

13 Mentalization and Structural Functioning: Therapeutic Implications

13.1 The Impact of Structural Functioning for the Embodied Self

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As psychotherapists in the field of psychosomatic medicine we cannot think of the self but as embodied, especially reflecting the conditions of early development in early childhood. In psychodynamic treatment two types of disorders led us into great difficulties for a long time – personality disorders and somatoform disorders – until we changed our aetiological and pathogenetic hypotheses and our psychodynamic view. On the basis of Operationalized Psychodynamic Diagnostic (OPD) we started to differentiate between pathology on a high structural level of unconscious conflicts and the lower level of structural deficiencies concerning functions like self reflection, object perception, regulating and communicating of affects, empathy, understanding bodily signals, internalising gut relational experience and so on. Focusing therapeutic work on these points – similar to Fonagy's Mentalization Based Treatment or Heigl's Interactional Method – we were enabled to cooperate actively even with difficult patients and to develop structural tools, using a therapeutic attitude of parenting. This concept of a modified psychodynamic psychotherapy, which will be discussed in detail, has a great resonance in inpatient psychotherapy as well as in outpatient treatment, especially for patients with structural deficiencies across different diagnosis (e.g. in personality and somatoform disorders) and especially in adolescent and young adults.

Therapeutic Problems Reaching Patients with Personality Disorders

When I read a contribution in German language, I am functioning like a mentally normal person. I can give words to what I think and what I feel; I can play with words using metaphors and jokes so we get into nice interactions.

But, when I try to speak in a foreign language as I do now in my poor English, my level of functioning is like one of the patients I am talking about, patients with structural deficiencies. I have only minimal verbal representations of what I want to say, I am not sure whether I can communicate and I am always afraid to be misunderstood, which can get me into affective arousal and bodily stress.

It is good to know how this type of patients feel and behave because in psychotherapeutic treatment we have great difficulties with them (in every therapeutic approach).

Dealing with psychodynamic therapy since 1970, we started to discuss therapeutic problems in two types of disorders, which are labelled today as personality disorder,

Table 13-1 Clinical traits of structural disorders.

The Patient
<ul style="list-style-type: none"> ● does not understand himself ● does not know who he is ● is not familiar with his own body ● does not understand other people ● does not know how to deal with social situations ● feels emotional, flooded or empty ● gets into interpersonal catastrophes

Table 13-2 Structural deficiencies (in all diagnosis, esp. in personality disorders).

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| <ul style="list-style-type: none"> ● 30 to 40% outpatient psychotherapy ● ca. 60 to 80% inpatient psychotherapy ● bad therapeutic prognosis because of: <ul style="list-style-type: none"> – patients focussing on negative stimuli – dysfunctional patterns of relations – negative counter transference – developing real dependencies – therapeutic crisis and drop outs |
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and somatoform disorder. In those days we had difficulties even in naming them. My 1977 book was titled “Disorders in the Area between Neuroses and Psychoses” and focused on the developmental and interpersonal aspects of the self. Under this perspective the clinical phenomena mentioned above were summarized as intentional communicative disorders (Rudolf 1997).

Our starting point was the difficulty in performing effective treatment on the basis of psychoanalytic theory. Within the last thirty years we modified our psychodynamic theories and changed our therapeutic approach up to the manual of structure-oriented psychotherapy, published in 2004, which had a broad resonance in German speaking psychotherapists (Rudolf 2004). Between the rising of questions in 1977 and the answers of 2004 there is one more important development concerning the diagnostic system OPD which gave us a consensus of psychodynamic concepts and language, so we could do a lot of studies on clinical and therapeutic aspects in severe disorders in inpatient and outpatient therapies (AG OPD 1996, 2006).

What is the main problem of patients with severe personality disorder and somatoform disorder (see Table 13-1)?

- They live as personalities which do not feel alive and hopeful, which do not understand themselves in their intentions and emotions.
- They live in a world which they do not understand in its meaning and which they often cannot bear emotionally.
- Again and again they are getting into interpersonal problems which they cannot understand or manage.
- They live in a body which often keeps alien to them, which they often treat like a slave or an enemy, and which rises anxiety and pain by its malfunctioning. Their body seems to be an outer object more than an aspect of the subjective self.

In summary, the mental person, the bodily self and the interpersonal social situations cannot be integrated in a concept of the self and its relations to the world, they cannot be understood by cognitive means and they cannot be tolerated or regulated emotionally.

