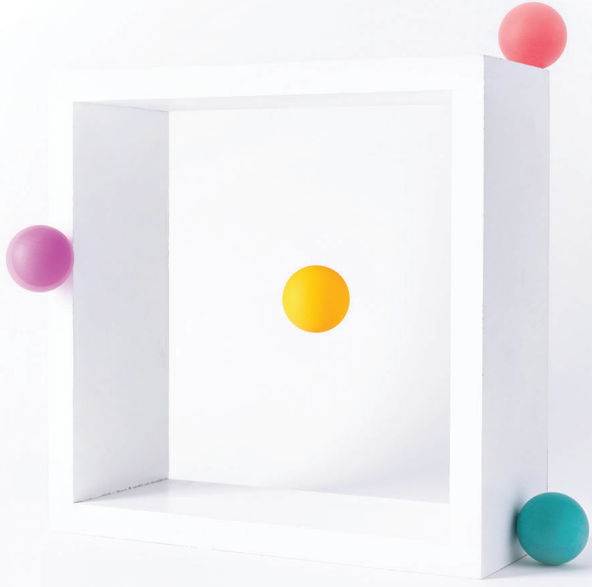
Mentalization-Based Treatment with Families



Eia Asen | Peter Fonagy

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Preface

Three decades ago we each inhabited distinctly different therapeutic worlds: One of us was wholly dedicated to the systemic paradigm, and the other practiced psychoanalysis and psychodynamic therapy. However, increasingly we both felt that these worlds were getting rather small and exclusive, and some 15 years ago and after previous collaborative work on research projects, we decided to critically examine each other's clinical work and their underlying theories and concepts. Accepting an invitation to give a 2-day workshop in Scandinavia—which we called "Psyche Meets Systems"—provided a welcome opportunity to scrutinize and compare our respective approaches "live" in front of a large audience of therapists of quite different orientations. This was the beginning of an inspiring collaboration that over the years has led us to develop what we now call MIST: *mentalization-informed systemic therapy,* the subject of this book. It is *our* version of mentalization-based treatment with families and throughout this book we will refer to it as MIST. It has the structure of systemic work but is enriched by mentalizing concepts and techniques. Mentalization-informed systemic therapy is perhaps the more accurate description, although it could probably be equally well described as *systemic mentalization-based treatment* (SMBT): mentalization-based work enriched by systemic concepts and techniques. The reversibility of the term speaks to the flexibility with which we approach the task of integration. Our priority is to identify effective and efficient ways of supporting children, young people, and families, and not to create yet another "school" of psychotherapy.

Just as our emerging fresh approach had generated interest all those years ago in the Scandinavian audience and subsequently via the

frequent workshops we have held in many European countries and in North America, we hope this book will inspire therapists and clinicians of different persuasions working with individuals, couples, families, and larger systems to create safe environments for thinking about their work and to innovate as we have tried to do. Yet MIST is not wholly new. We claim no discoveries or fresh insights into family or individual mental function. The spirit of MIST is pulling together concepts and practices that can be integrated into the current clinical practices of most therapists, almost regardless of orientation. MIST has the singular aim of supporting clients in identifying and overcoming barriers to mentalizing. The model holds an optimistic view of the mind, assuming that the recovery of mentalizing will ensure that solutions will be found—and through this view, obstacles and barriers will be overcome and a natural process of healing will occur.

