Transcription: Reflective Function with Dr. Steele

Episode number: 213

Dr. Puder (00:00:13): Welcome back to the podcast. I am joined today with Dr. Howard Steele. He is a full professor in psychology at the department in the New School for Social Research in New York City. He has written multiple books on attachment. He is the chief editor of a journal article called *Attachment and Human Development*. He was co-author in the initial reflective function manual with Fonagy, and he is, I would say, the top voice on reflective function. He teaches it every year; he teaches a course on reflective function.

If you have been listening to this podcast for a while, you know that I have been interested in mentalization-based therapy, which Fonagy and Bateman created. Interestingly, I found out recently that Fonagy and Dr. Steele co-authored the *Reflective Function Manual*. This manual is something I became very interested in because there was an article that I was exposed to, I found, which was really looking at what separates the best therapists versus average therapists.

In this article, they split therapists into three groups. They examined their outcomes with their patients using the OQ-45, which is one of the best ways of tracking session-to-session change in someone. They followed a group of therapists' patients and divided [the therapists] into three groups. They found that the therapists with the highest reflective function had the best outcomes. This accounted for 70.5% of what made the best therapist the best therapist. For me, this was quite remarkable. Usually, in research, when we look at common factors, we see correlations of 0.3. This finding was huge, a significant revelation that made me realize the importance of examining this manual.

Dr. Steele was one of the authors of the manual, and since then, we have been in conversation about reflective function. I thought, why not bring in the expert himself, who has written books on this and conducts courses on reflective function? So, Dr. Steele, welcome to the podcast.

Dr. Steele (00:02:31): Thank you so much. Good to be here, David.

Dr. Puder (00:02:34): So maybe talk a little bit about what reflective function is and how you got into studying this.

Dr. Steele (00:02:42): Sure, I'd be happy to. It takes me back to the early days of my PhD studies, which I undertook in London, England. That's where I met Peter Fonagy and many other people. We were using something called the Adult Attachment Interview, which had just come on stream, as it were. It was introduced in a 1985 publication and I began my PhD studies in 1986.

The publication introducing the Adult Attachment Interview was by Mary Main, Nancy Kaplan, and Jude Cassidy. That was a watershed moment in developmental and clinical psychology. It introduced an interview that asks people to talk about their childhood experiences with their mother and father, as far as they can remember, and then to evaluate those experiences via questions like, "Why do you think your parents behaved as they did during your childhood?"

Now, some people, when they are asked, "Why do you think your parents behaved the way they did during your childhood?" might say, "My parents, why they behaved the way they did? How should I know? You got to ask them." Or, "My parents behaved the way they did because they loved us. Don't all parents love their children?" Yet, other people respond to that question differently, saying, "I have to think about my grandparents and the lessons that my parents learned from their parents. Which they may have been guided by in how they behaved toward me as a child."

When we saw those kinds of responses in the Adult Attachment Interview, we thought, "This is fascinating." Some people, when they are asked to talk about other people in close relationships, make an informed guess as to what the motives were that guided the behavior of the others. Now, in the initial scoring system that is still valid and used, and I teach it in two-week Adult Attachment Interview institutes, there is a notion of metacognitive monitoring.

What that is speech as behavior and when we monitor our own speech, we have the capacity to stop and correct ourselves and we do it all the time when we say: "Oh, I didn't quite mean that. Let me put it differently." That is a virtue if we can do that, but we looked at that idea and we said: monitoring your own speech, behavior, and thoughts. What about monitoring other people's speech, behavior, and thoughts like some people do when they are asked, "Why do you think your parents behaved the way they did during your childhood?" So we expanded that notion of metacognition and eventually came to call it reflective functioning.

And Bateman and Fonagy, as you rightly pointed out, took the reflective functioning idea and turned it into mentalization-based treatments, which are everywhere for every kind of problem that people might be having. So there's something very powerful in the idea of reflective functioning.

I will say two or three other things about it: It is not a new idea. People, since they have been studying psychotherapy, have known that psychological mindedness is a good thing that goes back many decades. Psychological mindedness is a nice idea; it speaks to the possibility that some people might have an informed idea about how the mind works, but there was no way of measuring it, operationalizing it. Similarly, there was an idea of the self-observing capacity of the ego when ego psychology was very popular in the 1950s, 60s and 70s. There was not a great way of measuring that. With reflective functioning, we have taken those ideas and come up with an 11-point scale from very low reflective functioning, even hostility toward the idea, to people who embrace, play with, explore the idea of guessing what's in the minds of other people and what are the motivations that other people have for the behavior that they show.

Dr. Puder (00:07:28): I will just jump in here, -1 is the lowest score, and nine is the highest score, so -1 would be, and we all have heard this in clinical practice, it is like, “What was that like for you as a kid?”, “I don’t know, you tell me you’re the psychiatrist.” So it is a denial of…

Dr. Steele (00:07:47): It is more than a denial. It is a harsh rejection of reflective functioning. It is sort of like, “How the hell should I know the answer to that question?”, and as if you are repelling the possibility of thinking about the motives guiding other people, that is minus one. When we saw that we had to create that minus one point when we looked at interviews from people incarcerated for violent crimes and people who were incarcerated for repeat drunk driving offenses. So those are people who have not been well loved, who have not been given the experience of interacting joyfully with another human being, and so they’ve probably had a lot of harsh, very abusive experiences, and they are abusive in return. Not everybody, we know about resilience and reflective functioning is the way out of harsh experiences, but those people who commit violence toward other people, it makes sense that they would not have an appreciation for the humanity of the other and if you don’t have that appreciation, then you can, of course, behave quite dismissively and violently.

Dr.Puder (00:09:08): Are you talking about the Cassel Hospital study? Is that the one?

Dr. Steele (00:09:12): Yes, that is right.

Dr. Puder (00:09:13): Is it correct that you were the one actually doing the Adult Attachment Interviews or grading the Adult Attachment Interviews on that study?

Dr. Steele (00:09:22): I was reading and rating the attachment interviews on that study. There was a research assistant collecting them. She got into a little bit of trouble with the therapist on the hospital ward because she was showing a lot of interest in questions in the attachment interview. She frequently asked, “Do you think that had an influence on the kind of person you are today in adulthood? Do you think that had an influence? What about your mother? What about your father?” And then those patients went to their therapists and they said, “Why aren’t you so nice and inquisitive as the researcher who asked those questions?” It was not so much the Cassel Hospital study because those were inpatients on a psychotherapy ward. No, it was studies done in prisons with incarcerated individuals that I could share the references with you.

Dr. Puder (00:10:20): The Prison Health Center study. Right. What was interesting, when I saw the mean reflective function score was 2.5; this is 22 prisoners, 11 of them with BPD and compared to that, to normal controls of 5.8, so remember 11-point scale, I am going to be talking numbers, we are going to learn it: negative one is the lowest, nine is the highest. So the prisoners on average had a score of 2.5.

Dr. Steele (00:10:47): Let’s not confuse prisoners with that Cassel study. They were not prisoners. Those were psychotherapy patients. 2.5 average was the average of people living with long-term mental health troubles. We think of anyone with a score of three or lower as

having low reflective functioning. That is, people have difficulty, in an organized way, guessing what is in the mind of the other.

