Mentalization, Affect Regulation, and Development of the Self
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MENTALIZATION, AFFECT REGULATION, AND DEVELOPMENT OF THE SELF

The panel chair, Glen Gabbard, opened the two-day panel with some reflections on the place of mentalization theory in psychoanalytic discourse. Although in recent years we have had few new paradigms, mentalization theory appears to be a genuinely new model of psychoanalytic developmental and clinical theory. This model extends the clinical observations of object relations theory and calls to mind Fairbairn’s assertion that the libidinal motivation of the infant is primarily “object seeking.” Mentalization theory provides models both of early childhood psychological development and of psychotherapeutic practice. The fundamental therapeutic application of mentalization to psychodynamic technique lies in the observation that adult patients may experience corrective developmental experiences “when the patient finds himself in the eyes of the therapist.”

DAY I: PSYCHOPATHOLOGY

Peter Fonagy gave a detailed presentation based on work he and his colleagues Target, Gergely, and Juris have done. In this work, mentalization is defined as the “implicit or explicit perception or interpretation of the actions of others and oneself as intentional.” This process occurs unconsciously and naturally, and is distinguished from conscious self-reflection. Mentalization theory is similar to the concept of “theory of mind” in the cognitive developmental literature, but is more comprehensive in that it includes attachment and the development of the self. In this model, psychotherapy derives its therapeutic value from...
the re-creation of an interactional matrix analogous to that of early childhood development. Psychoanalytic interventions such as clarification, confrontation, and interpretation serve to bring the patient’s mental experiences to conscious awareness, facilitating a more complete, integrated sense of mental agency. In Fonagy’s words, “the crux of the value of psychotherapy is the experience of another human being having your mind in mind.” This understanding of mentalization connects such analytic concepts as “observing ego” and “empathy” with biological and developmental research. The psychopathology of certain conditions, such as borderline personality disorder, traumatic developmental disruption, and developmental disorders, can interfere with the achievement of an adequate capacity for mentalization. In these situations, psychoanalytic psychotherapy may be able to repair previous developmental deficits through re-creating the mentalizing effects of the interactional matrix of early childhood.

To illustrate these points, Fonagy presented vignettes from a psychotherapy with a borderline patient. This was a woman with a long history of traumatic and abusive experiences, violent behavior, and self-injury, who presented for therapy in a confused, disorganized state. Fonagy presented material reporting her statements and his interventions. In his interventions, he focused not on making interpretations per se, but rather on clarifying unstated wishes, thoughts, and affects in the context of the here-and-now interaction between the patient and him. For example, when she appeared even more than usually confused and looked at him without speaking, he told her, “You don’t know what to say to me, and I don’t know what to say to you.” She followed her disturbed, disorganized narrative with a clear statement that she was afraid of losing her therapy. Fonagy replied, “I think you feel you know that I will reject you, no matter how hard you try here. But, you want me to understand your distress, but perhaps also that you are not allowed to tell me about it. So you feel very confused.” He then said, refocusing on the immediate source of her anxiety, “You hope for something good to happen here, but also you are frightened and sometimes you feel you have to spoil it. And you want to be sure that I understand that.” This approach reflects his belief that the patient needs assistance not only with understanding the content of her associations, but with the basic task of recognizing the existence of the thoughts and feelings she is experiencing.

He presented what he described as the three core assumptions of self-development in mentalization theory: (1) that the sense of oneself
as an agent is rooted in the experience of the attribution of mental states by a significant other; (2) that this capacity emerges through interaction with the caregiver, who is usually but not necessarily the mother, through a process of “contingent mirroring”; and (3) that this capacity can be disrupted by traumatic experience. Attachment in this theory serves a cognitive role in that it supports the development of attentional mechanisms, reflective function, and such capacities as the ability to form internal representations of affect states.

Effective mirroring, in this theory, is characterized by “contingency” and “markedness.” The caregiver must accurately perceive the infant’s mental state, and must also reflect this state to the infant in a manner that conveys the message that this state belongs to the infant and not the caregiver. When incongruent mirroring predominates, the link is broken between the infant’s internal state and external reality, and cognitive development may be relatively dominated by a “pretend mode” in which there is little perceived connection between internal and external reality. When unmarked mirroring predominates, the caregiver’s expression appears magically to mirror the infant’s internal experience. This underlies the predominance of “psychic equivalence” mode, in which internal reality is assumed to be identical with external reality. In both cases, these normal phases of the development of psychic reality can persist. Incongruently contingent or unmarked mirroring creates a vulnerability for later distortions of subjectivity.

