A Tale of Two Minds: Mentalization and Adult Analysis

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In this article I examine the concept of mentalization, its utility in contemporary psychoanalysis, and the development of a mentalizing capacity as a requisite component of the analytic process with challenging, disregulated adult patients. Mentalization has generally been discussed in relation to child treatment. However, adults who have lacked the experience of attunement within the early infant–caregiver relationship exhibit profound deficits in their capacity for mentalization. These adults typically have a history of disruptive and traumatizing attachments. I propose that, with these adult patients, the development of mentalization within the analytic relationship shapes the initial focus and beginning phase of analysis. The initial analytic process, with a focus on developing a mentalizing capacity, would have a different shape and feel from a process that focuses on interpretive interventions. I use clinical vignettes to illustrate a contemporary analytic process as patient and analyst engage in a relationship that facilitates the patient’s experience of being understood and promotes the development of the capacity for mentalization—an implicit, nonconscious process that facilitates self-reflection and the ability to make use of interpretive understanding.

Behind every story that begins “When I was a child,” there exists another story in which adults are fighting for their lives.

—Gail Godwin

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Analysts can only do their work, like and unlike parents, because they … can tell compelling stories. … To walk into an analyst’s consulting room, like being born into a family, is to walk into a very elaborate family of stories …

—Adam Phillips

The elaborate stories of “when I was a child” highlight aspects of early childhood experience that give shape to our sense of self and self-with-other. These cocreated stories compose the very fabric of the analytic process and emerge as a unique piece of living art; an intricately woven tapestry distinguished by the particular design of each analytic dyad. It is the vitality of this shared labor, this creative endeavor, that gives birth to the psychoanalytic conversation and the possibility of something new.

Contemporary infant research illuminates the imperceptible nuances of infant–mother interactions that have been extrapolated to the analytic dyad in adult treatment as patient narratives unfold—the nonverbal elements that facilitate therapeutic action in the “talking cure” (Lichtenberg, 1985; Stern, 1985; Mitchell, 1996; Boston Change Process Study Group, 1998; Lyons-Ruth, 1999; Beebe and Lachmann, 2002). Infant research also offers us new perspectives for understanding the implicit emotional signifiers that contextualize communication. The findings from infant research indicate that the nonverbal aspects of communication such as facial expression, tone, rhythm, timing, and intensity of verbal and gestural expressions convey attunement or misattunement within the mother–infant dyad. The significance of the nonverbal dimension of communication has compelling implications for defining new conversations about the complexity of what is mutative in the psychoanalytic relationship (Beebe et al., 2005; Stern, 1985). The attachment literature and neurobiological research findings further stimulate our thinking about the “something more” that mediates change in analysis (Slade, 1990, 1999; Boston Change Process Study Group, 1998; Pally, 2001; Wolf et al., 2001; Boston Change Process Study Group, 2005; House and Portuges, 2005; Mayes, 2005; Litowitz, 2005).

There is another element of this area of research and theory that has significant implications for addressing those other back stories “in which adults are fighting for their lives” (Godwin, 1983, p. 252). This is the area of mentalization, or reflective function, a developmental achievement accomplished within the intersubjective experience of the good-enough child–caregiver relationship (Stolorow, Brandchaft, and Atwood, 1987;
Stolorow and Atwood, 1992; Fonagy and Target, 1998; Fonagy, 2001; Fonagy et al., 2002; Jurist, 2005). Adults who have lacked the early experience of attuned caregiver responsiveness exhibit profound deficits in their capacity for mentalization. These deficits are typically apparent in an individual’s inability to (a) identify or reflect on his or her own emotional states or the emotional state of another, (b) regulate him- or herself or tolerate the discomfort of examining internal and external reality from different perspectives, and (c) have the experience of true intersubjective relating (i.e., engage in a relationship in which there is a mutual recognition of two distinct subjectivities; Stolorow et al., 1987; Benjamin, 1990; Stolorow, Atwood, and Brandchaft, 1994; Aron, 1996; Coburn, 2001; Stolorow, 2002; Beebe et al., 2003).

