

**Mirroring: A calculated therapeutic technique or *just* conversation? Understanding how and why a shiny reflective surface might heal.**

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Perhaps there is more debate about the definition of, and use of “mirroring” in psychotherapy than might first be apparent. As I have posited in previous articles, we (psychologists) sometimes appear to be in agreement about terms we use, e.g., he was being *defensive*, or I was *mirroring* him, but we may actually not share the same applied dictionary. When we use such language in our vernacular, unless accepted as synonymous, we run the risk of diluting our work and communication with one another. Not surprisingly the very same process of misunderstanding is possible when we communicate with our patients; hence the use of mirroring as a tool for clarification and confirmation. Yet the “act of mirroring” may not only serve in our understanding of people but function as a potent intervention as well.

By mirroring a patient we might just be making our best efforts to understand his or her presentation. Why then do we mirror some patients more than others? Why might we never, or rarely choose to mirror certain individuals? Why intervention (with the use of a mirror) is different from person to person may help to illuminate the efficacy of this as a part of treatment. Furthermore, we may also more thoroughly understand the mechanism of cure for a patient.

A closer inspection of what we mean by mirroring and how and why this activity may or may not be helpful is germane to informed practice. I forward the following operational definition.

**Mirroring:**

*An attempt by the psychologist during a therapeutic interaction/setting/context, via verbal communication with a patient, and perhaps the purposeful inclusion of nonverbal gestures (animation/expression), to repeat, reflect, and represent a patient’s remembered emotional, cognitive, and historical experience with great accuracy and true reflection of the real (subjective), remembered experience by the patient.*

I emphasize, “attempt” because mirroring is a proximal attempt on the part of the clinician. By better understanding a person with a mirror, we may choose specific interventions, for example the use of Dialectical Behavior Therapy (DBT) for those who become emotionally upset or disorganized after mirroring. For many other patients I posit that *the act of trying to understand* can be an effectual instrument in creating change and growth by itself. Thus, I suggest in the above definition that mirroring is actually an intervention and at times part of our method of providing treatment, not just an instrument for understanding and assessment.

For the purposes of this commentary if we can agree that mirroring as an activity is actually an intervention, then questions arise as to why and how it works. If we provide a reflection of a person, back to that person, why would it help? Furthermore, what happens during that interaction that makes a reflective image result in improvement?

What function is served by providing a reflection from which the patient may then view him or herself? As with much of our work, we may want

and need to believe that treatment is helpful. But as with any intervention, i.e., antibiotics, surgery, we bear the responsibility of explaining why and how we believe treatment is curative. For the day-to-day practitioner, our starting point of understanding is usually theoretical orientation. We rely on theoretical tenets to describe the *mechanism of improvement* for a patient.

For myself, an interest in this subject matter was sparked while lecturing to a youthful and energetic audience of first year graduate students. During this *Introduction to Psychotherapy* lecture, some students had strong reactions to the concept of mirroring. Students' reactions varied and for some it included irritation or even dismissal of the concept. I became curious about what was happening in the classroom and why such reactions surfaced.

The following hypotheses of how and why mirroring might be useful, may also help to illuminate why the aforementioned trainees expressed mixed feelings when presented with the concept of mirroring in a lecture. The brief diagnostic conceptualizations in the following text might also help to discern who may and may not benefit from the use of mirroring.

### **Identifying and Labeling Affect**

As psychologists one of the first reasons we might mirror a patient is to help the person identify feelings. The assumption, practical and theoretical, is that some people develop and grow throughout their lives without forming a sufficient vocabulary for feelings. The belief is that such individuals are unable to adequately articulate and describe their experiences because they are unfamiliar with feelings. If you are not an electrician, you are likely unfamiliar with the tools and materials associated with the trade. Some people never receive formal training in feelings.

A stereotypic example is the patient that looks mechanical. He describes factual detailed information but never identifies feelings. As he continues, his description of events might lead many to assume angry feelings but the patient never actually says, "I'm angry." The therapist might then introduce affect words so the patient has a new language to describe his or her experience. For example, "You look frustrated. I could see how that could have made you resentful? (questioning tone)." There are many variations of possible presentations by the clinician, which is a topic of a paper in itself—said variations are well beyond the scope of this discussion. With the above application of mirroring, I suggest the following mechanism of action for improvement for this patient.

