Mentalization with reservations

Helen Stein, PhD

The relationship between mentalization and Melanie Klein's concepts of depressive and paranoid-schizoid positions is noted, as well as commonalities between mentalization and narrative coherence. Two case examples are presented to illustrate the vicissitudes of mentalization as a psychotherapeutic tool and to explore the context in which mentalization can flourish. (Bulletin of the Menninger Clinic, 67[2], 143-149)

As other contributors to this issue have noted, mentalization is not unlike other, more familiar psychodynamic concepts. I would like to make two connections that have helped me see both the applications of mentalization and its limitations in facilitating the psychotherapeutic process.

The first connection comes from my training as an attachment researcher. One of the most interesting tools of adult attachment research is Mary Main's Adult Attachment Interview. Main and Goldwyn's (1984) psycholinguistic rating system for this interview focuses on narrative coherence. Narrative coherence involves telling a story—one's own story—in a way that makes sense and is believable. The story is neither too short nor too long and is expressed in a "fresh" way that grabs the attention of the listener. The narrator provides credible evidence for the conclusions and presents the relationships among the characters with balance and perspective. Narrative coherence also involves sensitivity to rules of discourse and hence to the listener. Mentalization, like narrative coherence, is an inherently relational concept. It requires taking into account another person's mental state, through attunement, and it involves learning to tell a story that the other can understand, believe in, and empathize with.

As therapists, we want to maximize our own mentalizing capacities, but we also want to enhance this capacity in our patients. The mentalizing therapist pays attention to how the patient experiences oth-

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Dr. Stein is a psychologist at New York Presbyterian Hospital. Correspondence may be sent to Dr. Stein at 16 East 60th Street, Suite 400, New York, NY 10022; e-mail: 102451.436@compuserve.com

ers, including the therapist. He or she conveys this to the patient, thereby enlarging the patient's repertoire of relating. He or she helps the patient convey important feelings through words rather than actions. In this way, the therapist can help the patient to create more opportunities for secure relationships.

The second connection that I want to mention is between mentalization and Melanie Klein's (1935, 1948/1975; Ogden, 1989) description of the depressive and paranoid-schizoid positions. The depressive position is mentalization in its best clothes. In this mental state, we feel sad and guilty about having hurt others. We understand their pain and empathize with their feelings. We realize that we cannot change our past mistakes; at best, we can make reparations. We take stock of our losses and mourn them. The image that comes to mind is of a sad, wise sage, perched on a mountaintop, surveying and reflecting upon a painful past. In contrast, the paranoid-schizoid position is an anti-mentalizing state. In this position, we live in the present. We divide the world of others into those we hate and those we love with total conviction and clarity. There is no time or space for reflection; action is all. Although Klein suggests that the depressive position is a more evolved state of mind, we need both of them. Life would be very boring if we mentalized constantly, and if we gave up moments of passionate love and hate.

The two positions are also appropriate to different contexts. The depressive position is most attainable in psychologically secure situations, where vulnerability can be exposed—alone on a mountaintop, but also in the presence of a trusted companion or therapist. The paranoid-schizoid position and the defenses and states of hyperarousal that accompany it are necessary and helpful at times of great danger. Empathy is superfluous, at best, and quite risky in the face of physical or verbal assault. Thinking about mentalization in relation to Klein's concepts reminds us that mentalization is a skill appropriate to some contexts and not others. It is very helpful to psychotherapists and psychopaths alike, and thus it is sometimes used for good ends, and sometimes not.

The following vignettes may illustrate these points.

Case examples

Jade: Mentalizing the therapist

Jade is a 37-year-old woman with a history of severe childhood abuse by nonparental caregivers, in a family where this went unnoticed. In early adulthood, she married, began a career, and had a network of friends. However, after a bicycle accident at age 28, a series of breakdowns ensued, with symptoms that included delusions and hallucina-

tions, dramatic mood instability, self-harm, risk-taking behaviors, and serious suicide attempts. Although she had previously been able to keep her psychotic symptoms under control—she recalled that they began when she was 4—they were now glaringly evident.