I am proposing that when these adults show up in our consulting rooms, the absence of the capacity for mentalization, with all of its behavioral and emotional concomitants, has significant ramifications for the process that unfolds in adult treatment. The development of mentalization, with its implications for defining and regulating self and self-with-other, becomes the initial primary focus of adult psychoanalysis. To develop reflective function, the analyst must provide the function that the parent was unable to provide (i.e., the function of “lending her mind” to her adult patient so that her patient can begin to develop the capacity for mentalization within the context of a new, transformative relationship).

In the beginning phase of analysis with these challenging patients—adults who have experienced profound early environmental failure—a focus on developing mentalizing functions significantly changes the shape and feel of the analytic process and the types of treatment interventions. The analyst would very explicitly focus her attention and the analytic process on allowing her patient to “share her mind” through empathically attuned and contingent verbal responses that would provide an experience of being understood. This is similar to Kohut’s (1971, 1977) concept of mirroring selfobject functions, Winnicott’s (1965) concept of the “holding environment,” and Stolorow et al.’s (1987) emphasis on early parental attunement and responsiveness to emotional states in facilitating the integration of affect and organization of self-experience. Fonagy et al. (2002) and his colleagues particularly focus on repeated experiences of the caregiver’s reflective understanding and thoughtful responsiveness to the infant’s and child’s inner experience, within a secure attachment relationship, as the requisite element in the development of mentalization, a sense of self, and the capacity to manage affect. The analyst in this phase of the analytic process would facili-
tate several experiences for her patient: (a) that of being understood, despite the patient’s initial inability to identify feeling states accurately in himself or others; (b) that of having an overwhelming or disregulated feeling state regulated within the patient–analyst relationship; and (c) that of an ongoing relationship that provides a basis for the patient to develop the capacity for regulating his or her own emotional states.

What becomes initially transformative for these patients is not verbal interpretation but the experience of the analyst explicitly sharing his or her thoughts within a new, previously missed, attuned relationship (Shane, Shane, and Gales, 1997; Coates, 1998). Seligman (1998) describes this distinction:

Insight is neither idealized nor isolated from its relational contexts … understanding and interaction … are part of a unified relational process. … Understanding is not about experience. It is itself an experience, and this experience involves the crucial presence of another person with whom one feels secure, in part by virtue of feeling understood [p. 84; italics added].

As self psychology has evolved it has incorporated the complexity of multiple perspectives. These perspectives acknowledge the contextualization of the explicit, verbal aspect of the analytic dialogue within the implicit, nonverbal relational components of the analytic dyad (Coburn, 2006). When we choose to enter into a relationship with those adults who are “fighting for their lives” in a disregulated, unmentalized state, we need to reconsider, from these new perspectives of change, what it means for the analytic process and our initial interventions as we listen to the stories our patients tell us of “when I was a child.” The contemporary concept of mentalization is based on an attachment perspective as the foundation for affect regulation and the integration of emotional experience rather than dis-integration in the face of overwhelming aﬀect. When adults have been shaped by a history of disruptive and traumatizing attachments they have missed this early experience of an attuned, mirroring selfobject experience in the infant–caregiver relationship. They come to us with an unarticulated hope that somehow, despite their early experiences, two minds are better than one.

This tale of two minds usually begins with “the worst of times”—an early history of abuse, disruption, and chaos—and slowly, hopefully, works toward “the best of times”—a dedication to a shared state of mind from which will emerge both a newfound capacity to mentalize and reflect and
the capacity for recognition of different subjectivities within relationships (Kohut, 1984; Benjamin, 1990; Stolorow and Atwood, 1996). I will weave together clinical material and the literature to illustrate and discuss this proposition in terms of defining the treatment focus, the analytic process, and treatment interventions. First I will present impressions of my initial meeting with my patient—“the worst of times.” Then I will look at points in the treatment process with this patient, as interventions were shaped and informed by a focus on the development of mentalization and different forms of intersubjective relating (Beebe et al., 2005)—movement toward “the best of times.”