Dr. Puder (00:11:19): Okay, thank you for that clarification. The Cassel Hospital study, this was inpatient psychiatry, but what I found interesting about this study was that the average for people with borderline personality disorder was 2.7 standard deviation of 1.6, whereas like depression was 3.8. It is still low, so I am looking at these numbers. I am trying to compare them.

Dr. Steele (00:11:42): I know that table you are looking at in the clinical sample studied in that paper, the lowest levels of reflective functioning were shown by the people whose primary diagnosis was borderline personality disorder or individuals living with an eating disorder. Then depression was a little bit higher and the average for the community controls was above five.

We think of five on the 11-point scale. That is a good enough score. Somebody who shows moderate levels of reflective functioning.

Dr. Puder (00:12:19): One of the reasons why I think this is so powerful is because there is this study on transference-focused therapy. With the transference-focused therapy, they are meeting twice a week with the therapist and they are talking a lot about what is going on between them and the therapist.

In this study, there was an increase in reflective function from the beginning to the end of the study. Whereas, one of the control arms was dialectical behavioral therapy, which I imagine if you are a dialectical behavioral therapy fan, you probably will look at this study and find some problem with how they did dialectical behavioral therapy, in this study. But, nevertheless, transference-focused therapy had an increase in reflective function. I am trying to pull up those actual numbers.

Dr. Steele (00:13:09): That is a study by Ken Levy and colleagues that was helpful in validating the concept of reflective functioning and showing that, through therapy, even with people living with the troubles that borderline personality disorders suggests, there are treatment modalities that can move people to a higher level of reflective functioning. And in brief, we can call that a move toward a greater appreciation of the humanity of other people and one's own humanity with all the complexity that that includes.

Dr. Puder (00:13:46): Okay, here are the actual numbers: the mean start of reflective function in that study was 2.86 and it increased to 4.11, whereas the DBT group showed no improvement, and the supportive psychotherapy treatment showed no improvement.

Dr. Steele (00:14:08): Bateman and Fonagy say that their mentalization-based treatment is very similar to transference-focused psychotherapy. There's a lot to be said for dialectical behavior therapy. I think you are right to say that someone who practices DBT might want to study that paper and ask who is delivering the DBT? Because I do think that DBT is not so

different from MBT, either. In mentalization-based treatment, you monitor the patient's thoughts and feelings; in DBT, you closely monitor the patient's behavior.

Dr. Puder (00:14:43): Right. I want to get a little bit more help in wrapping our heads around what we are actually looking at. I think one thing that I found helpful when I was trying to understand this was, when you are looking at the Adult Attachment Interview, you are really focused on a couple key questions in the Adult Attachment Interview and scoring the reflective function. Like, "Why did your parents behave as they did during your childhood? Do you think your childhood experiences have an influence on who you are today? Did you ever feel rejected as a child?" What is it about these certain types of questions? Why is it helpful to look at those questions when gauging reflective function?

Dr. Steele (00:15:28): Thanks, David. Those questions include the word why or how. They are questions that demand evaluation or demand reflection. If I ask you to describe the childhood experiences, you can remember from the family into which you were born, there is no requirement to be intensely reflective. You can simply say, "I grew up in this place. My father and mother were involved in this work outside the home. I had two or three siblings, or no siblings. There was a dog. There were grandparents." It is a question asking people to describe circumstances. In describing circumstances, it's quite important, but it's not reflective functioning.

Reflective functioning is the task of thinking about why people in our lives behave the way they do. What motivates them? What motivates us? How can I think about ways of connecting with other people and showing some understanding and empathy toward them?

Dr. Puder (00:16:41): If the person responds to, "Why did your parents behave as they did during your childhood?" and you said, "Well, my mom was a narcissist and that's why she behaved that way." Is that low reflective function or high reflective function and why?

Dr. Steele (00:16:57): When people use clinical terms like that, my mother was a narcissist, my father was a chronic depressive, we do not consider it reflective functioning. We consider it a bit of a cop out, drawing on some label that is widely used in the psychiatric or clinical psychological and social work literature but it is not emotive, it is not personal. We say to ourselves about the use of those words, you cannot score the passage above a three. You have to decide how low you go, but three is miscellaneous, low reflective function, simple reflective function, or a hyperactive reflective function as if someone is spinning their wheels in the sand and not going far. That would get a score of three or lower and would never be scored above a three for that reason.

It is a bit of a cop out; it is leaning on some well-known label that applies to many people. With reflective functioning, we want people to talk in a way that speaks about events and circumstances deeply personal to them, with details about parents' life, mother's life, father's life, other people, and to lean on labels is a bit of a cop out, but it's understandable because there's some safety in doing that.

Dr. Puder (00:18:32): I think that was a very helpful point for me to come across. I found out about reflective function through reading this score that talked about what are the best therapists. So you have to imagine the best therapists, the high reflective function group, this was seven or higher. And I was thinking to myself, "What is it that someone who is seven or higher doing? What would it be like to sit in the presence of someone who is seven or higher? This is seven or higher about their own attachments. I think some people are very skillful at empathizing with people they are disconnected from. This is like looking deep. This is someone who has looked deeply at their own childhood. Right?

Dr. Steele (00:19:16): That is right. The other thing is, and I will answer your question, but reflective function can also be observed in literature.

We see high levels of reflective functioning at the level of seven in some of the most classic, important, enduring pieces of writing. Not pulp fiction or romantic novels so much. Those are great examples of description of passionate states of mind, but the complexity of mind and the capacity to hold multiple distinct truths that on one hand seem contradictory, but the person with level of seven can hold them together in a way that shows a valuing of relationships or a valuing of attachment.

The other thing to note is that in the reflective functioning manual, we have discreet dictionary-like definitions of moderate to high reflective functioning that goes into a score of seven. There are 23 discrete indicators of moderate to high reflective functioning.

There are only six or seven indicators of low reflective functioning. Low reflective functioning indicates a narrowing of the mind. High reflective functioning represents an opening of the mind to a range of possible considerations from a point of humility.

One of the central characteristics of high reflective functioning is that the speaker shows an awareness of the limitations on understanding. There's an impossibility of knowing exactly what is in the mind of others. You do not get a high score for saying, "Why did my parents behave the way they did? I know exactly why they behaved the way they did." That is not possible. It is not possible for us to have a transparent, clear understanding of our own minds. The issue, at heart, is whether we give up on that account and say that is impossible. "I cannot understand who I am or other people it, fuck it, I am not going to engage with you about this topic."

But the interesting thing is that the person with a score of seven says, "It's worth it. I am going to take a chance at guessing what are the motives of other people that I care about. How did they come to be the people they are? And how did I come to be the person that I am? I am referring here to the recognition that there are limitations on insight, a kind of psychodynamic idea. Can't understand everything.

Freud had the notion of over-determination that anything we care about was determined by multiple causes that we won't ever be able to fully capture, but it does not mean we should not try.

Dr. Puder (00:22:14): In the reflective function manual, 4.1.1, the opaqueness of mental states, this is the idea that the person who is receiving this Adult Attachment Interview is tentative about their hypothesis on other people's feelings or thoughts. They are acknowledging the complexity of it. It is not completely clear. The glass is not completely clear, it is a little bit opaque. Is that kind of a good way of understanding this?

