Treating Trauma with Plain Old Therapy

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Overview

Generic application of MBT

Developed in the context of The Menninger Clinic as a way of providing an anchor in the face of eclectic treatment approaches, diverse patients, and multiple treatment modalities.

Trans-theoretical, trans-diagnostic, multiple treatment modalities

Appropriate for generalists who refer to specialists when needed

Evolution in the context of trauma, broadly defined, renders the mentalizing approach broadly applicable to a wide range of patients whose problems with emotion regulation are embedded in attachment relationships.
Psychoeducational Program on Mentalizing

Started out intending to help patients understand how we think about treatment so as to foster collaboration, employing a three-part curriculum

- understanding mentalizing;
- how impaired mentalizing is intertwined with various psychiatric disorders, including personality disorders;
- how different treatment modalities enhance mentalizing.

Evolved from explaining to patients how we think about their treatment to advocating that they attend to mentalizing not only for the sake of treatment but also for improved relationships more generally.

Introduced mentalizing exercises to enable patients to practice mentalizing, get a “feel” for it, so as to be more attentive to it in their relationships. Also promoting a mentalizing ethos in the therapeutic community.

Incorporated education on attachment as the crucial context for mentalizing.
**Experimental situation**

Satisfied marital couples brought into lab; wife hooked up to receive shocks (and was shocked periodically). Conditions varied: holding husband’s hand, stranger’s hand, or no one’s hand. Multiple brain areas scanned.

**Result**

Lowest levels of brain activation associated with holding hand of husband; highest levels with holding no hand. High quality of marital relationship associated with least brain activity.

**Conclusion**

Attachment is the most potent and efficient means of emotion regulation. **Outsource your emotion regulation.** Note that common treatments (e.g., DBT, CBT) promote self-regulation, the most effortful.
Adult Attachment from a Dimensional Perspective

- Secure
- Ambivalent
- Avoidant-Dissingning
- Avoidant-Fearful [disorganized]
see M. Shaw,
ORT Institute
I. Why we need plain old therapy
Problems with Practicing Empirically Supported Treatments

If many remedies are prescribed for an illness, you may be certain that the illness has no cure – Chekhov, *The Cherry Orchard*

The proliferation of treatment manuals targeting single disorders, sometimes with trivial differences among them, leaves the mental health professional with no clear way to choose one manual over another and little chance of ever becoming familiar with most of them, let alone trained to competence in their delivery. Deepening understanding of the nature of emotional disorders reveals that commonalities in etiology and latent structures among these disorders supersede differences (Wilamowska et al, 2010).

There is irony “in the fact that although there is an increasing requirement for practice to be based on evidence, we are not aware of systematic evidence demonstrating the benefit of this process” (Roth & Fonagy, 2005).
My non-brand of psychotherapy
Much, if not all, of the effectiveness of different forms of psychotherapy may be due to those features that all have in common rather than those that distinguish them from each other.

—Jerome Frank (1961): *Persuasion and healing*
Mentalizing is the most fundamental common factor among psychotherapeutic treatments...perforce, clinicians mentalize in conducting psychotherapies and also engage their patients in doing so.

—Allen, Fonagy, & Bateman, *Mentalizing in Clinical Practice*

In advocating mentalization-based treatment we claim no innovation. On the contrary, mentalization-based treatment is the least novel therapeutic approach imaginable.

—Allen & Fonagy, *Handbook of Mentalization-Based Treatment*

Forewarning: This product may contain traces of originality. These are only trace contaminants, occurring as part of the production process, and should not spoil your enjoyment of the product.

—Fonagy, *unpublished*

Mentalizing, even if not always explicit in our language, is implicit in many forms of psychotherapy...Allen and colleagues, of course, have already said this, when they suggest: “You’re already doing it.” And indeed we are, if we’re doing our job.

—Oldham (2008), Epilogue to *Mentalizing in Clinical Practice*
Plakun’s Y model: Generic and specific facets

- Cognitive-behavioral
- Psychodynamic

  - Formulation
  - Boundaries
  - Alliance
  - Empathic listening

Common factors
Plakun’s Y model: Generic and specific facets

cognitive-behavioral
psychodynamic

mentalizing
Mentalizing: Generic and specific facets

Implications: extensive overlap between MBT and other treatment approaches to BPD; BPD was the context of discovery for the broadly applicable value of mentalizing.

Mentalization-Based Therapy
specialized techniques to promote mentalizing and interrupt non-mentalizing

Dialectical Behavior Therapy

Transference-Focused Psychotherapy
Research Evidence for MBT and plain old therapy

Mentalization-Based Treatment is an evidence-based treatment for BPD

- standardized through training and treatment manuals to promote treatment adherence
- randomized controlled trials demonstrating effectiveness

Mentalizing-informed (plain old) therapy

- Mentalizing promotes a therapeutic relationship and alliance, which evidence demonstrates contributes significantly to treatment outcome
- Attachment research demonstrates the principle that mentalizing begets mentalizing
- Attachment research links mentalizing to secure attachment and links attachment security to optimal functioning
Mentalizing as a distinctive style of generic psychotherapy

