing identity, coercive relating

Vicious cycles of poor mentalizing

- Affect regulation more difficult, and emotional dysregulation may exacerbate mentalizing failure
- Social and emotional life more stressful ➔ 'internal working models' from adverse childhood attachments reactivated
- Defensive withdrawal, paranoid interpretations, clinging to damaging relationships, depressive distortions

Or: virtuous mentalizing cycles

- Improving mentalization of self and other and relationships can increase
  - emotion regulation
  - effortful control over maladaptive schemata
  - flexibility of coping strategies
  - robustness of self-experience (take a 3rd person position, recall of contrary experiences and more benign attachment models, etc)

Mechanisms of disorder

Mental processes

- Mentalization main one of a *set of mental functions* which may be under-developed of distorted in development
  - representation of self / other; imagination, and play with ideas; logical inference, etc

Mental representations

- Content of *thoughts, intentions, feelings*: products of mental functions and objects of mentalization

Mechanisms of disorder vs treatment approach

Mentalization

- As a descriptive/diagnostic framework
  - therefore relevant to all forms of talking therapy, a common factor
- As a basis for treatment technique
  - Directly teaching more effective / realistic processing
- As a measure of outcome
  - Either one of the above should lead to rise in / enrichment of mentalization as treatment outcome

Mentalization general focus of talking therapies

Explicit focus of work, but under various names

- Dysfunctional cognitions and schemata, unearthing unconscious fantasies, elaborating experience
- Aim to identify and help patient challenge dysfunctional interpretations of experience
- Get better at noticing fixed perspectives distorting understanding and communication
- Better mentalizing supports change in mood and behaviour

? Mechanisms of change: representations

- Distinguishing, labelling disruptive affects
  - **Contingent, marked, congruent** responding to patient's affects and intentions
- Alternative perspectives on mental experience:
  - noting 'transference' distortion (re-experience / provocation of attachment expectations)
  - explicitly addressing misunderstandings, ruptures of alliance, loss of felt safety

Dimensions of mentalizing in therapy

- Implicit – automatic ➔ explicit – controlled
  - Challenging assumptions
- Elaborating internal representations of mental states
- Connecting feelings with thoughts
  - Better linking of affect and cognition
- Differentiating self and other

The Opportunities of Psychotherapy

- Activates Attachment system
- Challenges
  - Mentalizing capacity about painful attachment situations, and under attachment pressure within therapy
- 'Pretend' frame allows safe re-activation of unintegrated emotionally central self-experiences
  - Felt intensely, but insulated from external life

➔ Chance to re-think past, consider current thoughts without moral stricture, try out and check out perspectives

Needs to generalise, or worse than useless

How does analytic work actually work?

- The dangerous ‘realism’ of psychic equivalence
- The safe ‘freedom’ of pretend mode
- The analytic setting as a formalised relationship ‘lab’
  - strict rules
  - things can be found out, and tried out

Working within the sessions

- Observing ‘embodied cognition’ at different levels
- Using the attachment (transference) relationship
- Complications
  - Inhibiting mentalization
  - Overstimulating mentalization
  - Dependence, regression and love
  - The hot topic of sexuality

Early relating

- Early relating between parent and baby
  - and the anxieties and desires it stimulates,
  - becomes established as patterns of unconsciously enacted character through later life

- These patterns are resistant to change
  - they incorporate compromises in relation to unconscious, internal developmental conflicts
  - they represent, unconsciously, havens of safety from interpersonal threats

Attachment and the self

- Not speaking about broadly classified infant ‘attachment strategies’ predicting later development
- But focus on how micro-level of early relating, with associated feeling-states, expressed in later manner of treating oneself and navigating relationships

Object relations, ‘embodied cognition’, phantasies based in action

- “The way we experience thoughts, including attachment-related thoughts and the cognitive structures that underpin them, may be seen as linked to physical aspects of early infantile experience. Since the mind never, properly speaking, separates from the body, the very nature of thought will be influenced by characteristics of the primary object relation.” (Fonagy & Target, 2007, p 428)

Object relations and ‘embodied cognition’

Consistent with recent developments in cognitive science:

- Symbolic thought emerges out of multilayered, sensory, emotional and enacted experience with the primary object.
- Infant’s bodily experiences for eg Isaacs are determining of *defenses* as well as of *representations* of libidinal and aggressive drives.