Dr. Steele (00:22:50): Absolutely. People know those shower doors that are opaque, you take a shower, you do not want someone to look into the shower necessarily. We choose to create windows and glass like that. The notion is, when we look into the mind of the other, as I look at you, David, and with your earphones on, I try to guess what is in your mind. I can be tolerably accurate, I hope, but I cannot know for sure. So there is an opaqueness around mental states and related to that as well, is the notion that mental states are amenable to disguise (4.1.2).

Dr. Puder (00:23:38): Yes. Good, good.

Dr. Steele (00:23:39): What I am referring to here is the fact that a three-year-old who gets a gift from their grandmother that they hate, the grandmother's going to know it. The child might give a sad, sad face look to the parent, throw the gift down, the grandmother will know. A three-year-old is more transparent in their feelings than that same child will be at age seven.

At age seven, a child who gets a gift from grandmother that they do not like, grandmother is going to hear a nice thank you. They won't know that the child hates the gift. The child will know that you have to show on your face one emotion while you feel inwardly another, knowing that mental states are amenable to disguise, is a good thing.

Dr. Puder (00:24:30): One of the examples of a four, was, "I am so angry at her, but I would never show that to her." So why was that only a four and how would it become more than a four?

Dr. Steele (00:24:51): It is only a four because it suggests that the speaker understands that mental states are amenable to disguise, but the example is not detailed enough to merit a score of five. We give a score between three and five (that is a four). Now it would be more than a four if the person said, "I was so angry at her, but I tried not to show it. She was my mother. I depended on her and I did not want to inflame her anger even more. And so I protected myself by not showing my anger."

Something a little more detailed and personal is required to give a higher score of five. We often settle on those interval points between the odd numbers. A four is not a bad thing. You saw in the study of people with borderline personality disorder. That was the outcome from therapy.

The other thing to say is, we score when we look at a transcript, and it is possible to score reflective functioning in psychotherapy transcripts, not only in attachment interviews, in any spontaneous speech sample. What we do is we circle every mental state word.

Every time somebody says: I think, I feel, I considered, I realized, I thought and the word KNOW is interesting, because sometimes people say, “How should I know?” We circle the know, and we ask, “Is this being used in a way that advances an understanding of self, other, and relationships? Or is it being used defensively” with, “I don’t know”, or “How should I know?” That’s rather defensive, shutting down conversation, rather than opening it up.

Dr. Puder (00:26:51): I think it might be interesting to go back to this idea of literature. I know I am jumping around, but do you have any passages that you can pull up and read to us, and explain why it is a high reflective function passage?

Dr. Steele (00:27:08): This dawned on me when I went to a conference a few years ago, David, discussing reflective functioning and literature.

There is a Vietnam memoir with the title, *The Things They Carried*. The author, Tim O’Brien, writes a powerful memoir of the thoughts and feelings an American military person had of their memories of their experience in Vietnam. They talk in a very compelling way about what motivated them to accept the draft and go away, the close relationships among comrades, and the fears, the dreams, the hopes that that person had. Then, on return, the thoughts and feelings that the author had about family life, the impingement or difficulties they had.

So there is one point where the author of this book, *The Things They Carried,* remarks on his daughter asking him, “Did you kill anybody when you were in Vietnam?” He gives a very thoughtful reply that there are sometimes circumstances where you have to protect yourself and engage in behavior that you regret, but all the same, it’s required and it’s all very complex. As I cited these remarks about the book, somebody approached me afterwards and said, "Tim O’Brien had spoken on a previous occasion, and put into the book a lot of fictional stuff, and he was not a parent, there is no daughter, but in imagination, it made a very compelling story.”

I wanna make that point that we see high levels of reflective functioning in literature; it’s a reflection of the imagination of the writer.

Dr. Puder (00:29:30): Absolutely. I think all good literature probably has higher reflective function. A future lawyer is working for me on some projects. I have been having him read through the *Reflective Function Manual* as he prepares his personal statement. We’re trying to increase the reflectiveness, you know, in his personal statement. Because I think that something intuitively that we know, when we see it, it is beautiful. Like Shakespeare and Dostoevsky, they can describe in a couple lines what it might take me two pages. It is so densely packed with such beautiful ways of describing things so concisely.

Dr. Steele (00:30:08): Maybe it would be helpful if I tell you just the broad outlines. We have talked about two of the 23 indicators of moderate to high reflective functioning. The opaqueness of mental states is amenable to disguise, but the 23 indicators break out into four domains. First of all, what we have talked about—opaqueness of mental states, mental states amenable to disguise—those are part of five examples or indicators of how people show an awareness of the

nature of mental states. Then there are seven indicators to do with links between mental states and behavior. There are further seven indicators to do with developmental aspects of mental state.

Dr. Puder (00:30:49): Mental states with behavior. How would you describe that?

Dr. Steele (00:30:58): One example of that is when people make what seemed like accurate attributions of mental states to others.

Dr. Puder (00:31:06): When a person gives a specific common sense account of a behavior in terms of the thoughts or the emotions that underline the behavior.

Dr. Steele (00:31:18): We can say, for example, you have listeners who will be watching this video. We can guess that many of the listeners will be very curious. Many of the listeners will be perhaps a little bit frustrated if we are not making clear what reflective functioning is and those are accurate attributions to your listeners. That would be an example of that.

Then the other thing is speculating on mental states underlying behavior. You are asking me interesting questions about reflective functioning because you are motivated to come up with a compelling podcast, a compelling conversation, and you want reflective functioning defined.

That might be an example of mental states tied to behavior. There are many different elements to this but it is talking about the here and now and how mental states influence behavior and how behavior leads to mental states. The developmental piece is the there and then, back then in the past. How are my thoughts and feelings changed about the past?

Dr. Puder (00:32:32): Let me deepen my sort of reflectiveness on the audience at this point. The audience at this point, most of these people who listen are mental health professionals, or they aspire to be mental health professionals or the serious curious, the person who is really wanting to take their own mental health journey to the next level.

Pretty much, every person that has reached out to me to, to consult on a case or see me to do some work, I run the Big Five on them, and they all have one thing in common. So the Big Five is the most studied personality inventory. They are all high openness, like two standard deviations above the mean. Which, I wonder if there is something about the way that I ask questions, or the topics that I cover, or how I cover the topics, that it just drives anyone who is not high openness absolutely crazy.

Because I am not just telling people the answer. Often I am trying to say this is what we know, and then you have to form your own conclusions. You have to dig deeper, you have to be curious. I am on a journey with them. So I'm on a journey. When I reached out to you this week, I was like, okay, I'm ready to do this episode.

Out of all the episodes I want to do, it is this. I want to learn more about this. I know I can struggle through the manual. The manual is dense. It is hard to read. So, my hope is that if

someone's listening to this, they will be curious enough to read the manual, maybe read some of your research that you have done, actually look at the hardcore papers. I think there is a lot of meat there to understand human nature, to understand what we do as mental health professionals. So, I am imagining someone listening to this and hoping that it gives them a little bit of a head start when they start to crack open those studies and the manual. I kind of have a framework, I have this general idea of what we are talking about here. Because it is hard to understand, but people want something deeper than just the superficial attachment research. I think it is hard to know how to get into it. It is hard to know how to jump into it.

Dr. Steele (00:34:51): Maybe this is a good point for me to say that I, once or twice a year, I offer these three half-day seminars on reflective functioning. What we do is we get right into reading interviews and what it means to circle mental state words and think about how that mental state word is being used.