All this leads to emotional states of despair and to the conviction of a dangerous world with threatening people and a threatening body. Reacting to this, there occur

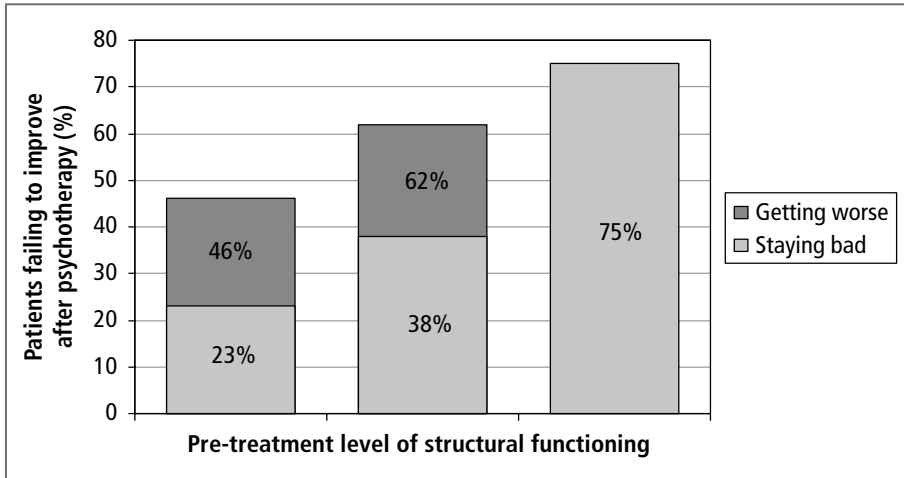


Figure 13-1 Negative outcome due to structural level. Patients with medium or low level of structural functioning have a higher risk to stay bad or get even worse (62% and 75% resp. compared to 46%).

a lot of emergency reactions such as social retreat or building up traits of grandiosity or a depending and demanding for medical procedures or social help (doctor hopping, capacity killing) or an emergency self-management such as self-mutilation, drug abuse, bulimic attacks and so on.

The clinical experience shows that a large number of patients in inpatient psychotherapy and approximately 30 to 40% of outpatient psychotherapy are dealing with these problems (Rudolf 2006b). If these treatments are done in a supportive way, they give wellness to some of the patients as long as therapy goes on, but they show no structural change and no lasting effects (see Table 13-2).

If they are treated in a strictly psychoanalytic way, they take an even higher risk to produce negative effects such as confusing and destabilizing the patients, especially by complex transference interventions. If therapy goes for a long time, it takes a risk to end in a state of high depending and helplessness of the patient who can afford pharmacological treatment or inpatient psychiatric treatment when psychoanalytic therapy is ended. Pre-treatment structural level of the patient is a predictor of therapeutic outcome (see Figure 13-1).

Structural Oriented Psychotherapy: Concepts

Considering these risks, our treatment proposal of structure-oriented psychotherapy follows the same principles as Bateman and Fonagy's (2004) mentalization based treatment does. Both groups (Bateman & Fonagy and ours) worked independently, without knowing each other before the publications. The difference is that we do not

Table 13-3 Roots of structure oriented psychotherapy.**Structure oriented psychotherapy as modification of psychodynamic therapy was supported by**

- conceptual development in Operationalized Psychodynamic Diagnostic (OPD)
- progress in aetiological understanding by research on babies, attachment, developmental psychology
- better understanding of neuropsychological aspects of affects

Table 13-4 Early development of structural functions.

- having affects
- communicating affects
- coping of negative affects by significant others
- sharing positive affects
- differentiating own and others affects
- empathic understanding for the affects of others
- self-reflecting and understanding of own affects

focus only on mentalization but on a broad range of structural functions, which we try to strengthen and to develop, or at least we try to support mastering strategies (see Table 13-3, see also Table 13-6).

As the Fonagy group did, we based our therapeutic concept on early aspects of personality development in the baby-parent-interaction (see Table 13-4). This perspective of the early development stresses the idea of an embodied self. There is a very bodily interaction between the baby and its parents. But also there develops a greater and greater mental attribution when the parents anticipate even the not yet born baby as an intentional being with emotions and aims, as a personality with certain traits and capacities. Parents do not only anticipate the future mental person of the baby but also do an intensive training of interpersonal behaviour with him (e.g. in 30 000 smiling response interactions per year, in the common regulation of painful affects, in sharing affects of pleasure and joy, in shared attentions to third objects, in differentiating own and foreign affects and so on).

We are very grateful for the basic work done by the Fonagy, Gergely and others group, published in 2002. These results helped us to reformulate psychoanalytic theory of early personality development and to come to a new understanding of structural personality dysfunctions and therapeutic consequences.

Now we can understand how a severe postpartum depression of the mother or social catastrophes of the family can block this early animation of the embodied self so that structural functioning remains vulnerable or deficient for the future life. Later the patient as a child and adolescent or an adult suffers of a deficiency of these structural tools which he needs for his emotional, mental and social functioning. In this sense we gave a definition of personality structure as the availability on structural functions which are necessary to regulate the self and to establish interpersonal interactions (Rudolf 2002).