Natural, with individual therapist variability
Active, engaged, transparent
Conversational
Commonsensical
Present focused
Collaborative; therapist *obligated* to mentalize, patient not
  (mentalizing begets mentalizing)
Moderately structured around a therapeutic focus/formulation
The patient has to find himself in the mind of the therapist and, equally, the therapist has to understand himself in the mind of the patient if the two together are to develop a mentalizing process. Both have to experience a mind being changed by a mind (Bateman & Fonagy)
A remarkable convergence: Mindfulness of Mind

**Developmental Psychopathology**
- psychoanalysis
- attachment
- trauma

**Buddhism**
- philosophy
- ethics
- spirituality

MF of Mind

Mindfulness

ways of contending with suffering
Mindful attentiveness: a foundation for effective mentalizing

- Constructing biographical and autobiographical narrative
- Reflecting on the meaning of mental states
- Making inferences about mental states
- Awareness of mental states as representational
- Nonjudgmental attitude; acceptance, compassion, curiosity
- Attentiveness to mental states in self & others
- Bare attention, present-centered
The Mentalizing Stance (mentalizing mindfully)

Psychological aspects

- inquisitive, curious, playful, open-minded
- “not knowing” (cleverness as cardinal sin)*
- not creating the capacity but rather promoting attentiveness to the activity of mentalizing

Ethical aspects (as in parenting, for example)

- good will and compassion
- acceptance and forgiveness
- respect for autonomy
- love

*To do anything well you must have the humility to bumble around a bit, to follow your nose, to get lost, to goof. Have the courage to try an undertaking and possibly do it poorly. Unremarkable lives are marked by the fear of not looking capable when trying something new.—Epictetus
II. Mentalizing in the development and treatment of attachment trauma
Thesis

The experience of being left *psychologically alone in unbearable emotional states* is potentially traumatic owing in part to the absence of mentalizing. Treatment entails creating a secure attachment context by means of mentalizing in which previously unbearable emotional states can be experienced, expressed, understood, and reflected upon—and thus rendered meaningful and bearable.
Intergenerational transmission of security and mentalizing: *mentalizing begets mentalizing*

- Parental security of attachment ↔ Parental mentalizing capacity
  - Mentalizing interactions with infant
    - Infant secure attachment
      - Enhanced mentalizing capacity in childhood
Attachment trauma: Two senses

- Trauma that occurs in an attachment relationship, in childhood or adulthood
- Trauma that adversely affects the capacity for secure attachment—the bane of the therapeutic relationship
“Trauma” broadly construed

AFRAID
unbearable emotional states

ALONE
absence of experience of being mentalized
feeling abandoned, neglected, unloved, invisible

IMPAIRED MENTALIZING CAPACITY

DBT: affective dysregulation
invalidating environment

BPD
Non-mentalizing in the intergenerational transmission of attachment trauma

- Parental attachment insecurity ↔ impaired parental mentalizing capacity
- Infant affective dysregulation
- Non-mentalizing parent-infant interactions
- Infant attachment disorganization
- Impaired mentalizing capacity in childhood
Triple liability associated with attachment trauma in childhood

- provokes extreme, repeated stress
- undermines the development of the capacity to regulate distress (i.e., through mentalizing in the context of attachment)
- impairs openness to social influence and learning
Beebe: 4-month predictors of disorganized attachment

Second-by-second video analysis, 150s, free interaction: mothers instructed to play with their infant placed in an infant seat on a table; play as usual but without toys.

Strange Situation attachment classification at 12 months

Future disorganized infants’ behavior:

- high levels of emotional distress (facial and vocal)
- discordant responses, e.g., one infant joined sweet maternal smiles with smiles of his own, but meanwhile he whimpered as his mother pushed his head back and roughly smacked his hands together
- behavior erratic and unstable, moment-to-moment, potentially making it more difficult for mothers to read (mentalize)
- low levels of self-soothing, emotion-regulating self-touch
Beebe: Maternal behavior predicting disorganized attachment

(1) gazed away from their infant’s face more often and unpredictably
(2) loomed into the infant’s face more often and unpredictably
(3) did not respond to their infant’s self-touch with complementary affectionate touch
(4) showed less variable emotional responsiveness, that is, relatively rigid, closed-up facial expressions
(5) were less likely to follow the infant’s shifts between positive and negative emotions, for example, less able to “emotionally ‘enter’ and ‘go with’ infant facial and vocal distress”
(6) showed discordant emotional responses, responded to their infant’s distress with surprise or positive emotion. Discordant responses are indicative of denial of the infant’s emotional distress, attempting to ride negative into positive, e.g., “Don’t be that way” or “No fussing, no fussing, you should be very happy”
Mothers are not generally less empathic; rather, failure of attunement during moments when infant is in a state of distress.

I’m so upset and you’re not helping me. I’m smiling at you and whimpering; don’t you see I want you to love me? When I’m upset, you smile or close up or look away. You make me feel worse. I feel confused about what I feel and about what you feel. I can’t predict you. I don’t know what is going on. What am I supposed to do? I feel helpless to affect you. I feel helpless to help myself. I feel frantic.
Parallel contributions to mentalizing: Meeting of minds in therapy

Patient

Therapist
the role of the psychotherapist is to provide the patient with a secure base from which he can explore the various unhappy and painful aspects of his life, past and present, many of which he finds it difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance.

JA: “The mind can be a scary place.”
Patient: “Yes, and you wouldn’t want to go in there alone!”