Is it being used, as I said earlier, to advance an understanding of self, other, and relationships? Or is it being used to kind of shut down thinking to close off the conversation? I am gratified by what you say about the high levels of openness among your listeners because I think that is actually an important part of reflective functioning. The capacity to be patient, to be reticent if you like, to wait and see and listen and ask questions and form a judgment that you have high confidence in, but not absolute confidence in.

Dr. Puder (00:35:54): High openness people, they are usually more creative. I find that if you are very high openness, like two or three standard deviations above the mean, you usually do some sort of art: writing, drawing, artwork, or music. Often these people make good therapists because when they approach someone, there is natural curiosity, an openness to discover something new that they did not know before.

Dr. Steele (00:36:28): I mean, another thing that is relevant here, and many of your listeners will know about the value of metaphors. There are therapists who work from a point of view, they want to encourage their clients or patients to use metaphorical language. There is an overlap between metaphorical language and reflective functioning. I had a PhD student, Lauren Dent, some years ago show that empirically, but it was reflective functioning that predicted child outcomes better than metaphor use. It is the case that reflective functioning overlaps with so many of the things that psychiatrists, psychotherapists, counselors, social workers, aim to teach the people that they're trying to help. I think the piece of it that I think is so central and vital is the developmental piece. We see that very clearly in response to the question that you raised, "Why do you think your parents behaved the way they did during your childhood?"

And when someone talks about their grandparents in response to that question, they are taking an intergenerational perspective. We all have a history. We are very curious about ancestry. There is Louis Gates on PBS helping famous people explore their ancestry. We know that we have a history, but some of us are more interested in it than others.

To be interested in your history, your own personal history, the history of your parents, history of your grandparents, that is a good thing. It might well dovetail with taking an intergenerational perspective, taking a developmental perspective, revising thoughts and feelings about childhood in light of understanding gained since. I'm sure you and many of your listeners will be able to think about aspects of their childhood experience that they have changed their thoughts about. There's one of the most powerful examples of reflective functioning that persuaded us that this really matters, was a pregnant woman expecting her first child and she used the word fear to describe her relationship with her mother during childhood. And she was asked to elaborate on it.

She said, "It was one thing that I recall about my childhood, as if to say there's other things I recall, there's other things I don't recall, but this is one thing I can recall, that my mother's way of keeping control was to frighten us because she was physically unwell, frequently physically unwell, and in a lot of pain. It suited her to keep us at a certain distance and frighten us. Now, as a child, I felt very frightened. You learn to cope with that as you get older, but as a child, I remember feeling very threatened."

The interesting thing there is, it is a coherent speaker who gave more detail than I conveyed, who could talk about an experience in childhood when fearful emotion was felt, but as an adult recalling it, they do not feel afraid, they feel organized, they feel thoughtful. They can describe childhood, their thoughts and feelings as a child, and indicate that you learn to cope with that as you get older. She had a quite positive relationship with her spouse, and she was able to talk about positive experiences in therapy that no doubt helped. The central piece here is that we gain reflective functioning through conversations with other people.

Dr. Puder (00:40:16): I would say in my own therapy journey, which is ongoing, it is not complete. Will it ever be complete? I do not know. Every now and then, I realize something else in the pieces of things, and that helps me understand something that was going on. I am curious, in your own journey, doing your own work in psychotherapy, has learning about reflective function been helpful for you? How have the two intermixed?

Dr. Steele (00:40:59): I agree. In my own journeys, reflective functioning has been enormously helpful. I've actually, early in my career, I was patient in a quite a classical psychoanalyst experience where I was lying on the couch five days a week for about 15 months until I said, "This isn't for me." I did, in the process, come to some understandings of my childhood that I did not have before.

As a young man, for various reasons, I was very angry with my father and it was troubling. But, I learned in that not so satisfying psychoanalytic experience, that he was doing the best he could. I did not any longer feel a need to be angry with him. So, that is one typical experience that people arrive at new understandings of their parent's behavior that, prior to that understanding, they were troubled and preoccupied with; that's one thing I can share.

Dr. Puder (00:42:13): Can I ask a follow up on that? It sometimes happens with transference that you feel some of that anger towards the therapist that you may have felt towards your father. Was that part of the journey that was helpful maybe at the time or later on?

Dr. Steele (00:42:34): That was part of the journey, and, of course, now people work with interpersonal, particularly in the contemporary world in New York City, there are many different interpersonal styles of therapy that do indeed pay attention to transference/countertransference.

They do so from a relational perspective where the experience of transference is also acknowledged as a kind of enactment that each partner to the interaction are participating in. Where the patient ascribes, if you like, a role to the therapist and elicits from the therapist behaviors that remind the patient of typical interactions from their childhood or adolescence or past.

Knowing that one can look at it and talk about those enactments and what was it that I was communicating that might have elicited that behavior? Why was the therapist willing to engage in that role that was assigned to them? It is all very much in the domain of reflective functioning.

Dr. Puder (00:43:49): Do you feel like that style, which I tend to lean more there compared to the classical, analytic perspective, that it is 100% the patient. In this sort of new genre of attachment work and probably stemming from attachment theory comes this idea of enactment, where you rather enter into a role that might actually be a different role than you are not usually in with a particular patient. Maybe in your early analyst work, somehow the analyst got drawn into the role more of your father, and kind of embodied some of those characteristics in some way. Is that what you are saying?

Dr. Steele (00:44:41): No, that is fine. I think you put it quite well. Ned Ackman, I mean, my teacher of that stuff was someone called Joseph Sandler who said that we have scripts in our minds that bring us a sense of comfort and safety. Because they are very familiar. Scripts for how other people are likely to behave, people in power, how they are likely to behave, how I should behave in response and what we do with transference is we bring those scripts into view.

I will give you a definition of transference. It is a thing we do to make the strange seem familiar. I try to elicit behavior from you that reminds me of people that I am very familiar with and if I can do that, I am going to feel safer. I should, if I'm doing that, it would be helpful if I know that I'm doing that and with you to analyze why I am doing that and consider ways of interacting with more freedom in the present that acknowledges you are a person in your own right and I shouldn't try and impose a role on you.

I should listen to you and see what it is you can teach me, what it is we can achieve together. I would put it that way. You are quite right that attachment is hugely popular. I think it is so popular because attachment research has validated an important assumption of Freud and that was the assumption that what happens in childhood matters and has an influence on later development. We have some 50, 60 years of research showing that that is just the case. That childhood

experiences with attachment figures—mother, father, and parent substitutes—influence how we relate to other people across the lifespan. There is robust research along those lines and **reflective functioning is one of the mechanisms that allows people to overcome adverse experiences and arrive at an understanding of them that frees the individual to be more secure and promote security in others.**

Dr. Puder (00:47:06): I want to jump to this one study by Peter Fonagy, et al. 1996, of 82 non-psychotic inpatients.

In this study, he looked at the interaction between abuse, reflective function, and borderline personality disorder. He concludes that the likelihood of reported abuse being associated with borderline personality disorder was greater in the group of patients with low reflective function than those with high reflective function. Thus, reflective function in itself does not appear to be an independent risk factor for borderline personality disorder, but is highly predictive of borderline personality disorder in the presence of abuse.