This allows an important widening of the pathogenic concepts in psychodynamic therapy. It seems useful to distinguish between at least three pathogenic conditions. The first of them is the neurotic condition (see Table 13-5), resulting from internalisation of conflictive experience in later childhood with the result of unconscious conflicts, pathogenic beliefs, suppressed wishes and affects, negative expectations in

Table 13-5 Aetiological models.

Conflict related approach
<ul style="list-style-type: none"> • internalisation of negative experiences in object relations (mentalized but unconscious)
Structure related approach
<ul style="list-style-type: none"> • lack of positive relational experiences leading to deficient development of mental tools

relations and so on. This is the well-known classical psychoanalytic topic of neurotic personality development.

The second pathogenic condition means the deficient development of structural functions under restricted conditions of early baby parent relations, that means the deficient stimulation of early emotional interpersonal development such as being seen and mirrored by the parents, regulating painful affects, sharing of positive affects and getting introduced in self reflecting and empathic experience and starting the development of mentalization.

The third pathogenic condition, which I will not discuss today, is traumatization by overwhelming life threatening experiences which can occur in every period of childhood or adult life.

Table 13-6 List of structural abilities.

1. Self-perception and object-perception	
<i>Self-perception</i>	<i>Object-perception</i>
1.1 self-reflection	1.4 self-object differentiation
1.2 affect differentiation	1.5 whole object perception
1.3 identity	1.6 whole object perception
2. Capacity for regulation	
<i>Self-regulation</i>	<i>Regulation of object-relationship</i>
2.1 impulse control	2.4 protecting the relationship
2.2 affect tolerance	2.5 balancing of interests
2.3 self-worth regulation	2.6 anticipation
3. Emotional ability	
<i>Internal communication</i>	<i>Communication with the external world</i>
3.1 experiencing affects	3.4 establishing contact with others
3.2 using fantasy	3.5 communication of affects
3.3 bodily self	3.6 empathy
4. Attachment capacity	
<i>Attachment capacity: internal objects</i>	<i>Attachment capacity: external objects</i>
4.1 internalization	4.4 ability to make attachments
4.2 use of introjects	4.5 accepting help
4.3 variability of attachments	4.6 severing of attachments

Considering this in the initial diagnostic contact with the patient we recommend a diagnostic procedure that not only considers unconscious conflicts and the hidden offers of transference behaviour but also actively checks a list of structural capacities. Learning from our OPD-based studies on diagnostic and other issues we developed checklists for structural functions. The following list (see Table 13-6) seems to be useful for diagnostic and therapeutic issues (Rudolf 2006).

Let me give some comments to these items, especially concerning the embodied self. Most structural functions on perception concern both, mental aspects of the self as well as embodied aspects of the self. Especially in point 3.3 we stress the structural capacity to communicate with a vital feeling of bodily self. Structural dysfunctions usually disrupt the psychosomatic entity; for example the incompetence to tolerate and regulate affects leads to overwhelming emotional tensions (feelings of explosion or implosion, fragmentation and devitalisation), which again leads to emergency coping which is often directed against the own body (self-violation by cutting the skin and so on).

Also patients with somatoform disorders are often structurally unable to differentiate affective signals coming from bodily or from mental stress conditions. They get afraid of somatic catastrophes, if indeed they are running to emotional interpersonal tensions. On the other hand they have no somatic self-perception, especially for the needs and the limits of their bodily capacities as well as they are unable to accept help from good external objects (Rudolf 2008).

Last but not least, all aspects of object related structural functions have an aspect of embodiment (Thompson 2007). For example I want to mention Kohut's idea that empathy is something very close to bodily holding. At least in the early development of the baby all the structural functions are related to intersubjective as well as to bodily experiences, for example in being fed and in bodily care and non-verbal communication so the self of a human subject is considered as a mental one as well as embodied.

Planning and Realizing Structure Oriented Psychotherapy

Let me turn to therapy planning and therapeutic work. Operationalized Psychodynamic Diagnostic (OPD 2006) generally stresses the idea of planning psychodynamic therapy by choosing the foci of therapeutic work and so we do in Structure-Oriented Psychotherapy. This advises several steps to the therapist (see Table 13-7):

- Points 1 and 2 are based of a psychodynamic interview which works out dysfunctional relational patterns, unconscious conflicts and structural deficiencies.
- Point 3 means to build up a hierarchy for the main points.
- Point 4 is important because we regard the patient as an equal partner.
- Point 5 the parental attitude means:
 - being available to support and develop patients' structural functions (e.g. working on self reflecting, self understanding, empathy, regulating impulses a.s.o.);
 - focussing on here and now experiences but more on every day life experiences in this special age of the patient and in his special social conditions;