**Mechanism:** By providing language and vocabulary to describe feelings, individuals can then use that language to better manage, regulate, and modulate feelings. It is hypothesized that the mechanism of change is the identification of feelings. As an example, if the individual above can more rapidly and accurately identify the feeling "resentment" he can then make decisions based upon that identification, for example leaving a job, addressing a conflict in a relationship, etc. The assumption would further that he would then experience greater mastery of his life because he can negotiate problems and conflicts with awareness and clarity. Consequently, he would feel more in control, confident, and secure—arguably positive improvements.

### **Uncovering Affect**

Related to the simplified example above is the use of mirroring to uncover buried, hidden, or defended affect. For this patient, the assumption is that he or she has troubling feelings that are morally unacceptable or too painful to acknowledge. A key difference from the individual who cannot *identify* feelings is that this patient has vocabulary for feelings but is unable or

unwilling to use that lexicon. To infuse this commentary with more precise theory, the Structural (Id-Ego-Superego) model of psychoanalytic theory might forward that a person has feelings that are inconsistent or in conflict. For example, a man that is highly selfish but needs to see himself as considerate and compassionate, must deny (conceal) any awareness of his egocentric desires. By denying such unacceptable and intolerable impulses he tries to reduce tension; of course, the conflict will likely surface in daily living, e.g., a romantic relationship, leading the person to therapy. In this situation the clinician is mirroring various aspects of the patient's presentation, some of which is highly contradictory and charged. An example might look like the following: "You seem really disappointed that she says you are so self-centered. I also heard you saying that you feel the relationship is unfair, because you can't do the things you enjoy (selfish desires)." Ultimately the use of confrontation as a technique may also be included.

Mechanism: In the above example, the achievement of insight (beginning with awareness via a mirror) is proposed as a mechanism of improvement. When the patient becomes aware of these conflicting parts of the mind he not only has a more comprehensive and accurate view of himself, but he may also choose different ways of managing these newly identified parts. For example, after having his selfish desires mirrored in the language of the therapist, he may later agree and accept this as real and accurate. Consequently he may need to leave a relationship, choose another partner, or try to become more considerate and less self-centered.

### **Reducing Defensiveness**

I respect with great care, that defenses are in place for protection. Defenses are designed to limit pain for the individual. When defenses—for example denial—cause problems in the person's

life and create more pain or prolong suffering, then their utility becomes questionable in the present. By making an effort to understand a person, by verbalizing an approximation of his or her experience (without apparent judgment) we appear non-threatening. I am not suggesting that we consciously manipulate others by appearing to agree with their values, but simply articulating their experience can for a time be separate from critically judging the experience (which may occur later). When feelings are discussed openly and understanding is attempted and established, it is hypothesized that for many people a sense of safety is experienced.

Mechanism: When we feel safe we tend to share more of ourselves, we become less defensive. When we feel genuinely understood by others we are probably more willing to look at weakness, fault, and vulnerability because the investigator appears non-threatening. Said more succinctly, when it appears that another person understands our perspective without a judgment attached we may believe that he or she is less focused on harming us.

Consequently, mirroring may reduce defensiveness allowing the clinician to learn more about the whole person. As noted previously, when we have the privileged position of seeing all parts of a patient we are better equipped to also use other interventions. It should be noted at this juncture that reducing defensiveness with the use of mirroring may also converge and synergize with other therapeutic benefits, i.e., insight.