Has that research been found to be true, as studies have been repeated, have there been studies that have countered that kind of idea? The idea that I'm hearing here is that you have some child with lower reflective function who undergoes abuse, and that kind of seems to be highly linked with borderline personality disorder later developing.

Dr. Steele (00:48:14): Peter Fonagy talks about this as the paradox of reflective functioning, that when we need it most it is unavailable. For the child who is suffering from neglect and likely abuse, it would be good if they had a sibling or an alternate parent who could help them understand what's going on, but often that's not the case.

In the moment when we need it most, we are activated with amygdala activation, and we are fearful and in a fearful state, we cannot engage in making sense of our experience.

That is the kind of experience that may lead (not in all circumstances) to borderline symptoms and eventually borderline pathology, but you have the Ken Levy study and work of Fonagy and Bateman to show that mentalization-based treatment, calmly attending to the mental states of patients, validating their thoughts, inviting them to consider other people in the group, all of that facilitates reflective functioning and helps people with borderline personality disorder move out of that diagnostic category and achieves success at work and success in relationships.

The study that you cite from 1996, yes, it just suggested that there are different pathways to borderline pathology. Some of them include explicit examples of abuse, some of them that is less clear and I think that is validated in other reports.

Dr. Puder (00:50:05): Going back to this initial study that excited me about reflective function, let me just pull up this image so you can see how pronounced this is. If you are on YouTube, you can kind of see what we are looking at here.

This is the OQ-45 and the different patients changing over time, comparing the different high reflective function, medium reflective function, low reflective function, you can see the OQ-45 in that low reflective function group does not change, in the medium it decreases, but the slope is not as large as the high reflective function group. So more than just mentalization- based therapy or transference-focused therapy, I think what we are seeing across modalities is that a high reflective function therapist is going to give the best results. Therefore, my listeners are going to be curious—how do we increase our reflective function? What do you think?

Dr. Steele (00:51:04): I think being familiar with the concept and how to measure it is one way of increasing one's reflective functioning.

As we highlighted earlier, reading literature, reading poetry, being appreciative of the diverse ways that people make sense of experience is all very helpful. There is a fourth element of reflective functioning that we have not talked about very much, which is **mental states in relationship to the interviewer**. I think the point there we've sort of demonstrated a little bit is each of us tries to imagine what are the aims, goals, purposes of the other in this conversation. I think that simply engaging in curiosity, organized curiosity, about the motives that underlie behavior and the mental states that are the consequences of behavior, is going to be very helpful.

Of course, we know in many forms of therapy, tracking feelings is central, so often as psychotherapists, we inquire about the feelings of the other or the thoughts, but there is a keen interest to track the emotions underlying the speech and underlying the behavior of the other. So much so that we have a very successful mode of therapy known as emotion-focused psychotherapy.

Dr. Puder (00:52:36): Which I do not know if you heard, but Sue Johnson passed away yesterday.

Dr. Steele (00:52:41): That was, that was on my mind and led me to mark on that. Of course, that was Les Greenberg and Jeremy Saffron's creation many years ago and then Sue Johnson trained with them and made an enormous contribution in the couple's therapy work. She did not call it reflective functioning necessarily, but she did call it emotion focused and the goal of the therapy was to get people to talk about their feelings.

Dr. Puder (00:53:07): So a couple things. One is she was on the podcast, so I got to meet her and interact with her, which I never felt like I would be able to, which was a huge blessing. Like I never imagined myself when I was going through training a decade and a half ago, being able to interact with her. She is a wonderful person, just absolutely wonderful and her writings, her approach is absolutely phenomenal. I was saddened. She had a three-year fight against cancer, which is publicly known.

Dr. Steele (00:53:45): That is right. I gather she was 76 when she passed away a couple of days ago. She spoke at a conference. I had the pleasure of meeting her and hearing her speak

at an international attachment conference that took place in Vancouver, Canada in July, 2019. I knew her before that. Of course, it's experiences of loss and trauma that destabilize us. Bowlby said that they, if it's a loved one who's suddenly lost, we feel disoriented and disorganized, which is the antithesis of reflective functioning—disorganized—not being quite sure where you are—disoriented—not sure what time it is. Reflective functioning is all about mapping our circumstances. Thinking about time, thinking about what precedes what, what follows from what. Reflective functioning is a path out of loss, out of trauma, and is a powerful proxy for what we call resilience.

Dr. Puder (00:54:55): Thinking about Sue Johnson, I have had some EFT therapy that I have experienced myself. I think one of the most helpful aspects of it is like, let's say you're angry, and that's kind of what's on the surface. I think what EFT does well is it helps you find other emotions like fear and maybe sadness that are underneath the anger.

For example, I had a patient just the other day who said, "You know, I don't feel respected. I feel angry because I do not feel respected by my wife." And then I helped him reflect deeper on what are the things that are underneath that, like, is there a fear of not being appreciated for all the hard work he does. His attachment with his parents, where his dad demanded respect, or there was corporal punishment. So he got imprinted this idea of respect is absolutely needed all the time.

What has been helpful in learning about this just in the last couple months for me, is it allows me to put words to something that it is like I have heard from different types of therapies, but it gives me a number to that, he is starting with a low reflective function stance as a therapist, I'm trying to help him deepen his reflectiveness on this, which is essentially what EFT does well for couples. I think Sue Johnson did a great job of charismatically convincing people of that.

Dr. Steele (00:56:52): Of course, it is a validated model for work with individuals, as well, and mining the emotions and asking people to think about what else might be going on. "What else might you be feeling?" Suggesting that complex blended emotions are very common and to the extent that we can acknowledge that we can come around to an appreciation for ways of changing, ways of evolving, ways of being more available to others that we love.

Dr. Puder (00:57:31): One of the areas of research I definitely want to highlight, that you have actually done, is you looked at the dyads between the mother's reflective function and the child's attachment. I was wondering if you could talk about the main studies that you did on that, and what were the findings?

Dr. Steele (00:57:56): The principal first study on that was the interviews we did with expectant parents—mothers and fathers expecting their first child.

We found that reflective functioning in the mother's interviews and reflective functioning in the father's interviews was a powerful predictor of child outcomes. It was most powerful, most

compelling, most strong when there was some notable adversity that the parent had dealt with, come to terms with, overcome in the context of valuing relationships where it was strongest.

For example, we at one point, sorted the maternal interviews into two groups—groups who experienced low levels of deprivation during their childhood and others who experienced high levels of deprivation during their childhood. If they had high levels of deprivation and had acquired and shown reflective functioning in their interview, 100% of the infants were securely attached. You've probably had previous speakers discuss what secure attachment is all about at one year of age.

Dr. Puder (<u>00:59:12</u>): Hold on, did I hear that correct? So they're scoring the Adult Attachment Interview of this adult, and this adult has been through really hard things, they have overcome it, and they are now secondarily able to talk about it in a nuanced way, they are not scattered. It is a cohesive narrative. Is that what we are talking about?

Dr. Steele (<u>00:59:43</u>): That is what we are talking about. In fact, I can show you a slide that details this. I was talking about the image on the right—mothers who experienced high levels of deprivation—and look at the sharp contrast. On the one hand, 10 mothers who experienced deprivation but showed high reflective functioning, all of their children at one year of age had a secure attachment to them. I'll define a secure attachment as the following:

A child who's securely attached when they're distressed, they have only one question in mind. Where is mother? Where is the caregiver? I am going to get back to her.