Sense of action embedded in metaphors

- Attachment takes center stage once we recognize the physical origins of thought.
- Thinking the internalization of action sequences and analogies (Johnson-Laird 1983). All thinking based on nonconscious metaphors? (e.g. Lakoff & Johnson 1999)
- e.g. Lakoff: metaphorical descriptions of close relationships derive from underlying conceptual metaphor that “a relationship is a journey”—movement through life with another person

Analytic setting – consistency and restriction allows 'action' to emerge

- can study close-up, at length
- words chosen
- physical postures
- idiosyncratic stance towards being close to new potential attachment figure
- Preconsciously we get to know (Ivan Fónagy)
- habitual tones of voice
- choice of channels of engagement (constrained, tense, expansive, mystifying, bored, denigrating, seductive - etc)

Aspects of patients seen and felt in every session

- act on us (nudge) and to an extent control us
- so pervasive and part being with the patient, can be increasingly unnoticed
- will be unconsciously registered and reacted to
- negotiation of this shapes
- analytic relationship and how much is achieved
- hence appropriate attention to countertransference as much as transference

Attachment theory adds necessary range

- other key formative, bodily experiences in early relationship
- *being held* in intimacy and security
- *being left alone*
- *pushed away*
- *grabbed and trapped,* or *used* within other's excitement.
- 'embodied cognition' lets us understand whole range of core feelings and phantasies - libidinal and aggressive impulses *but also* attachment feelings and self experience

Representation shaped by unremembered interaction

- symbolic thought emerges from multilayered, sensory, emotional and enacted experiences with the primary objects of infancy
- these bodily experiences and actions – *passive as well as active*, and anticipated further experiences of overwhelming pleasure and pain, shape
- defences
- modes of representation

Clinical examples

- Narcissistic patients (Dr C, Mr A, Dr P)
  - deadening intellectualising abstraction,
  - extremely detached manner, or
  - continual attempts at seductiveness, mystification and falseness.
- Affect regulation problems (Ms B, Mrs J)
  - Behavior and language communicating by impact
  - Very limited mentalization

Stable or unstable, split modes of psychic reality

- ‘teleological’, ‘psychic equivalent’ or ‘pretend’ mode predominates (Fonagy & Target, 1996; Target & Fonagy, 1996)
- other modes always around but hidden
- most important thing is split itself
- ‘thick-skinned’ vs ‘thin-skinned’ (Britton, 1998; Rosenfeld, 1987; Bateman 1998)
- Re-enactment in analysis including control of other

Affect regulation

- Deficit in particular ego capacity, despite others which were well-developed.
- Emerges most strongly in attachment relationship incl therapy (previous attempts).
- Certain subjects very inflammatory – sexuality, competition, criticism – angry, aggressive and intrusive behaviour ('borderline' presentation). Very paranoid attitudes, could get delusional, though Belinda retained playfulness / pretend mode

Modes of psychic reality

- Teleological – have to make something happen to change experience (flowers; families)

- Psychic equivalence – if I think something you know it's true. If you disagree, you are trying to drive me mad (I was abused; drivers are murderers)

- Pretend – everything is possible, nothing means anything real, serious, or able to help (I am a student here; theatre; sexual orientation)

Therapy and affect regulation

In contrast to the idea that deep anxiety must be mobilised for interpretations to lead to new learning, interpretation of primitive anxieties in patients whose affect regulation is impaired requires a context in which affects are being actively contained by the therapeutic relationship.

Parallel to contingent, marked and congruent mirroring in parenting a preverbal child, gradually allowing the child to represent and communicate his experiences - including emotional states - increasingly symbolically.

Containment first

When events now consigned to the inaccessible, past unconscious have not allowed sufficient structuring, censoring and regulation of expressions of the present unconscious, content may be more psychotic or affects overwhelming. First task of setting is to facilitate representation of what is conscious but uncontained and unsymbolised, allowing therapeutic relationship to be tolerated and sustained, not aiming at the representation of what is dynamically unconscious;

Clarification before new meaning

It can be helpful, as with the patients referred to, to interpret unconscious conflicts, the meaning of intrusive memories and the functions of behaviour within the transference, *after a prolonged period of affect containment and clarification of intentions of self and other*, and at all times with interest in and respect for the patient's interpretations, the logic of their psychic reality.

Adults like children can need ‘developmental help’ more than interpretation of conflict

Finding that children and adolescents with ‘ego functioning’ deficits needed intensive therapy but with ego developmental technique, and reliable safely mirroring therapist who contains affect and helps to differentiate and label experiences – including of being in intimate relationship

Developmental Approach

- Therapist tunes in to level of relationship to mental world that patient has reached
  - Generally; and/or in area of symptoms e.g. panic-focussed
- Therapist's awareness enables patient to think of his feelings and thoughts as representations, rather than replicas of external reality
- May free patient from alternatives of
  - Controlling vs being controlled
  - Retreat into defensive fantasy vs risk of trauma
  - Being overwhelmed by feeling/thoughts vs physical action (self-harm, avoidance, self-medication etc)

Therapies and life

- Therapies are **professional versions of natural social processes** that enhance mentalization
  - Attention
  - Understanding
  - Negotiation
  - Friendship
  - Love
- In various safe ‘packages’ - as relevant to patients

The original, unsafe versions also work!