In borderline personality disorder, interactions with the caregiver do not provide sufficient contingent mirroring, or contingent mirroring is disrupted through trauma, leading to a weakened sense of self. Such disruptions may occur because of deficiencies in the caregiver or vulnerabilities in the infant such that the caregiver cannot compensate adequately. Either the pretend mode or the psychic equivalence mode predominates, and internal experience is either denied or felt to be terrifyingly real. The infant develops a disorganized attachment style and an insecure sense of self. Affect representation and attention regulation systems function poorly. In the absence of a secure, authentic basis for selfhood, the infant uses available stimuli as the basis of a false, insecure sense of self that Fonagy calls “the alien self.” This alien self is experienced as incoherent and internally disruptive; through manipulative and controlling behavior, the borderline person externalizes this alien self, displacing it onto the available attachment figure. This externalization, which leads to many of the distressing
countertransference experiences that may be experienced in therapy with the borderline patient, serves the important function of restoring coherence to the patient’s internal world, and temporarily frees the patient from internal states that may be experienced as unsurvivable.

Summarizing the predicted consequences of traumatic interference with mentalization, Fonagy noted that “pretend mode” and “psychic equivalence mode” are universal developmental stages, and are indicative of pathology only when they become dominant and rigidly established. He described psychic equivalence, deriving from insufficiently marked mirroring, as akin to magical thinking: “If I think there is a tiger under the bed, there is.” In this mode, the experience of the mind can be terrifying, as there is no distinction between mental experience and reality. The patient excessively established in pretend mode may feel chronic internal emptiness and meaninglessness. The therapist of such a patient may experience a sense of superficiality, as the patient cheerfully endorses mutually contradictory beliefs. Finally, Fonagy noted Gyorgy Gergely’s description of the “teleological stance,” in which the action of the mind that underlies experience has not been recognized. In this mode, physical results are valued over internal states and only changes within physical reality are experienced as compelling. For instance, the patient in therapy might believe that the therapist does not care unless ceaseless, heroic efforts at loving and caring are evident. The patient in this situation cannot perceive the intention and understanding of the therapist, but rather seeks a concrete demonstration of feelings to such an extent that underlying feelings are ignored and negated. This situation, familiar to therapists of borderline patients, can lead to the temptation to provide limitless attention, and can lead to boundary crossings or violations.

At this point, the panelists accepted questions from the audience. Jonathan House asked the panelists to clarify the distinction between implicit and explicit perception. Implicit awareness occurs automatically, Fonagy said, without conscious intention, while explicit perception involves the conscious, self-reflective awareness of knowing what one knows. Gergely noted that mentalization theory is related to the concept of implicit knowledge in cognitive developmental psychology. The infant’s ability to use implicit inferences about the mental states of another person has recently been demonstrated as early as thirteen to fifteen months.
Glen Gabbard next directed questions to the panelists from the chair. He began by asking about the potential for overextension of this model. He commented that Kohut’s self psychology had originally been developed for the treatment of narcissistic personalities, but that by the end of his career it had been extended to all forms of psychopathology. Gabbard asked, “How applicable is this model to your garden-variety neurotic patient?” He wondered whether this model might be more applicable to patients with severe borderline personality disorder who would be sitting up in psychotherapy.

Fonagy acknowledged, “It’s hard to keep oneself from wanting to take over the world, but one can try.” In fact, this model originally was developed to study children with uncontrollable, brittle diabetes. He and George Moran, working on with these children psychoanalytically, found that while traditional psychoanalytic interventions worked poorly, the children benefited substantially when they had assistance putting their thoughts and feelings into words. Such interventions had dramatic effects on their blood sugar regulation.

While deficits in mentalization will be most prominent in patients with severe character disorders, some degree of difficulty with mentalization is a universal human problem. In working with a neurotic patient who has temporarily lost the capacity for mentalization, it can be helpful to bring the patient back to a psychological frame of reference. When the patient has regained the capacity to mentalize, to reflect on thoughts and feelings in a fluid, meaningful manner, one then can engage the patient in an analysis of the defensive reaction that was involved in the loss of mentalization. With borderline patients, it is less helpful, particularly early in therapy, to analyze their defensive activity, and more helpful to engage them in interactions that can improve their mentalizing capacity.

Mary Target admitted extending her use of this model. In her own practice, she usually sees neurotic-level patients. She feels that distortion or suppression of mentalizing capacity can be seen in all levels of character pathology. In working with the neurotic patient, she would ask why mentalization failed at a particular moment, or repeatedly fails in a particular type of context. For instance, in a given patient there might be affect states or object representations that would repeatedly lead to characteristic blocks in mentalizing function.