Often Jade's husband came home at the end of the day to find her covered with blood from cutting herself, and when he left town on business, she made serious suicide attempts. He was financially unreliable and often disappeared for days at a time, possibly on drinking binges. They never discussed these problems and how they affected their marriage; Jade portrayed their relationship as idyllic.

I was Jade's inpatient and, eventually, outpatient therapist for more than 3 years. After months of treatment, she was diagnosed with schizoaffective disorder, bipolar type; dissociative identity disorder, and borderline personality disorder. While in the hospital, she cut herself many times, tried to electrocute herself with an electric appliance at a kitchen sink, knocked down a social worker during an elopement attempt, stole a jeep parked outside her unit, and made several attempts to kill herself, usually after a visiting family member departed or her therapist left for vacation. After each event, she apologized in a manner that the hospital staff found charming, witty, and sincere. She told me that she especially liked one psychiatrist who joked with her about her electrocution attempt as a form of ECT. Eventually the treatment team met with a visiting consultant who insisted that we take her behavior very seriously and confront it.

I tried to do this within a mentalizing frame. I began by trying to understand how Jade felt when she hurt herself. Cutting relieved and distracted her from emotional pain and helped her to ground herself. It expressed her anger. She longed to expose the inside of her body because it demonstrated the reality of her pain and suffering, which she then quickly disavowed. The suicide attempts as a response to separation made a great deal of sense. Jade's worst abuse came during a period when her parents left for a distant city to take her younger sister for cancer treatments. She remembered watching their departure with envy. Her sister died, and when her parents came back, there was no period of mourning. Her mother coped by pretending that her sister had lost a child rather than herself. Separation was associated with unspeakable loss and abuse. The family's inability to talk about their younger child's death or to wonder about the sources of Jade's troubled nature left her feeling unbearably alone, angry, and unmentalized.

It was tempting to see Jade's self-harm as inevitable, particularly when she described overwhelming command hallucinations. But I found myself increasingly unable to tolerate her self-destructive behav-

iors, particularly as she transitioned to outpatient treatment. When I discussed the idea that she might contain them, she felt blamed and insisted that I was demanding something that she could not deliver. I became equally insistent that Jade had the power to use her mind to modify her behavior, because I certainly did not have the ability to control it. I often couldn't think clearly in our sessions because of the intensity of my anxiety. I eventually began to ask Jade to mentalize me: I told her that her self-destructive acts created anxiety, frustration, and anger in me because I cared about her yet was helpless to contain her behavior. I reminded Jade that she had learned to be a terrorist from an early abuser, and I felt victimized by that part of her. I also related our struggles to Jade's marriage. Jade and her husband had never discussed the impact of her self-destructiveness and his irresponsible behavior on their relationship—in other words, they never mentalized one another, and the marriage fell apart.

Gradually, Jade began to expect more from others and take account of others' responses to her behavior. When Jade's parents came to help take care of her while she transitioned into outpatient treatment, her mother responded to Jade's cutting by saying that she couldn't bear it. At that point, Jade stopped cutting.

Why did this treatment work as well as it did? We had a lot of time to work together, although I don't think this was necessarily the most crucial aspect of the treatment. Jade and I established a high level of trust in each other. With some patients I would not have disclosed my vulnerability. I asked her to take account of me as her share of the work of making our relationship function. Jade also heard a consistent message from many sources: from her mother, from self-reflection, from her divorce, as well as from me. She also had many enduring supports—in her day program; from her parents, who were able to acknowledge their failings in her childhood and provide very sensitive support in the present; and from her other interests and involvements.

Katy: Frozen mental states

Katy had a history of drug abuse, one-night stands, self-harm, chronic suicidality, and recurrent severe depressions. She was diagnosed with borderline personality disorder, recurrent major depression with psychotic features, post traumatic stress disorder, and substance abuse and dependence. Although successful in her career as a highly competent auditor, she could identify no enduring positive relationships in her adult life. I worked with Katy during a 3-week inpatient stay as her individual psychotherapist.