The insecurely attached child has at least two or three questions. I am troubled, but what is going on for my parent? Are they available? Are they going to be someone I can confidently turn to, or should I deal with this on my own?

Or should I kick up a big fuss or should I be afraid? Those are the kinds of questions that insecurely attached children ask.

The green are children who know where their safe base is, where their safe haven is, where to go when you're distressed. That is essential in life to know where your safe base is, securely attached children and securely attached adults know this, and they manage on their own a lot of the time. After, once they go, once we get to school-age years, we have to manage on our own, and it becomes an issue across the lifespan, but as John Bowlby said, "We are dependent on others from the cradle to the grave." The pursuit of independence is a false goal. Anyways, deprived. Look at the other one. Mothers who experienced deprivation, and they were **low in reflective functioning**, 16 mothers, 15 of them had insecurely attached children, so against the background of deprivation, reflective functioning <u>predicts infant mother attachment security 95% of the time</u>. That's a very high statistic.

Dr. Puder (<u>01:01:58</u>): This, this is not like a 0.3 correlation, guys. This is like very, very clear.

Dr. Steele (01:02:04): Remember, it is language in one generation, the parent, the mother, and behavior in the one-year-old infant in the next generation. On the left, my left, the non-deprived group, it is still the case that if they had high reflective function, the children are more likely to be securely attached, but there are many more mismatches, and the prediction is more in the level of 65-70%.

That is why in this paper from 1994, **we argued that reflective functioning should be seen as an indicator of resilience against adversity.**

Dr. Puder (01:02:43): I have heard, the best gift you can give your child is to develop your own psychological mindedness before the child comes.

This is why of the importance of therapy for people who want to have kids, if they have had especially a really tough childhood, to work out some of those conflicts. What I have found in being a parent is that at every age, as my kids grow up, it somehow triggers some of the stuff that happened to me at that age. It's like I have to simultaneously work through.

Dr. Steele (01:03:29): That is right. As parents, we have to acknowledge those moments where we find ourselves automatically, unwilling, unwittingly behaving in a way very similar to our fathers or our mothers or somebody else to notice that is the beginnings of changing that pattern.

Dr. Puder (01:03:47): It is like, I notice a pull towards this type of parenting style, but I am choosing to do this.

Dr. Steele (01:03:56): That is a good way of putting reflective functioning. It speaks to that capacity in all of us to take control, some measure of control, over our experiences, our history, and achieve a state of meaning regarding those experiences. That is likely to change over time, but, nonetheless, if we can arrive at some valuing of the present, based on a reworking of the past, that is not a bad place to be.

Dr.Puder (01:04:30): One scoring method of reflective function, which was interesting to me, was how, if you use cliche terms, it is actually lower reflective function.

The highest reflective function people have a unique story. It is a story that you haven't heard before. I think about literature, as well, like good literature. It has that theme, of this is not just the story that you have heard a thousand times. There is something unique about it. There is something very sort of personal, I am wondering if you have any thoughts on that specifically and how that relates and maybe teach us about that.

Dr. Steele (01:05:16): Sure. Thanks, David. These days I am reading a lot of the writings of a psychoanalyst called Edgar Levinson, who writes from the interpersonal perspective. He argues that imagination is a foundational kind of motivational system and it is tied in with memory. In our psychotherapeutic work, we ought to be eliciting a detailed personal story from our patients, opening things up. From that place of digging around and remembering the details of childhood

experiences, the roles that different people played, a narrative is developed that has, I would say, the qualities of reflective functioning.

The cliches that you mentioned, we see them very clearly when people are asked, why do you think your parents behaved the way they did? It is a cliche if somebody says, well, it was the depression years. It was the Trump years. It was the Obama years.

It is making reference to some broad, big, wide-painted brush that applies to millions of people and also applies to me. We consider that to be a cliche or a generalization as opposed to a particular detailed sensory memory, including sights, sounds, taste. Somebody might say, "You want some words that describe my relationship with my mother during childhood? Loving. It was a very loving relationship." Where we follow up and we say, "As you think about your relationship to your mother as a loving one during childhood, from as far back as you can remember, through the age of 12, what comes to mind?" Somebody might say, "She just loved us, like all parents do." That is cliche. But somebody would say, "She was there when I got home from school in the elementary. I remember she was always home."

And then we would follow up and say, "Tell me about a time when you got home from school and she was there, what happened?" Then the speaker might say, "She would have homemade cookies and a glass of milk. I talked to her about what happened during the day." We know for that securely attached children, it is not that they are happy all the time. They have all kinds of adversities during the day, during the school day with peers in the playground, and difficulty interacting with the teacher. The question is, when they go home at the end of the day, is there a caregiver that they can talk to about those events and come to some understanding about them that prepares the child to face the next day with hope and confidence?

Dr. Puder (01:08:21): I am thinking about just this idea of being a parent, and it's like we're trying to deepen our own kid's reflective function when bad things happen. I tell my daughter, "Look, daddy gets critical remarks about his podcast. About 15% of people will just be unhappy with you in general. You're always going to have critics, no matter what." And maybe you tell stories of your own being bullied or you're trying to deepen like, what's going on in this person? What and why are they unhappy? Where are they getting these words? "Pathetic." "Where do you think she's hearing this? Is she hearing it on the television? Is she hearing it from her parents?" You know, not to dismiss that these things are mean and uncalled for, but I was almost seeing this as like there's going to be these people in our life, right, that are mean. It is this is her first experience of it. It is like, how do we give her the tools where next time it happens, she has a more reflective function, ability to handle it? Any thoughts on that?

Dr. Steele (01:09:32): You described that very well. I do have thoughts on that. Clearly, what you're doing for your daughter is you're giving her the experience of having a father who listens, who believes me, and asks good questions.

One way that parents of young children, 5, 6, 7 years of age and older perhaps can establish a pattern of talking about the day, is to borrow them from the metaphor of the rose.

To talk to the child at the end of the day and say, what was, what was the rose? Was there something good? Was there something kind, something memorable, something valuable that happened today that you want to hold onto, something beautiful like a rose? And maybe they mention something and then you ask, “What about the thorn, because roses, if you grab them the wrong way, you end up with a thorn.”

“Was there anything that was frustrating, fearful, painful?” And finally, “Did you see a bud? Did you see something that is beginning to grow that can be followed more next week?”

You orient them to thinking about the day and the past in terms of the best and the worst thing, and make them aware of the potential to grow in a new direction with the bud.

I mean, not all children will warm to that idea, but it is a general principle, informed by what you said about your creative way of responding to know what for you must have been a painful realization that your cherished 10-year-old is now exposed to some of the, some of the evil in the world. There are such processes around and they are related to harsh experiences. So certainly it’s linked in with the value of reflective functioning.

Dr. Puder (01:11:38): Okay. I want to see if we have covered all the things you want to cover in this talk.