I

**Vignette 1: My Meeting With a Mafia Moll**

Gloria arrived for our initial consultation thoroughly armored in her tough and edgy façade, successfully assuming an intimidating stance. I immediately felt suffocated by the amount of space this small, 35-year-old woman filled in my office. I was overwhelmed by feelings of intimidation and trepidation, as if I were, in fact, in the presence of a mafia moll. Gloria had a breathtakingly artful facility to use colorful language as a means of silencing rather than engaging me. Her manner of speaking was caustic, shrill, and pressured. Her imperious demeanor rendered me impotent and dumbstruck. She took charge of the session and did not hesitate to let me know that she had no more patience for “fucking therapists” who thought they knew it all!

Gloria presented me with a treatment plan based on her own evaluation of her needs. According to her authoritative self-assessment, she required psychotherapy focused on the stress she was experiencing while taking classes at a local vocational school. Her prior therapist had encouraged her to return to her nursing career. She had decided to do that with a change in her area of specialization that required taking some additional courses. Gloria had also decided to do volunteer work at a local hospital. She found the work gratifying but interactions with colleagues frustrating, in fact infuriating. Gloria emphatically and with a preemptive authority announced that the combination of school and work was the unequivocal source of her stress. I certainly was not about to disagree!

Gloria had begun treatment with her prior therapist, Therapist A, after a serious depressive episode that required hospitalization. Again, Gloria
provided me with her own definitive analysis of the cause of her depression. Her depression was the culmination of years of emotional and physical abuse. Her abuse began in childhood and had continued through adulthood, played out in abusive relationships with numerous men. Medication had been prescribed with no appreciable results.

Finally, Gloria had moved to escape her last emotionally and physically abusive relationship. However, she had not anticipated feeling isolated and even more depressed in the absence of her support system of friends and family. It was then that she slipped into a state of deep depression and fragility. Initially she had tried to self-medicate, using combinations of medications, both prescribed and “procured,” from hospitals in which she had worked. Finally, unable to function at work and sufficiently frightened by her state of mind, she voluntarily admitted herself into a hospital for treatment. Upon release from the hospital, she was referred to Therapist A and continued to see him for a couple of years until he moved out of the city. Therapist A had tried to provide referrals for her so that she could continue her therapy. She “despised” these referrals. She quickly and dismissively terminated each treatment, discarding Therapist B, Therapist C, and Therapist D in rapid succession. I, then, became the next link in this chain of eviscerated therapists—of analytic road kill.

It was obvious that Gloria was accustomed to fighting to get her needs met and that her tough, brassy bravado was a necessary protection against her fear of further humiliation, shame, and rejection. If she were to enter into treatment with me, she was going to do it loudly and defiantly—fighting to be heard, respected, and taken seriously. Clearly, this little mafia moll had been profoundly hurt and damaged. She appeared to have no awareness of her impact on me, or any obvious capacity or interest in reflecting on the recurring abusive patterns in her life as anything other than examples of her “fucking bad luck!”

II

Fonagy and his colleagues (2002) suggest that the nature of the infant attachment, the contingency of parental responses, and the coherence of the parent’s narrative style are significant in the development of the capacity to mentalize. The acquisition of this capacity is a crucial developmental achievement because it provides a foundation for the continuity of self-experience; it enables the child, and later the adult, to understand the action of others as meaningful through the attribution of thoughts and feelings to
others as similar or different from their own; it facilitates communication and intersubjective relating through the capacity to represent the mental state of the other and keep in mind that the other person’s behavior does not necessarily define reality but only one perspective (Fonagy et al., 2002, pp. 264–265).