### **Constructing a Sense of Self**

Depending upon your diagnostic impression and how you think about people and psychological development, you might employ the technique of mirroring in a slightly different way with a certain patient. I forward that some patients come to us with an incomplete sense of identity. The

construction of their personal identity is either in disrepair and was never finished, or the building process scarcely began. Some patients in this category describe experiences like feeling “empty” or they appear vacant to the psychologist. When asked how they feel they are sometimes sad, but have a limited and poor understanding of much more. If they do have an image of who they are, it can be vague and imprecise. To use a mirror in a metaphor describing the above patient, consider the following. When people look into a mirror they see a reflection. They see their appearance and along with the physical image that is visible, a host of impressions, judgments, and values began to circulate in the mind. For example, one patient sees the reflection and decides, “I am a bit overweight, I’m getting old?” Another wonders, “I wish I were taller like my brother.” Yet another decides, “I just feel worthless.” For others who look in the mirror they see very little reflected back; the image that is returned is ghost-like, shadowy, like the reflection in a mirror after a steamy shower. Said in a different way, when these patients self reflect they see a poorly formed sense of who they are; a few features might be clear, but much of the image is without detail. This patient might assert, “Well I know I’m smart, but I’m not sure about what’s important in my life, or even what I’m doing.” When in relationships, these patients sometimes even serve as an excellent net for unstable or volatile partners. Or they are sometimes tenuously bound with a fragile attachment. Because they do not have a sense of who they are, they are unable to describe a sense of self. The language does not exist for the patient because nothing exists to describe. Therefore, mirroring takes on a new quality.

How can a clinician mirror or reflect nothingness. Well certainly the initial attempts might include such statements like, “It sounds like you feel a void,” or “It’s like you just feel like nothing?” I reiterate that the person with an incomplete self may be partially constructed, consequently the

psychologist could mirror the visible components. A modified version of mirroring can occur in this context as well. Psychological mirroring in a clinical context almost always involves estimations, approximations, and inferences—unless you are parroting verbatim the person. When working with a person who is lacking in self-definition, the clinician is forced to rely more upon a range of “expected human reactions.” What I mean is that we might assume or suggest a range of feelings or experiences. The patient then considers the list of suggestions, sometimes remaining very unsure and indecisive. This process of consideration can be key in treatment as the person eventually commits to an identity by choosing from the list, or he or she has enough self-definition to alter the suggestion. For example, the psychologist might offer, “Well given the way you were treated when your employer took your commission, I could see how a person could be pretty angry about that.” The patient is then charged with exploring why “a person” would be angry. For illustration, “Is this immoral or an injustice, was I mistreated, do I have values that were challenged, and if so, what are my/those values?”

Mechanism: The above description of an incomplete person has straightforward implications for the use of mirroring. When we provide a reflection we are providing the building materials for the construction of an identity. As a hypothetical example, a woman enters treatment and shares that she feels sadness, but also feels uncertain and sometimes empty, unsure about her purpose in life. Her boyfriend believes she is depressed, has poor self-esteem, and lacks confidence. He does however love her accommodating nature and ease of being when they spend time together. The psychologist’s early interventions might include, “You seem like you are lacking purpose or direction in life?” The clinician might elaborate, “like you are not really sure about why you are here, or where you are going.” Further discussion reveals some basic

moral values that are present. The psychologist might suggest, “You said that you think honesty is a good quality to have?” With each exchange, and repetition of this process, it is hypothesized that the person begins the construction process. Because the person is participating in a reflection feedback system they begin to retain the proposed parts of the self. The patient might then report, “I really do believe I am an honest person based on our conversations—because of that I think I might need to choose a different type of work.” In actual practice I have suggested a couple concrete metaphors for patients. The first is to imagine that they are a building or structure. Some parts of the building were started, but because the building is incomplete we are uncertain what it looks like, or how it will function. A second example is like that of an early-model instant camera. When a picture was taken, it required a few moments for the image to surface on the photography paper. For this type of person the image is always indistinct, blurry, and with poor definition, as if the photograph never materialized.