Gergely observed that attachment is a phylogenetically ancient system whose evolutionary function is to provide protection from
predation by maintaining proximity to the mother. It is developmentally important to animals as well as to humans, though in the latter attachment evolved to serve an additional function. As attachment-mediated behaviors lead to communicative cues and displays reflecting the infant’s internal mental state, the mother’s response to these cues facilitates the unfolding capacity of the infant to mentalize about the contents of the mind of another, as well as of its own. It is important, Gergely said, to think of this as a complex, multilayered developmental theory. It is not just a question of whether a given person does or does not mentalize. As a function of the quality of early attachment interactions, numerous degrees and subtleties of function can be established that characterize a person’s use of mentalization.

Gabbard asked about the central importance of traumatic disruptions in this theory. Should one not take other data into account? For instance, the research of Uta and Chris Frith in the autism literature makes it clear that there are disruptions of mentalizing function that do not specifically result from trauma. Further, 20 to 40 percent of borderline patients appear not to have experienced identifiable trauma or neglect.

Fonagy responded that it is probable that mentalization research is studying a “final common pathway” that includes both environmental and constitutional factors. When an infant has a more susceptible constitution, he will need a mother who is more “powerful” in her use of mirroring skills to allow the satisfactory development of mentalization function. Nevertheless, traumatic events do have clear effects, even in patients with intact characterological function. Gergely added that current autism research shows a strong genetic component, and that in patients with severe autism adequate mirroring simply is not possible because there is such severe impairment of the mind’s underlying capacity for mentalization. There is evidence in cognitive neuroscience that cues indicating a communicative, intentional other are innately preferred by infants. Also, infants innately prefer to listen to “motherese,” the characteristic pattern of infant-directed speech that mothers produce instinctively across all cultures. Such cues help the infant identify a child-attuned partner who can engage in mentalizing interactions with the infant. Autistic children lack the ability to attend to these cues.

Robert Michels began the formal discussion by observing that the work of Fonagy, Gergely, and Target is exceptionally stimulating and wide-ranging. Nevertheless, he felt that Fonagy’s presentation
really covered several loosely related subjects and did not put forward a coherent theory. In the presentation Michels discerned (1) a model of psychotherapy, (2) a clinical case vignette, (3) a model of psychological development, and (4) a model of pathogenesis of specific character disturbances. Finally, while mentalization theory is the basis of Fonagy’s therapy, the therapy does not necessarily follow from the model.

Michels commented on Fonagy’s statement that the most important element of therapy is the experience of “another human being having your mind in mind.” Does this not, he asked, eliminate the importance of content? Although Michels said he admires Fonagy as a clinician, he suspects he does not follow his own theory. In his description of his theory, for instance, there seems to be no role for transference interpretation. However, in the clinical vignette Fonagy tells his patient, “I think you are afraid that I will reject you.” This is an apt, skillful intervention, but does not follow from the theory. Michels expressed his concern that in the hands of a less skillful clinician this theory could be applied badly. In the theory there is no mention of drives, conflict, or fantasy. He added that he has never met a patient without drives and fantasies, and that he feels it is an important role of therapy to make this content more meaningful to the patient.

Turning to the use of infant developmental observations in this clinical model, Michels expressed skepticism. Adult patients, he noted, are adult. They may act like infants, but are not infants. If they inhibit adult capacities, they must have had those capacities to begin with. If the goal of mentalization theory is to teach patients to mentalize as a mother might teach a child, is this not teaching them something they already know but choose not to use? Is this a good use of time and effort in therapy?

Finally, Michels argued, he views this theory as “antirelational.” It does not include any recognition that the patient’s self-understanding is developed through an exploration of the therapeutic relationship. This therapy appears to be more educational and, to Michels, even authoritarian. In summary, he felt this model is powerful but not comprehensive. Mentalization is but one developmental theme and should not be used as the sole model for a new therapy.

The panelists responded. Fonagy began by noting that in psychoanalysis there generally has not been much evidence underpinning psychotherapy. Michels interjected, “Yes, but you’re more dangerous. You’re a researcher and you present empirical data. That may
be misleading.” Fonagy responded that he views the attempt, even when unsuccessful, to link data and theory in understanding developmental and clinical change as enormously valuable. After all, patients share the same type of brain as the brain in clinical and developmental experiments. Finally, Fonagy believes that it is important for clinicians to be able to isolate the pathology such that treatment can engage directly with the target pathology.