The development of the capacity for mentalization is the end result of repeated early child–caregiver interactions in which the parent provides links between reality and fantasy, while accurately reflecting the child’s mental states. This ability to mentalize becomes a significant contributor to the capacity for affect regulation, the experience of self-agency, and impulse control.

When this essential aspect of attuned communication between caregiver and child has not occurred, we find ourselves with a patient who is missing a crucial prerequisite for analytic progress; i.e., the capacity to accurately label and reflect on his or her own feeling states and the feeling states of others (Stolorow et al., 1987). The adult entering our office has experienced an early relationship that has only fostered the psychic equivalence mode of functioning in which the child experiences his ideas and feelings as truths rather than as one possible reaction to, or perspective of, reality. An adult functioning at this stage is, therefore, unable to imagine that another person may think or feel something different from what he or she is feeling or thinking in the moment. Interpretive interventions under these circumstances would be meaningless at best. At worst, interpretive interventions could rupture the therapy relationship because there is a potential for the patient to feel misunderstood and to experience the interpretations as critical and judgmental attacks.

Furthermore, the inability to mentalize is evidenced in the lack of capacity to be interested in, or thoughtful about, one’s own mind—metacognitive monitoring—and the lack of capacity to consider or have options in the expression or regulation of emotional states—mentalized affectivity—(Slade, 1990; Slade, 1999; Fonagy et al., 2002; Jurist, 2005). The ability to identify affects includes the ability to understand the relationship or links between different and distinct affects, as well as the sense of one’s history or experience as contributing factors to the particular affect evoked in a situation and the meanings attributed to these affects. This ability to identify affects then yields a basis for the existence of a representational system that provides options for affect expression, contributing to a coherent organization and affective regulation of self and self-with-other. The inability to mentalize has profound implications for therapeutic work.
in which the capacity to reflect on both the source and the meaning of an affective response is a requisite element of change.

In working with children, Fonagy and Target (1998) state, “The appropriate focus of work is the exploration of triggers for feelings … highlighting differences in perceptions of the same event. … Interpretations are not global summaries, but rather attempts at placing affect into a causal chain of concurrent mental experience” (p. 109). They encourage the analyst to assume a mentalistic and benevolent stance to facilitate the development of reflective function and, ultimately, self-reflection in the patient: “… the representation that never fully developed in early childhood and was probably further undermined by subsequent painful interpersonal experience” (p. 109). This conclusion follows in the tradition of self psychological and intersubjective thinking on the vital significance of the early mother–infant dyadic system and the reverberation of early environmental failure on the developing sense of self (Kohut, 1977; Stolorow et al., 1987; Shane and Shane, 1993; Stolorow and Atwood, 1996; Shane et al., 1997).

III

VIGNETTE 2: A SHEEP IN WOLF’S CLOTHING

Gloria’s treatment evolved in an unusual and unexpected way. As the tough façade dissolved, I began to feel that I was treating a child. Gloria had decided to resume her nursing career as an intensive care pediatric nurse. She had enrolled in classes in psychology and child development to prepare for working in this new, hopefully gratifying, area of specialization. I would use what she shared with me about her class assignments as a springboard for relating the “concepts” she was learning to her own life experiences and to her inner life. The coherence or lack of coherence in the written assignments she shared was also a clear indicator of the emotional valence a particular topic held for her. As she became more anxious, although not conscious of this feeling state, her writing would become markedly less coherent. Carefully, I began to point this out to Gloria. I wanted to help her become more aware of her own internal state. Simultaneously, I wanted to facilitate her capacity to link this awareness with her understanding of the impact of her emotional state on her ability to think clearly and react thoughtfully. One day she softly and poignantly remarked, “You are the mommy I never had!”
As treatment was progressing, the ramifications of Gloria’s deficits in her capacity to mentalize were becoming dramatically clear. This provides one way of reconsidering her lack of affect regulation, her impulsivity, and her inability to understand and respond flexibly to the actions of others in her world. However, her emerging capacity to think about her thinking and make use of our relationship to begin to regulate herself was also becoming more apparent.