### **Validation-Fulfilling Dependency Needs and Providing Narcissistic Repair**

One of the most widely accepted assumptions about not just patients seeking treatment in our office but all people is that we need and want validation—to have our feelings confirmed. With equal popularity it seems that validation is accepted as an essential part of most talk therapies. Certainly in my work over the years, I have seen people relieved and even tearful feeling a deep sense of satisfaction when their perspective was reflected. Mirroring was the specific tool used to provide the experience of validation. However, underlying this therapeutic interaction is the notion that validating a person’s feelings somehow helps them in the psychotherapy context. The question surfaces: What is helpful about validating a person’s feelings? If a person has an emotional experience, why does it need to be confirmed, or

validated? One hypothesis is that a subgroup of individuals seeking treatment are in need of, at least in part, the confirmation or validation of feelings to repair early developmental invalidation. This assumes that the patient has experienced feelings in life but because he or she is not confident of the reality, importance, or normalcy of such feelings, it results in damage to their person—more precisely, narcissistic wounds result in feelings of insecurity, inadequacy, and lack of self-efficacy. For these patients, it appears they have a desire to know that other people might also share their experience (as suggested by the psychologist’s provision of a mirror). When they are more certain that their feelings are worthwhile and valuable, they may then feel a greater sense of personal worth, confidence, and emotional security.

Mechanism: When we validate someone’s feelings we are supporting the notion that what is felt is indeed important and has worth. It’s as if we are saying and agreeing to the idea that, “Your feelings are worthwhile.” When this is communicated by mirroring it seems the mechanism of improvement is a change in self-concept, “If my feelings matter and are important, than I suppose I matter and have worth—even when others disagree.”

If you are able to imagine a person with dents, scrapes, and broken parts, then you might imagine ways in which to repair the damage. The patient with narcissistic injuries (dented parts) may experience a type of repair when emotions are reflected back. As described briefly above, mirroring appears to add worth to a person via validation, ultimately resulting in a more resilient and less defensive personal identity. The mechanism of improvement/repair appears subtly different for some others with prominent narcissistic injuries. The *attention and effort expended by the therapist* seems to be the healing ointment. When the psychologist mirrors, he or she is giving attention, recognition, and

acknowledgement of the person. If the patient has a deep need to feel special, than the therapist's interest in understanding, and the provision of undivided attention, is reparative.

### **The Unwanted Reflection**

If mirroring as a technique has so much utility, is there a time that we should not use the intervention, or a time when even worse, it is contraindicated? Mirroring may be damaging when delivered to the wrong patient at the wrong time. Foremost, a therapeutic alliance with shared goals and trajectory may become askew.

Assessment and diagnostic impressions will be the underlying assumptions guiding treatment and identifying the wrong candidates for mirroring. Consequently, when a person has been assessed as having a more complete and secure sense of identity, and he or she is mirrored, I predict the result will be poor. When an individual knows and values his or her own experience, it is likely not necessary or helpful to reflect that experience. Feeling patronized, the person may become angry. Having a professional parrot your feelings when it is not needed can feel infantilizing or belittling, or in the least like the speaker doesn't know you at all. An exception is when a relatively stable and secure person is significantly weakened due to life stressors, for example following a loss. At that point, a mirror designed precisely for that person and his or her circumstances might be experienced as supportive. When in therapy such individuals typically improve quickly.

In a nonclinical example, take a close friend who reports that he is upset due to a recent minor auto accident. Knowing this person (assessment of sorts) as a friend, you would likely be able to discern how to be supportive. For some the response would be, "Are you going to have your car fixed?" For others the response might be, "Oh my gosh, that sounds awful—even scary." Yet for others it might even be, "I bet that made

you mad, the guy wasn't even paying attention." All of the above rather natural responses are only appropriate for the right audience. I argue that assessment may occur in many subtle and less conspicuous ways. As clinicians (not friends) we may be operating from unidentified sources of information when choosing if, and how to mirror.

So the reason some students found the concept of mirroring upsetting? They revealed with their reactions that for their unique personality and psychological makeup, they did not want or need a reflection from another person, and rather found it contrived, disrespectful, and patronizing. Said differently, these students already knew how they felt, and saw no benefit in having a professional repeat it back. Consequently, when they imagined themselves as recipients of the mirror (patients), the intervention seemed insulting. To correspond regarding this or other articles, please contact me, Dr. Jason Camu via email at: [dr.camu@fuelforemotionalhealth.com](mailto:dr.camu@fuelforemotionalhealth.com).