With respect to Michels’s comments about the role of content in therapy, Fonagy stated that it is crucial to talk about motives, conflicts, beliefs, and fantasies. Mentalization can be engaged only when one is discussing such content. Yet he does not feel that the ultimate aim of therapy is to provide insight into unconscious motives or conflicts; rather, the aim is that patients become able to think more clearly about the mental processes that underlie their actions. He added, “We don’t want to teach people about mentalization. We want to engage them in a relationship in which mental states are the currency of exchange.”

Michels responded that when Fonagy states that he is seeking to develop a problem-specific intervention, “I’m terrified of such therapists.” A therapist should be confused, trying to “sort it out” together with the patient. If a therapist is sure about his intervention, he may not be mentalizing. He added that Fonagy’s clinical interventions do not operate at this rigid, didactic level, but “I’m afraid that someone will listen to you, think that’s what you do, and then try to do it.”

Gergely added that while it is conceivably true that in theory one could talk about anything when one is “having the patient’s mind in mind,” that would be a caricature. Effective mentalization involves psychologically relevant content. In dealing with patients with attachment difficulties, there will have been specific nonconscious representations of parent-child interactions. Experiences of attachment, and self- and object representations, provide different kinds of “content problems” that must be dealt with. Finally, the problem of the “alien self” will correlate with the internalization of a perceived other who is hostile or indifferent. The patient’s inner states will remain inaccessible and inexpressible. “This is a specific kind of defense and otherrelation that has to be dealt with. The feeling of emptiness must be transformed. This is the content.”
DAY 2: THE APPLICATION OF THEORY TO TECHNIQUE

After a review by Gabbard of the previous day’s session, Target presented the case of Dr. C., a “thick-skinned” narcissist who sought her help for chronic depression and anxiety. This highly intelligent, successful man related to people around him with contempt. He liked to think of himself as a computer and behaved as if those around him literally were objects. Target saw this patient for analysis five times weekly, using the couch. For much of the early part of his analysis she struggled with the apparent emptiness of his emotional life. He described thoughts and feelings as if from a great distance and did not report associations. In this early work she attempted to talk with him as if he did have an emotional life, and sought to make sense of his thoughts and feelings. In doing so, she was playing a part analogous to that of the mother whose early attributions of feeling and intent to the preverbal infant help the infant gradually to know itself as an intentional being.

As they worked in this manner, C. moved from dreams of utter emptiness and aloneness to seeing himself as a small, feeble toddler screaming in an empty desert. In the course of their work, C.’s dreams and fantasies became increasingly colorful, detailed, and affect-laden. He described fantasies of annihilation with evident pleasure. This enrichment of the analytic material created difficulties for the analyst, who found herself experiencing the fear and horror that he had successfully split off from his destructive fantasies. At times she felt as though her mind had been “invaded” and “colonized” by his nihilism and destructive rage. They analyzed together his fears of being trapped in a dangerously emotional maternal world. His mother had been both extraordinarily detached from him when he was an infant and sexually intrusive and overstimulating when he was an older boy. C. fantasized about using his superior success and mental power to overpower her and then leave her.

Target had not been using mentalization-based concepts as the main basis for her clinical technique at the time of this work. Nevertheless, this process demonstrates the use of concepts of psychic equivalence and pretend modes in therapy, and the manner in which psychodynamic therapy centers on a kind of contingent mirroring that facilitates the development of mentalization. C. believed that emotions
were dangerous because he believed they made actions inevitable. Target sees this as an example of the psychic equivalence mode, in which inner experiences and external reality cannot be differentiated. But C. also had a pretend mode of function, in which he entertained fantasies of omnipotence and destructive power. He imagined that he was a "war machine," a destructive computer with complete control. These fantasies were secret and disavowed, existing in the split-off pretend mode. Having experienced traumatic disruption of the development of his mentalizing capacity, C. could not modulate or integrate these modes of function. As a result, he experienced rigid, poorly integrated shifts between his private fantasy world and a concrete relationship with external reality. These shifts between psychic equivalence and pretend mode at times dominated Target’s mind, as she experienced periodic losses of her own mentalizing capacity. She described feeling "literally as though all the exposed parts of my mind, my capacity for relating and understanding, would never work again." Looking back at this experience, Target thought that she had experienced this subjective psychic annihilation in psychic equivalence mode, temporarily taking the experience for reality. By interpreting C.’s expectation that she act like his intrusive, disapproving mother, Target helped C. move from the literalism of psychic equivalence mode to a more flexible perception of reality. By maintaining a posture of receptivity and nonintrusive responsiveness, she demonstrated for him the possibility of a different kind of interaction. He became increasingly curious about her as a new kind of object, a warm, spontaneous maternal figure.