Gloria was intrigued and excited by what she was learning. This new area of study was providing opportunities for her to remember events of her own physically and emotionally abusive childhood. I continued to feel concern that the deficits in her capacity to mentalize would become a serious impediment to successful interactions when she finished her classes and began full-time hospital work. I suggested that she consider increasing our weekly sessions. My suggestion, coming from my own concern and not her awareness that there was reason for concern (my mentalized processing, not hers), was an unfortunately disruptive move away from my empathic listening stance. She experienced my suggestion as a devaluing criticism of her competence and as a persecutory statement of my feeling that she was inadequate. She became enraged, cancelled her next session with me, and indicated that she was unsure about when she would schedule her next appointment.

I suddenly assumed the role of critical, demeaning, and shaming mother. In attachment theory terms, we could say that, at that point in time, she did not have sufficient experience of me as a secure base during times of disruptions. Therefore, my suggestion was a rupture to our still tenuous secure attachment. She was thrown back to old resistant and disorganized attachment patterns of self-with-other. From a self psychological point of view, we could say that my suggestion that she needed additional sessions disrupted the mirroring and idealizing selfobject transferences through which she was beginning to experience herself as competent and worthwhile. The analytic situation had “become the traumatic past” (Kohut, 1971, p. 178; italics added), and I had “become the traumatizing selfobject of early life” (p. 178; italics added). Or, as Stolorow et al. (1987) explain it, when on the basis of early experiences of faulty attunement affects do not signal a changing self-state, affects instead signal impending emotional disorganization. In applying the concept of mentalization, we could say that my failure to make this suggestion in response to Gloria’s felt need, instead of mine, immediately defined it as a noncontingent and nonempathic response, thereby disregulating Gloria and thrusting her back
to the psychic equivalence mode of processing her emotional experience when she felt disrupted. It required several months of work to repair this rupture in our relationship. During these months, holding in mind a perspective that focuses on the development of mentalization, I never interpretively linked Gloria’s reaction to her history. Instead, we focused on the mistake I had made in suggesting what Gloria needed rather than on responding to her stated concerns, a far less than “optimal responsiveness” (Bacal, 1998) on my part. I listened to Gloria’s angry tirades about my “fucking incompetence” and her vituperative expressions of blame toward me for being one more person who had made her feel devalued in her life.

Finally, Gloria felt safe enough to raise the question of what I could possibly have had in mind when I suggested an increased number of sessions. We could then look together at what I had been thinking and compare our thoughts on this suggestion. She became curious about what had triggered her intense response, and we were able, at that point, to link her early experiences of lack of attunement to my lack of attunement in that moment. Gloria and I shared the experience of understanding that we could have separate states of mind and maintain a dialogue, rather than engage in a tirade in which one of us would end up feeling shamed and inadequate. Then, on her own, she made the decision to come in more frequently.

IV

This transitional time in treatment presented an opportunity for us to experience the process of her emerging capacity for mentalization, built on repeated experiences of feeling understood by me. Infant research findings highlight the exquisitely delicate and complex fabric of communication, intricately woven and contextualized by the cadence, tone, rhythm, intonations, and bodily and facial expressions that uniquely define and shape each dyad (Stern, 1985; Boston Change Process Study Group, 1998; Lyons-Ruth, 1999; Knoblauch, 2000; Beebe and Lachmann, 2002; Beebe et al., 2003). Beebe and Lachmann consider mother and infant as a system in which organizing patterns of interaction are shaped: “ ... the organizing principles describe lifelong modes of regulating interactive processes at the procedural emotional level of action sequences ... the only ‘language’ mother and infant have is the nonverbal process” (pp. 33–34). This is reminiscent of Stern’s (1985) comment, in his landmark book, that “ ... early in
life affects are both the primary medium and the primary subject of communication” (p. 133).