Dr. Steele (01:11:47): One thing we should do, David, is briefly mention some of the difficulties that people get into that is low reflective functioning. Because we mentioned rejection, we mentioned hostility. “Why do my parents behave the way they did? You are the psychiatrist. You tell me. When is this over? I have got to go.” Some of the other indicators of low reflective functioning are disorganization, bizarre, atypical remarks. I mean I have had some experience with patients who are very disorganized. It is hard to follow. Like countertransference experience is one of confusion, some despair, wondering why. These might be clever people, accomplished people, but when they’re asked to talk about relationships and what’s going on in their life, they’re not very organized. Now that is what is called **unintegrated**. And, of course, with therapy, our goal is to help patients arrive at a sense of wholeness and integration.

The other is **disavow** where someone just says, “I don’t know.” Or that they’re out. “Were you maybe feeling, you say you were feeling sad. Was there some fear there as well, perhaps?” “I don’t know.” It’s kind of like disavowing. That is a low example and then there is something called distorting self-serving.

Dr. Puder (01:13:19): Okay.

Dr. Steele (01:13:20): We define **distorting self-serving** as those people who elevate themselves. “I’m fine. The other people, they don’t matter. They disappointed me.”

I interviewed one expectant father many years ago. I said, “What was your relationship with your father like?” He said, “Oh, he was an idiot! I knew it by the time I was 11. When I was in my

teens I tried to be nice to him. I gave him a job and I had to fire him." What's this person doing there? It is kind of a cold dismissal of the parent and an elevation of the self.

I asked that same man if he was ever sick as a child. He said, "No, I was never sick. Oh, I had TB once." I said, "how did you get over that?" "I got over it on my own."

There are these tough, you know, inflated, narcissistic, if you like, individuals who praise themselves and put others down. We call that distorted self-serving. We don't quite believe the attributions to others. It seems distorted. It's, there's also, a distorted sense of the importance of the self.

Then we have those naive, simplistic replies to, "Why did my parents behave the way they did?" "All parents love their children, don't they?" "It was the depression years." And then finally, and we see this in people with borderline symptoms, kind of intense interest in relationships, but they do not go well and the reflective function is hard to track, because it is overactive, hyperactive.

As I said before, this is like somebody who got their wheels stuck in the sand and they are spinning, they are often angry, these people. They had some difficult experiences in childhood, but you're not quite sure what they are, and clinically, the goal there is to slow down the narrative.

Whereas, in the people who are disavowing, the goal is to kind of warm things up and ask lots of questions so that they get comfortable telling their story. The person with hyperactive reflective function has an intense interest to tell their story, but they are not organized. They are rushing.

And so, interestingly, Bateman and Fonagy and mentalization-based treatment, you might have talked about this in previous podcasts, they draw on the metaphor of the remote control—pause, rewind, review. They use that language with patients. You know, "Can we pause? Can we just rewind a little bit?" They tell that story again, and a little slower so I can follow better.

Dr. Puder (01:16:07): I was thinking about **somatization**, as well. Not feeling emotions, not having a narrative because it is almost too painful. They just feel it in their body. I am wondering if that would be low reflective function.

Dr. Steele (01:16:26): That would be a form of low reflective functioning. Definitely. And with those patients, of course, I imagine what you do is you ask them to talk about their body, "Where's the pain? What are you feeling as you think about that pain in your leg, your arm?" and so on. To kind of open, open things up a little bit. I think the somatization is a little bit like **disavow**. Cannot talk about it with words. I experience it in my body and we know that trauma work is very much focused on the body as Bessel van der Kolk has said, "The body keeps the score."

Dr. Puder (01:17:11): So the somatization, the disavow, it is like, I had a patient who said, and they were describing how horrible their body pain was. And I said, "Would you rather have the body pain or feel emotion?" And they said," I would rather have the body pain." Because the emotion was so painful, and it was, it was probably emotion of a loss of a relationship, loss of an attachment.

Dr. Steele (01:17:44): Sure.

Dr. Puder (01:17:44): It was so painful.

Dr. Steele (01:17:45): I think this also applies to **self-harm**, as well. Non-suicidal self-harm and suicidal thoughts, as well.

Dr. Puder (01:17:55): I was thinking about that, not with the self-harm, but with the **violence** in the prison population, that reflective function being so low. It seems to me that that is a way of expressing emotion in a very, sort of outward physical way. Rather than, putting to words, or processing what it might be, or just someone's impulsiveness to violence might be much higher if they're misreading people, if they are not seeing the world accurately, if they feel like people are after them.

Dr. Steele (01:18:30): I think that is a great example. We talked about it earlier. I think that these are people who do not fully appreciate that speech is a form of behavior. They think that behavior is something you do with your feet and your arms. We know, of course, that when people are angry, blood rushes to the hands when they are afraid, blood rushes to the feet to help you run, but when you are high in reflective functioning, the blood is distributed evenly throughout the body and there's a flexibility of thought and feeling.

Dr. Puder (01:19:08): One thing, one thought that I had, which I do not know if you have thought about this, is there's this idea of sensorium, like brain function, and brain function naturally fluctuates. Probably the extreme version of this is an old person who gets an infection and gets delirium where they are now psychotic, they are not seeing things that are not there for the first time. They do not have a history of psychosis. Or there is also something called hypoactive delirium, which is more they are stuporous, cannot focus, cannot concentrate.

But when I think of sensorium, I think about myself and, you know, there's certain parts of the day, especially if I'm sleep deprived, especially if I haven't eaten well, especially if I've been stressed out for a couple weeks where I may not be my normal brain. I think in those moments, I have lower reflective function. Have you thought about reflective function as something that shifts throughout the day, potentially even for normal people?

Dr. Steele (01:20:07): For sure. It shifts throughout the day. It tends to disappear in those moments when we are most tired or most hungry. Nursery school teachers know this. They do their instruction in the morning, when children are, we are meeting in the morning. Maybe that is why you wanted to meet so early in the morning…

Dr. Puder (01:20:30): My audience can benefit from a higher reflective function.

Dr. Steele (01:20:33): Anna Freud remarked on this that children are engaged with the most intense, challenging learning experiences in the morning. In Germany, until seven years of age, you only go to school in the morning. The afternoon is for running around and playing. My mother was an elementary school teacher, and something she felt fiercely to be important was recess, you know?

Running around and releasing one's energies so that you come back a little more settled for some more learning before the lunch break. So yes, there are fluctuations in reflective functioning, and as I said, there is this paradox that when we need it most, when we are threatened, we tend to draw inward and reflective functioning leaves us. It hopefully is something that we regain later in the day through conversation with a family member or supportive person, or the next day. So we have to nurture reflective functioning and make it a kind of a habit of mind that we can recover quickly if we need to.

Dr. Puder (01:21:54): I think probably the extremes of this in human behavior is someone with borderline personality disorder. Fonagy and Bateman call it psychic equivalence mode. It is basically when they're losing their ability to metalize accurately someone else's state or their reflective function drops.

Dr. Steele (01:22:17): This is their speculation about what precedes reflective functioning. Reflective functioning is not really observable until 11, 12 years of age, 10, 11, 12 years of age. Then it takes off and grows. In young children, 1, 2, 3 years of age, Bateman, Fonagy and Mary Targe and Peter Fonagy suggested that the 1-year-old is governed by psychic equivalence. I am not so sure of that. We do not know what's going on in the mind of the 1-year-old, but we do know how frustrated they may be if they don't get what they want in the moment that they want it.