Target closed her case presentation by noting that by the end of the analysis C. had become able to experience a broad range of emotions and to relate playfully within their sessions. These changes in his personality correlated with important gains in his external relationships. She believed that she had helped him see that “his feelings had been alternately overlooked and obliterated by the maternal image.” In the therapy he had had an experience that identified and repaired his sense of an “invaded, dangerous self.”

Target went on to discuss the case presentation and the clinical applications of mentalization-based therapy. In this type of therapy there is a change in emphasis from that of other analytic therapies, but it is not an entirely new technique. Mentalization theory contributes to clinical work chiefly by changing the way the analyst thinks about the work. The central focus in this paradigm is the analyst’s curiosity.
about the patient’s state of mind in the present moment, in the room with the analyst. The analyst is curious about what is in the patient’s mind, how it connects to the analyst’s mind, and what history has led to the way the patient thinks. She emphasized that an important part of the application of this theory to therapy is the necessity of a therapeutic stance of “nonjudgmental curiosity” characterized by a posture of interest and receptivity. The analyst, in this model, is not undertaking a hunt for repressed material. Rather, the analyst seeks to clarify the patient’s present affect state, to accept it as inherently valid, and to help establish conditions that provide safety and containment within the frame of the analysis. The analyst, keeping the patient’s affect state in focus, clarifies for the patient the cost of rigid defenses against unwanted thoughts and feelings.

In working with psychic equivalence and pretend modes, the analyst attempts to observe what mode the patient is using, and tries to help the patient create a link to the other mode. Such links occur through playful, creative interactions in the analysis. Target commented that it is important that the analyst avoid a defensive retreat into a shared “pretend world.” To avoid this retreat into disconnected fantasy, it is important that the analyst keep a focus on whatever is affectively “hot.” The analyst should avoid relying on abstract concepts. Humor and irony can be helpful if used skillfully and sensitively. The analyst assumes a position parallel to that of a parent with a young child. Nevertheless, Target emphasized, we always must be aware that the patient is not a child, but rather is an adult who has had many years of “rocky” development.

Returning to her discussion of Dr. C., Target commented on the manner in which he processed reality in the omnipotent mode of psychic equivalence. This defensive stance fended off the memory of disturbing maternal experiences in childhood. By “playing dead” he protected himself from the fantasied perverse appropriation of his mind by an intrusive mother, which he experienced as a constant threat to his reality as a separate human being and as a man. This dynamic became the central feature of the transference. C. defensively sought to turn human beings into objects and related to Target early in their work as though he did not have an emotional life. Target’s chief intervention in this early work was to speak to him as though he did have one. She understood his fantasy of being a computer as a “secret pretend mode.” In reality, he had depressed and anxious feelings that troubled
him a great deal. Later, when the omnipotent elements of his fantasies became more evident, Target used her countertransference to elaborate her understanding of their interaction in terms of psychic equivalence and pretend modes. Translating this to the work with C., she “named” his fantasy and in doing so bridged the gap to the real world.

Gabbard closed this section of the panel by commenting on the centrality of the transference in this type of work, and the focus on experiences of psychic equivalence and pretend modes in the thinking of the analyst. This emphasis, he said, may be the chief clinical contribution of this theory.

Owen Renik began his discussion of Target’s case by praising her for this “clear, evocative, and moving account” of her successfully conducted analytic work. Nevertheless, he noted, it appeared that much of the treatment was not directly connected to mentalization theory. While it was tempting to do nothing but admire the treatment, the subject at hand was how theory directs the analyst’s thinking and choice of interventions.

In contrast to Michels, Renik felt that there were clear links between Fonagy’s theory of psychopathology and his clinical theory. The mentalization-based theory of development focuses on two early modes of function: psychic equivalence mode, in which there is no distinction between psychic experience and reality, and pretend mode, in which there is no relationship between them. The integration of these modes results in mentalization, and this development can be disrupted by early trauma.

Nevertheless, Renik felt that there are important questions about the application of this theory. First, how can we tell when psychic equivalence is operational? Do we not all equate experience with reality? He observes that if he sees a chair, his immediate assumption is that it is real, not that it is a subjective organization of sensory data. Similarly, although we experience ourselves and others as having minds, the “mind” really is only a construct and is conceptualized differently in non-Western cultures. Is it possible, he asked, that we all function predominantly in psychic equivalence mode and that there are times when it is adaptive and others when it is not? What criteria, then, would we use in making this distinction? Is psychic equivalence mode defined by the identification of experience with reality? If not, what is it?