Applying Beebe and Lachmann’s (2002) model, one could frame this overall transitional period, or the individual sessions during this time, by using their concept of the three principles of salience. This bidirectional model of regulation of self and self-with-other could be applied on the micro level (within each session) or on the macro level (the entire transitional period). The process between us, as well as the process defining Gloria’s internal state, was characterized by oscillations between periods of ongoing regulation, disruption, and repair, resolving in heightened affective moments (Beebe and Lachmann, 2002). The dyadic, interactive regulation of each session resulted in an increasingly stabilizing self-regulatory process.

Applying Fonagy’s (2001; 2002) model, this period of time marks the beginning of Gloria’s capacity for mentalization (i.e., an increased capacity to think about her thinking; to understand and reflect on her experience from different perspectives; to create links between her internal state, her history, and her choices for responding; to self-regulate; to develop a more coherent sense of self). However, Gloria’s still tenuous capacity to maintain a mentalized stance, or make use of “a mind of her own,” is exemplified by the rupture between us.

V

VIGNETTE 3: TWO MINDS ARE BETTER THAN ONE: THE BEGINNING CAPACITY FOR MENTALIZATION

During the next phase of her treatment, Gloria began to develop a real curiosity about the cause of some of her reactions. A pattern quickly emerged between us. She would present her perspective on a situation or person as if it were the only truth. She would rail in her mafia moll mode. It felt as if she were taunting me to find any alternative explanation. I would then gently ask her if she would like us to reconsider the situation together. This gave us an opportunity to play with other perspectives as well as to understand and clarify her initial dismissively disdainful, but necessarily protective, comments. For example, Gloria asked me to read her transcribed interview with a young mother who had been asked questions about her parenting style. She had discussed this interview as part of a class assignment. She shoved the paper at me while simultaneously spitting out the following words:
“Read this. I hate this person. She denies all of her problems and blames other people—even her kids. I hate people who say such stupid things. I just call them dumb shits and get rid of them.” My response was that this young mother was very reminiscent of her own parents who were not reflective, who were abusive and insensitive to her feelings and problems—in fact, ignored or denied them—and who just made her feel inferior. I then added that of course she would feel angry when she encounters someone like this. She knew how damaging this kind of parental response could be. I confirmed her feeling that it certainly was upsetting. Gloria became noticeably calmer. She was beginning to have the capacity to make links between her emotional reactions in the present and her experiences in the past. This interaction, and many more like it, has become an opportunity for her to begin to question and reflect on how she learned to cover up her sense of inadequacy with anger, rage, and impulsive or explosive reactions meant to hurt others and “get rid of them.”

We began to explore the meaning and impact of other people’s reactions as a means of helping her understand both the conscious and the unconscious relationship between her reactions, her behaviors, and her internal emotional states. She would enter my office after a disturbing confrontation, vehemently cursing some “dumb fucking person” she had encountered. All of these individuals alternatively felt to her as if they were attempting to stymie her extraordinary efforts to be effective, or as if they had failed to recognize her abilities and skills. Slowly, we were able to disentangle her anxiety from the meaning she attributed to these interactions. First she would make use of my thoughts about her experiences. Then she would begin to consider, on her own, the different possible meanings of other peoples’ reactions. Mentalization was clearly becoming a more integrated part of her experience. She was beginning to attempt to clarify situations and reactions before responding. In telling me this she added, “You taught me to do that, instead of making assumptions!” I responded, “You mean, to clarify someone’s feelings about you, rather than to just react as if you know how they felt?”