They describe this state of psychic equivalence, that I want something, we know in adulthood, just because I want something doesn't mean I should have it or can get it as quickly as I want it, but for the 1-year-old in the moment of want, it's connected with the belief that what you desire should be right there. We think about four- or five-month-old infants crying because they want to be fed. They are crying because they can't wait.

Dr. Puder (01:23:34): They are communicating directly their needs in the moment without filter. Right.

Dr. Steele (01:23:41): Without filtering, without the ability to delay gratification.

Dr. Puder (01:23:44): The thing about psychic equivalence mode, which I find helpful, when someone is in that state, and I think we all can enter into that state when we are stressed and hungry and tired, but in that state, your reality is the reality—that is the truth. There is no other reality. So if someone hates you, if I am sitting here thinking, (which I am not), that Howard

Steele hates me, he does hate me. That is a hundred percent true. It is not, perhaps he hates me. It is no, he really does. So there's no question in my mind that my mind may be inaccurately giving me messages. Right.

Dr. Steele (01:24:32): Well, that is well put. It strikes me that somebody in a florid psychotic state is vulnerable to that same phenomenon. I question it a little bit because we have so much information and data now from the infancy researchers, that we come into the world with a capacity to hear—seeing comes online and we have a rudimentary understanding by 2-3 months of age of how gravity works. I not, I'm not entirely sure that the 2-, 3-, 4-month-old is completely unable to manage without depending on psychic equivalents. It is a tradition in the psychiatric psychoanalytic literature to interpret infancy in terms of what we know from adult psychopathology.

Dr. Puder (01:25:30): And that is where I think attachment literature and the work that you do and being an editor makes you so unique. Because you are really in more an of an observation capacity. You know, you are trying to observe what is actually happening.

I think that is why we have to ground ourselves as clinicians in that research, right? If you are a mother that has done her own work and done her own therapy, and maybe you came from a very deprived childhood, but now your reflective function is high because you have done a lot of work on yourself, you can be confident.

Dr. Steele (01:26:07): That is right, for the person with moderate to high reflective functioning, when we listen to them, when we listen to the speaker with moderate to high reflective functioning, the conclusions we draw about their experience are likely to be the same as the speaker. There is a kind of consensual reality that is achieved.

That is a term that Harry Stack Sullivan used for his goal of therapy to arrive at a consensual reality. That what the patient understands and believes about their experience agrees more or less with what the therapist or psychiatrist understands.

Now, this is related to John Bowlby's assumption about the internal working model. He said, in the securely attached individual, the internal working model of self and others provides a tolerably accurate model of the outside world, a tolerably accurate model, not a completely accurate model, a tolerably accurate model.

Of course, when we start out our work with patients, their models often seem muddled and confused. It is unclear what happened to them, how they think and feel. We entertain all kinds of hypotheses about maybe this happened, maybe that happened, and most we do not say, but over time, there is a kind of coming together and an increase in reflective functioning for the patient, facilitated by a therapist with high reflective functioning. And the consensual reality might emerge that the patient feels gratified by.

Dr. Puder (01:27:50): I think this is why the adult, even if they had a fairly deprived childhood, with higher reflective function, has a securely attached child because they are able to enter into the mind of the child to some degree, to see what that child is feeling, thinking, reflect it back to them.

The child then understands what they think or feel. The opposite of that is that the child is always only experiencing the parent's world. The parent is not reflecting back anything about the child's world to the child. It is only in relationship to a parent that is in their own, stuck in their own experience, so to speak. Which, I think I have had several patients that I feel like I have successfully been able to help through that, but has taken years because you are the first attachment in that person's life that has attuned to them in a stable way over years, in an ongoing, repetitive way and in a reflective way. You are interested as a therapist into their internal experience. I am curious about their kind of deepening their own reflective capacity, reflecting back their experience to them.

Dr. Steele (01:29:20): Sure, there is an attachment piece that we have to take account of in those cases that we work with. As you said, it takes years. I think one reason why it takes years is that people are very reluctant to give up their thoughts and feelings about family members, mother, father, siblings. Those are very important to everybody. We, the therapist, we are a stranger. This is one of Levi Levinson's points that therapy fails.

You pointed out that therapy fails because therapists may not have sufficiently high reflective functioning, but all therapists face the dilemma or problem that we are outsiders, strangers to the patient's experience. The very familiar people that they deeply love are mother, father, however they were treated by those people. We have to gently, over time, establish and maintain trust and persuade the patient that we are not here to trouble them in any extreme or overwhelming way, that we invite them to tell their story again and again and again so that the story takes on the characteristics of belonging to the past, freeing the patient to respond in new ways in the present.

Dr. Puder (01:30:51): Ya, and sometimes I think what I have found is that you could have very well-intentioned parents that do not have the communication abilities that I possess. So I'll point that out to the patient, you know, like, "Despite your dad or mom's best intentions, it sounds like they really had a difficult time in this instance communicating warmth or caring to you." I think that has been helpful as well to kind of not go all bad on the parent.

Dr. Steele: I am sure that is a clever, adoptive way to go.

Dr. Puder: The parent could have great intentionality, but poor execution on the intentionality.

Dr. Steele (01:31:41): How does the saying go? The road to hell is paved with good intentions.

Dr. Puder (01:31:46): Can lead to a lot of suffering sometimes when that's the case. Okay. Wrapping up our time together, what do you feel are some of the gaps that, like if you had a

PhD candidate right now, and you were to say, “Here are some of the things that we do not know yet that we should know about reflective function, about attachment.” Are there any things that jump into your mind right away?

Dr. Steele (01:32:09): We say in the *Reflective Functioning Manual* that it is not yet clear. What are the distinctive, reflective, functioning difficulties that particular patient groups show? I currently have a PhD student who is looking at a community sample of adolescents and young adults with varying levels of borderline symptoms. Not people with borderline pathology, borderline personality disorder, but there are questionnaires that measure extent of borderline symptoms and she is engaged in the study trying to understand what types of functioning are most associated with borderline symptoms. The preliminary work suggests that it is the hyperactive.

Dr. Puder (01:32:59): Wonderful. It is helpful for me to be able to think in that category to be able to help people. So it is wonderful in that way.

Dr. Steele (01:33:17): I would welcome other students who might want to study people living with chronic depression or people living with… I have another student studying obsessive-compulsive disorder. We’ll look at levels of reflective functioning in that group. So if we can know what the distinctive, reflective functioning troubles are of particular patient groups, we might be better able to engage with them and help them.

Dr. Puder (01:33:47): I really like that. Well, Dr. Howard Steele, it has been a true pleasure. I want to have you back on for sure. I feel like we could spend another six hours talking about this and getting, and getting super granular and I think. I will put a link in the show notes and in the article that will go up with this, the link to your training that you do on reflective function and to your website. I encourage anyone who is listening to this to go check that out.

Dr. Steele (01:34:17): Thank you. You can include my email and people could reach out to me by email if they have an interest in any of the trainings that I do online. I do them all on Zoom like this experience was.

Dr. Puder (01:34:29): Great. Then there are also some books you can check out by Howard Steele on attachment (deep dives), his articles. I am excited to highlight you and your expertise and the hard work you have done over decades on attachment. I think it has been a real contribution.

Dr. Steele (01:34:48): Thanks very much, David. This was a pleasure. All the best.

Dr. Puder (01:34:52): All the best.