For instance, Target believes that psychic equivalence mode is operational when C. believes that having a fantasy will lead to
inevitable action. In traditional terms, we would see this as a defensive avoidance of anxiety related to the fear that he might act on his feelings. In ordinary analytic work the analyst would explore the defense, the anxiety, the assumptions underlying the anxiety, and the historical determinants of the patient’s related fantasies. Target believes that C. is not capable of working in this manner and so does not approach his defensive function in that way. Renik asked how she made this determination and what criteria she used.

In her interventions, Target suggested that C. might be able to “play” mentally with his feelings rather than act on them. This was helpful. Target had suggested a possibility C. had not previously considered. Is this how one helps a patient mentalize? Renik suggested that all analysts do this, suggesting other points of view to the patient, and that in fact most consider this type of activity central to analytic work. In other theories, one might call this the making of interpretations, offering oneself as a self-object, or a number of other terms. Renik asked if there was any distinction between mentalization-based therapy and the empathetic and thoughtful offering of another perspective.

As for Target’s descriptions of “pretend mode,” Renik agreed that it is important to avoid turning an analysis into a “sequestered playpen” that might function indefinitely as a retreat from real living. Nevertheless, Renik questioned whether it is really helpful to look at C.’s feelings as pretend in any way. “Isn’t psychoanalysis really a seductive situation?” Renik suggested that most of us think of analysis as a situation that tends to lead to sexual feelings. Did Target, Renik wondered, consider this to be pretend? If we do not acknowledge the reality of the inherent seductiveness of the analytic setting, are we not in effect “gaslighting” the patient? Would this not repeat, rather than correct, early faulty mirroring?

Renik wondered how Target and C. handled disagreements and how mentalization theory conceptualizes the distribution of authority. When C. felt that Target was rejecting him, she made an assumption that he was functioning in psychic equivalence mode, and was responding as if his internal experience of rejection reflected reality. While Renik did not question this assumption itself, he thought that there was at least some possibility that C. was “picking up” on something Target wished to deny. Such experiences are common, he noted, in analytic work. Did they ever disagree about or discuss Target’s view
of the mode in which C. was functioning? Could there not have been a collaborative process around these determinations?

Renik asked what Target meant when she said she felt “colonized, alien, and sterile” when C. related his destructive fantasies. Renik wanted to know how this experience happened. He expressed skepticism about the idea that Target’s mind could be “invaded” by her patient. Wasn’t this essentially giving him responsibility for her thoughts and feelings? He expressed concern that this might be similar to the faulty invocation of projective identification, in which the analyst attributes his or her feelings to the patient without considering other explanations.

Renik commented on the “intersubjective” role of Target’s theory in interacting with C. When C. spoke about annihilating the universe, did he mean this literally? If he did, he would be delusional. Renik suggested that this type of interaction reflects a “language” collaboratively developed in the intersubjective matrix of the analytic work. C. drew his expressions from the concepts Target offered him to express his experiences. Renik noted a stylized quality in Target’s presentation, a similarity between Target’s and C.’s expressive styles. Was this a reflection of the reciprocal influence of analyst and analysand on each other?

Finally, he wondered if there might be a significant limitation to the use of mentalization concepts in clinical theory. While Target appears highly attuned to C.’s affect states, her discussion of her work seemed to lean away from affect and toward a cognitive emphasis, and perhaps from the particular toward the abstract. Renik wondered how C.’s particular experiences contributed to his defensive structure and his avoidance of painful affect states. While Target appeared sensitive to this issue in the clinical material, Renik was not sure in what manner Target’s theory contributed to her defense analysis. Was this a theory that could be used successfully only in combination with other theories? If so, could Target and Fonagy clarify where mentalization theory fits in the broad tradition of psychoanalytic thought? Which aspects of psychoanalytic theory are replaced by the new theory and which are supplemented? Is it the case that this theory actually helps by directing the analyst’s attention to specific, affectively charged experiences in ways that perhaps had not been made clear? Renik commented that he found the statement that Target was helping C. to “mentalize” general and vague. He described interventions Target had made that he had found useful and that helped work with C. in a sensitive,
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nonjudgmental, and accepting manner. The effect of such interactions, however, could be understood in terms of the corrective emotional experience, the facilitation of a helpful self-object experience, or other theories. How would such formulations relate to the concept of mentalization?

Gabbard commented that in his many years of involvement with mentalization theory, the comments made in this panel were among the best he had heard, leading the discussion to the heart of the theory and its implications. Target said she found Renik’s comments exceedingly helpful and agreed that the role of pathology in their theory is clearer than their theory of technique. Since she was not trained originally in this theory of technique, certainly other influences dominated in her work. Target agreed that all theoretical approaches work to increase mentalization. In her view, whether one thinks of mentalization centrally or not, it is a process that happens in all approaches.