Her innate intelligence and capacity to integrate new understanding have become increasingly apparent. She has become more actively intrigued by my perspective on different meanings and options in linking her thoughts, feelings, actions, and experiences. She is now interested in understanding and reflecting on her responses in the context of her history—a more analytic approach to understanding affect and behavior. This change has facilitated the emergence of several themes as we have come to under-
stand her reactions in the present as linked to her past experiences. We have discussed in greater depth her childhood experiences of abuse. We have connected her history of repeatedly putting herself in abusive relationships to her early experiences with appropriate expressions of sadness rather than the overwhelming despair, depression, and rage she had experienced in the past. We have explored her childhood sense of being invisible in her world as a factor in the intensity of her enraged reactions when she feels inadequate, unrecognized, or misperceived in the present, as exemplified by the rupture in our relationship.

VI

This tumultuous period of treatment resolved in clear triumphs and gratifying changes. Gloria began to use her capacity for mentalization. She could imagine the possibility that other people have a separate state of mind. This process, emerging within the context of our relationship, became evident in an improved capacity for self-reflection and self-regulation. She has developed a new sense of self. Although still fragile in many ways, Gloria has managed to let go of her mafia moll façade and “kill or be killed” demeanor in most situations. She has developed a capacity to reflect on her behavior when she becomes angry, think through ways of “repairing the damage” that do not feel humiliating to her, and begin to “try on” and integrate other ways of being in the world. The disregulated feeling states, with all of their combative ferocity, are no longer present. She has found a new, gratifying focus in her career. Significantly, it is one in which, as a neonatal intensive care nurse, she facilitates the creation of secure bonds between parents and their fragile newborn infants.

We are now at the stage of treatment where interpretive interventions are useful in understanding and thinking together about her behavior and feelings. We reached this pivotal point in treatment by beginning with the limitations of the frightened and enraged little child, the “behavior problem,” who entered my office “fighting for her life” with no ability to reflect. Gloria is a dramatic example of that group of patients who, due in great part to their extraordinary deficits in the capacity to mentalize as evidenced behaviorally in their disregulated states and their impulsivity, challenge us as contemporary psychoanalysts to (a) creatively and imaginatively apply the findings of contemporary psychoanalytic research to our clinical work and (b) reconsider what is mutative in psychoanalytic treatment.
The work of researchers in the area of the infant–mother dyad compels us to consider dimensions of the nonverbal, implicit aspects of the analytic relationship as significant mutative components in providing a basis for repairing early infant–caregiver deficits. Mentalization, as an emergent capacity, can be developed through the previously missed experience of a sustained and sustaining empathic experience of responsive relational attunement, a feeling of being understood—a vital experience in creating a space for the development of the capacity to mentalize and ultimately self-reflect and self-regulate. Viewed from this perspective, mentalization is a construct that bridges the development of a sense of self and self-with-other through providing the necessary scaffolding and linking between self-coherence, continuity of self, sense of agency, affect regulation, intersubjective relating, and meaning-making in relationships. It emerges when a new secure attachment, within the analytic dyad, provides a relational space that facilitates the development of a representational system and provides options for affective expression through symbolization and self-reflection. Coburn (2006) comments:

> Despite Kohut’s preoccupation with the self as an individual entity or structure, we are increasingly exposed to a psychoanalytic contextualism and complexity that, pervading many perspectives now associated with self psychology, suggest that emotional experience … [is] distributed across a relational network of which each of us is considered a component [p. 3].

The concept of mentalization embodies this complex relational and emotional experience of understanding as part of a contemporary self psychological evolution, from Kohut’s theory of self psychology through intersubjectivity theory, specificity theory, relational theory, and nonlinear dynamic systems theory while extrapolating from contemporary infant research—all of which have concluded, from their own perspectives, that for optimal development two minds are better than one!