Katy described her father as a rageful alcoholic. When he was not criticizing family members or exploding with rage, he showered Katy

with affection and attention and constantly compared her physical attributes to those of her mother and older sisters. Even now, after several years in recovery, he still treats her as his beloved, often in her mother's presence. Although Katy finds her father physically repulsive, the idea of marrying someone else seems to constitute infidelity and betrayal on her part. She feels jealous if she sees him looking at other women, yet guilty when he showers affection on her in front of her mother. One precipitant of Katy's recent episode of illness was her attempt to set limits with her parents around the frequency of their phone calls and visits.

When I asked Katy to describe her relationship with her father, she blurted out, "He is my breath!" I asked her to try to write about what this meant. She wrote, "He is my existence. Without him, I am nothing. If he dies or goes away from me, I would be nothing." Yet she also believes that he does not need her in this all-encompassing way, and that he loves her only for her physical attributes. Her belief that he will never reciprocate the degree of love and dependence she experiences leaves her feeling desperate and contemplating slow death by drug abuse or a faster death by intentional suicide.

Katy and I could have explored her problems in a number of ways—by looking at the history of family adversity in her childhood, by looking at separation-individuation or oedipal dynamics. I decided to work with Katy on her inability to mentalize. Like many other survivors of a troubled childhood, Katy views herself and her father as frozen entities in a time warp. This view leads her to the inevitability of suicide as resolution—her existence is threatened by separation or distance because her father is her breath; it is threatened by the intolerable status quo in that she will never mean as much to him as he does to her. It is threatened by her forming close relationships with others. The only *safe* way out of this box, it seemed to me, was first, to take seriously her view of their relationship (thereby mentalizing her), and then to help her begin to question her basic assumptions (thereby helping her to mentalize their relationship). What was the nature of their relationship when she was younger? Who are they now, and is their relationship different? Do they have separate identities? By trying to mentalize the relationship, she could begin to account for the passage of time, to see herself and her father as they were in her childhood, as they are now, and how they might be in the future.

Katy was intrigued by my suggested approach, but the treatment failed. She chose to leave the hospital quite abruptly. I think this occurred for many reasons: Katy was often not able to be present enough to work on this issue, she was not ready to contain the strong feelings that it elicited, and certain aspects of the status quo were very rewarding

to her. She spent most of her energy enacting the family triangle with various treaters. I also think that clarity of thought may well have led her into territory that she did not want to think about (whether incest had really taken place). I did not really know how to help her feel safe enough to begin to reflect or how to assure her that she would have alternative sources of support other than her parents.

During the mentalization conference, I began to think about what specific measures might have made for a different outcome with Katy. Anthony Bateman's comments about what integrated treatment of borderline patients requires was particularly helpful. In describing the day program that he runs in London, he spoke of the importance of clarity, coherence, and consistency within the program and with respect to staff decisionmaking. Splitting is understood to be inevitable, but as something that has to be dealt with openly. Patients know that they will be treated according to their individual needs, but within a consistent structure that they can count on. The therapist is part of the team, and individual team members do not make administrative decisions in isolation from one another.

In retrospect, I believe that we did not offer Katy as much coherence and consistency as she needed to begin to mentalize. I suspect that shoring up her sense of internal security should have preceded efforts to promote mentalization. Regular participation in substance abuse treatment and a strong focus on self-soothing and coping techniques to use in the face of intense feelings—learning this in individual or group sessions and practicing it on the unit—would have provided her with more tools for containment. The therapist was not part of the inpatient team, a situation that fostered splitting. I suspect that dissociative symptoms were a very important part of her presentation, but the treatment team tended to focus on her borderline symptoms. The family work was problematic for a number of reason. Given Katy's dependence on her family as her main source of support and the absence of other helpful relationships, she may well have fared better in a setting in which she could have transitioned to a day treatment or partial hospital program without relocating. What we could offer left her in a particularly vulnerable position. Looking seriously at her relationship with her father might indeed leave her with nothing to put in its place.

In conclusion, the concept of mentalization can help psychotherapists to visit important territory in a more self-conscious manner and to move around in this realm with greater ease and more persistence. However, it is also very important to consider how to create an atmosphere or context of trust in residential programs within which patients and therapists can begin to mentalize.

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