She commented on Renik’s questions about pretend and psychic equivalence modes. While it is true that in daily life we do take our experiences as a working model of reality, we still know this is only a model. C. had trouble seeing that there could be any possibility other than the one he imagined, and he devalued anyone who suggested anything else. For example, she described an interaction in which he described talking at great length to his wife about his concerns. His wife said, “You know, I also have concerns and we never talk about them.” C., taken aback, said “who?” At that time in the course of his treatment, C. had been unable to imagine that anyone in the world other than himself had thoughts or experiences. He became the only person in the world, and his wife was only a mirror. This was what Target often felt in working with him. In another example, Target described that when she told him once that she would be gone for a session, he responded, “Just leave the door unlocked, I’ll come anyway.” C. had not been joking, but literally had felt that Target’s presence was unimportant to the analysis. Target, in response, felt her mind deaden. She could not access a sense of relatedness, since for him he was “all that there was.”

In response to the question about the analysis of disavowed feelings, Target said that she did focus on this, but the first step had been to work on C.’s recognition that there were feelings. He really did have a lot of trouble seeing that. In one session, he had told her about a very erotic dream, describing it mechanically. She had interpreted,
“You may have some sexual feelings toward me.” He had responded, “Of course I don’t. I’d have to leave my wife.” This was the type of thinking she meant by “psychic equivalence.” Later on, he became able to experience this kind of statement in a more “as if” manner, and could see that it was one model of reality and could be questioned and changed. In the beginning, he had felt that many types of feelings could not be allowed because of what they would make him do.

Target acknowledged that intimacy and seduction are real aspects of the analytic relationship. She had not explicitly acknowledged this with him, and when she had “hinted” in that direction he had shown a phobic response. On one occasion, when he was trying to decide whether he should buy an expensive sports car, her responses made it clear that she was familiar with the models he was describing, and he realized she might like those cars as well. He had panicked, terrified by the idea of a shared pleasure. Later, he said that if Target liked or knew about that kind of car, he would have to buy it and go with her everywhere in it forever.

With respect to Renik’s comments on Target’s experience of “colonization,” she said that this was a powerful experience in the first year and a half of work. C. had made constant demands on her, did not recognize her in the room, or allow a connection with him. She said, “I felt he had driven thinking out of my head. He was like a tank, just going on. I couldn’t do anything with it. All I could do was catch on to the things he didn’t know about and introduce them, particularly the affects he was keeping at bay.” When he had spoken of Armageddon, this had not been a delusion. Nevertheless, he had been gripped by this fantasy, and it became the only reality in his pretend world. She did not believe that this came from an intersubjectively created “shared language,” although she felt they had such a language in other ways. C.’s Armageddon fantasy had felt new, alien, and disturbing to her. “I had all the feelings, and he was a pure thinking machine, which is what he wanted.” She did feel that he meant this destructive fantasy literally.

Target added that there was a postscript to the analysis. She had contacted C. after the termination of the analysis to ask his permission to write about their analysis. She had asked him if he wanted to read it. Initially he declined, and then he had said that he would like to read it. He was able to give up the earlier repeated fantasy that he and Target would write together after the analysis, and to let her go ahead with this while teasing her gently that it might be a “love letter”—as she had
once said a long e-mail she had from him seemed to be. In his playful comments, as well as the distance he felt from his earlier self (described starkly in the paper), he had showed the change in his thinking. It was clear that he could now express a real fantasy and know that it was quite separate from reality, and he could be somewhat playful, as well as deeply serious about what she had written.

Fonagy agreed with Target’s comments. The crux of the debate seemed to be whether there was anything genuinely new in mentalization theory and, if so, what its implication was for clinical practice. If the appropriate focus of psychoanalytic discourse is the mind, mentalization theory concerns how one represents “mind.” Does this give an added advantage in general clinical work? Perhaps not. But when a patient is having particular difficulty in representing mental states, it can be a useful additional tool.

C. did have difficulty mentally representing states of mind, beyond the norm of most patients. Mentalization theory was helpful in conceptualizing this difficulty. While the theory might not tell the analyst what to say, this is the problem with all theory. “In reality, we never really know what to say.” The value of mentalization theory is not that it tells you what you should say, but that it does tell you what you should not say. Because of the enormous power of the psychotherapeutic relationship, it is important that our theories help us understand our patients accurately. If we are misguided, we may harm them through imposing inappropriate models. Finally, while mentalization theory does not dictate the content of analytic discourse, it does emphasize the importance of the analyst’s comfort with thinking and playing freely in the analytic situation.