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1In referring to this complex experience as relational attunement, I mean to emphasize the emergent, dyadic, nonlinear, relational quality of this multilayered and multisensorial phenomenon. In so doing, I differentiate it from the concepts of implicit relational knowing, the prereflective unconscious, emotional resonance, empathy, the unconscious meeting of minds, mentalization, the unthought known—each of which includes some, but not all, of the defining features of relational attunement (Grebow, 2004).
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En este artículo examino el concepto de mentalización, su utilidad en el psicoanálisis contemporáneo, y el desarrollo de la capacidad de mentalizar como un requisito necesario del proceso analítico con pacientes difíciles y con dificultades en la regulación. La mentalización se ha discutido en general en relación al tratamiento de niños. Sin embargo, los adultos que no han tenido la experiencia de sintonía con los cuidadores de su primera infancia presentan déficits profundos en su capacidad de mentalización. Estos adultos suelen tener una historia de attachments disruptivos y traumáticos. Propongo que, con estos pacientes adultos, el desarrollo de la mentalización dentro de la relación analítica constituye el foco inicial y la fase de comienzo del análisis. El proceso analítico inicial, con el foco puesto en el desarrollo de la capacidad de mentalizar, tendrá una forma y una atmósfera distinta a aquel proceso que se centra en las intervenciones interpretativas. Utilizaré viñetas clínicas para ilustrar un proceso analítico contemporáneo en el que paciente y analista se vinculan en una relación que facilita la experiencia del paciente de ser entendido y promueve el desarrollo de la capacidad de mentalización –un proceso implícito y no consciente que facilita la auto-reflexión y la habilidad para utilizar la comprensión interpretativa.

Dans cet article, j’examine le concept de mentalisation, son utilité en psychanalyse contemporaine, et le développement d’une capacité de mentalisation en tant que composante requise du processus analytique avec des patients adultes dérégulés. La mentalisation a généralement été discutée en relation avec le traitement des enfants. Toutefois, les adultes qui ont manqué d’expériences d’accordage affectif dans leur relation précoce enfant/soignant manifestent de profonds déficits dans leur capacité de mentalisation. Ces adultes ont typiquement une histoire d’attachements traumatiques et perturbateurs. Je propose que, avec ces patients adultes, le développement de la mentalisation dans la relation analytique constitue le centre d’attention initial et la première phase de l’analyse. Le processus analytique initial, centré sur le développement d’une capacité de mentalisation, apparaîtrait et se vivrait différemment du processus analytique centré sur les interventions interprétatives. J’utilise des vignettes cliniques pour illustrer un processus analytique contemporain alors que le patient et l’analyste s’engagent dans une relation qui facilite l’expérience d’être compris chez le patient et qui soutient le développement de sa capacité de mentalisation – un processus non conscient, implicite qui facilite la réflexion sur soi et l’habileté à utiliser la compréhension interprétative.

In questo articolo esamino il concetto di mentalizzazione, la sua utilità nella psicoanalisi contemporanea, e lo sviluppo della capacità di mentalizzazione come componente necessaria del processo analitico con pazienti adulti difficili e privi di una buona auto-regolazione. In generale la mentalizzazione è stata discussa in relazione alla terapia infantile. Tuttavia gli adulti che non hanno fatto esperienza di una buona sintonizzazione nella relazione precoce bambino/agenete delle cure mostrano un deficit profondo nella loro capacità di mentalizzazione. Questi adulti hanno tipicamente una storia di attaccamenti traumatizzanti e disturbati. Propongo che con questi pazienti adulti lo sviluppo della
mentalizzazione all'interno della relazione analitica costituisca il focus iniziale e la fase iniziale dell'analisi. L'iniziale processo analitico, focalizzato sullo sviluppo della capacità di mentalizzazione, avrebbe una forma e una dimensione affettiva diversi da un processo concentrato su interventi interpretativi. Uso delle vignette cliniche per illustrare un processo analitico contemporaneo, man mano che paziente e analista si coinvolgono in una relazione che facilita l'esperienza del paziente di essere compreso e che promuove lo sviluppo della capacità di mentalizzazione; un processo implicito e non conscio che facilita l'auto-riflessione e la capacità di fare uso della comprensione interpretativa.