At this point the panel accepted questions from the audience. Sylvia Jones asked about the patient’s reaction to Target’s absence. Had this been related to a dream she had described about Osama bin Laden? She wanted to know how Target conceptualized the role of attachment experiences in C.’s analysis. Target responded that attachment theory is implicit in this model. Clearly, early failures of attachment were central in C.’s pathology. He had an extreme omnipotent, dismissing attachment style that resulted from substantial rejection and neglect in childhood. His mother had developed a contradictory relationship with him, in which she had ignored him as a toddler, yet been excessively involved and intrusive with him as a teenager. In general, she had had no conception of him as a person. In response, he had
developed a “self-sufficient, crazy world” to keep his experiences in check. In their work, he had tended to deny reactions to separation. He did show reactions to her absences in his pattern of rescheduling sessions afterward. With respect to the particular dream Jones mentioned, there actually had not been a break before. C. had taken a plane trip, but it had been for one day and had not resulted in a gap in treatment.

Lawrence Friedman commented that every analyst has the problem of explaining his expectations, which in essence are that the patient be playful with his own mind. “Analysts expect the patient to come in, use the ‘pretend mode,’ and interact differently than in the rest of his life. We expect the patient to be happy about playing with questions about love and sexual fantasy. We expect the patient to suspend romantic plans and anticipation, but it’s not easy for us to say why we expect the patient to behave so differently from how he acts in ordinary life, or to play with such serious feelings.” Friedman’s reaction to this theory was that it offers a “serviceable mythology” for why we have these expectations of the patient. This allows us to feel we are asking for something normal. Friedman asked if Target could comment on the “armamentarium” she used in moving patients into a more flexible frame of mind. Target responded that they did not have a clear elaboration of the “armamentarium,” but that she thought “markedness” was important. It was important that she reflected back to C. what he thought she was feeling, and that there was a clear distinction between that and her real feelings. C. had been terrified that she would absorb him into an “all-about-me” world.

Theodore Jacobs asked if there was a place in this theory for more explicit ways of sharing. He wanted to know if Target would share her inner experiences with her patient, making them available to be played with by the patient. Could this expand the patient’s understanding of how another person might think? Could this also expand his sense of the analyst’s flexibility, which then he could incorporate and use for himself? Target responded that she had done that frequently in the beginning of their work. She had found it important to spell out exactly what she was talking about in direct, experiential terms. Otherwise C. would put everything in theoretical terms and then argue with her about it. Using her own experience helped to limit his use of intellectualization. For instance, she shared with him her own experience of his contempt toward her in the early transference.
Michels commented on Target’s interaction with her patient about the writing of the paper. He thought that this interaction recapitulated the process of the analysis. As he understood it, she asked him if he wanted to see it and he had refused. “That would bother me.” Michels added that this is someone who is fascinated by theory and by his analyst. Why would he possibly not want to see the paper? It seems like a repetition of a past inhibition. Then he changes his mind and says he does want to see the paper. Why does he do this? Is this in response to theory, or is this his real preference? He makes it clear that he sees the paper as a love letter, and Target defends against this by saying all papers are love letters. While Michels would agree that all papers are letters, they are not always necessarily about love. This paper, Michels felt, is a love letter, although Target struggles with the idea. This interaction summarizes the dynamic of the entire treatment.

Target agreed with Michels about this, commenting that C. had entertained a long-developed fantasy that they would collaborate in writing a book about his analysis. She saw this as a competitive fantasy related to feelings about her collaboration with Fonagy, as C. was aware they had published a lot together. She knew that C. would find out about the paper, and that it would be painful to him if she had not discussed it with him first. It was important to her to discuss the paper with C. because she thought it a more ethical approach, fairer to C.’s feelings, and because she valued his opinion of her description of their work. She corrected Michels’s summary, in that C. had not said initially that he did not want to read the paper, but that he was “fine with it” and trusted his analyst. Following this, he said he would not change anything in the paper, but was interested in what she had to say. She agreed but asked him to meet with her and discuss the paper and his reactions to it. With respect to his comment that the paper was a love letter, she said that she felt more defensive about it in this presentation than with him. He had made this comment as a joke, but a serious joke, knowing that it was real and not-real at the same time.

Gabbard commented that asking C. his permission for the writing of the paper even after the end of the analysis opened a “Pandora’s box,” recapitulated issues from the analysis, and could open up the hope that new things were possible that could not be possible during the analysis. As a profession, we are just beginning to grapple with the complexities of this dilemma.
Panel Report