A brief outline of this book's structure and content may orient the reader. Each chapter contains actual clinical case examples—all carefully disguised—that describe typical scenarios and therapeutic dilemmas and explain the concepts and principles that guide the work of MIST and illustrate the techniques we use. In Chapter 1, we establish how adopting, on the one hand, a "mentalizing lens" assists in perceiving and interpreting human behaviors and interactions in terms of intentional mental states, and we establish our guiding assumption that mentalizing is a fundamentally bidirectional (transactional) social process. The "systemic lens," on the other hand, permits viewing individuals and relationships in context. Combining the two lenses in MIST generates innovative roadmaps for clinical practice. The differences between effective and ineffective mentalizing are described in Chapter 2, with a specific focus on describing ways people think about their own and others' actions when mentalizing is not working well and how this can appear in a clinical context. We offer some suggestions about assessing mentalizing using a number of dimensions (or polarities) that can help to organize clinical experience. Chapter 3 describes a way of setting up mentalization-focused interventions by convening professional and family networks and bringing together many minds for a therapeutic purpose. This initial stage, as is the case for all subsequent stages of the therapy process, requires adopting a "mentalizing stance" that we need to maintain even as arousal increases in the clinical setting—as it invariably does. In Chapter 4 we introduce the "mentalizing loop," a pragmatic tool designed to facilitate the emergence of effective mentalizing.

Chapters 5 and 6 are the centerpieces of the book. They provide many examples of how concrete activities, exercises, and games can be playfully employed to stimulate effective mentalizing in order to overcome problematic family relationship patterns. All these techniques are

designed to create opportunities for *joint reflection*. Chapter 7 describes how MIST can be viewed as a transdiagnostic approach and how the focus on the general vulnerability to mental disorder—the "p factor"—can help focus on the common components of different types of disorders by addressing emotion dysregulation, executive function, and the capacity for social learning (learning from others). We have found the concept of epistemic trust helpful in this context, particularly in relation to the loss of trust that can be the experience of those who have suffered severe trauma. Moving into the digital realm, Chapter 8 examines the impact of social media on family life as well as its potential uses when delivering mentalizing work remotely. Chapter 9 looks beyond the individual family and examines the potential of a mentalizing approach when delivering multiple-family group work in various settings, above all in schools, and it provides a rationale for joint parent–child education. The last chapter takes an even broader brush and investigates the applicability of MIST across cultures and what happens when therapist and client come from different cultures. We focus on the role of the social environment around individuals and families in understanding mental health and vulnerability to disorder.

The MIST approach is both innovative and familiar, and it is also both serious and playful. Throughout this book, we try to demonstrate how seemingly simple interventions, when well chosen, can have tremendous influence merely by reigniting the natural processes of interpersonal interaction that without effort generates mentalizing. This is not a "cure," but rather a method for removing temporary or not so temporary blocks in family relations. MIST not only requires families to open their minds, but it also challenges therapists to have a continuously open mind and adopt (and model) a mentalizing stance. We very much hope this will be the spirit with which readers of this book consider the approach to clinical work we describe.

A NOTE ON LANGUAGE

They/them/their is our preference for gendered singular pronouns throughout the book, rather than *he/she, his/her,* and *his/hers*.

ACKNOWLEDGMENTS

We would like to thank all those who have directly and indirectly contributed to this book. Above all, we owe a huge debt to the many individuals, couples, and families with whom we have had the privilege of

working over the years and from whom we have learned, often by trial and error, more than from anyone else. We also want to thank many of our colleagues, both from the systemic and the mentalizing worlds, who have inspired us through their writings and clinical practices and without whom MIST would have never been developed. The mentalizing community is vibrant and constantly evolving. It is often hard to locate where particular ideas originated. We apologize if we failed to appropriately acknowledge the work of the pioneers of this model with whom it has been our great privilege to work over the past decades. The creativity, generosity, and good humor of this group energized our work, including the present contribution, which should have at least a dozen authors. Although we cannot name them all, we want to recognize at least one, Dr. Chloe Campbell, who played an important role in sharpening our ideas throughout the writing of this book. Finally, we wish to acknowledge that the process of putting our ideas into a (more or less) coherent book form has been hugely assisted by the editorial team at The Guilford Press: Jim Nageotte, Barbara Watkins, and Jane Keislar. They have provided most helpful and much needed detailed advice and guidance throughout our voyage from the beginning to the end of writing this book. Any omissions, errors, or mistakes are entirely of our own making.

Contents

Chapter 1

Integrating Systemic and Mentalizing Approaches

When Salim's mother, Mrs. G, telephoned the clinic to ask for help for her 6-year-old son, the therapist taking the call asked what the issues were that concerned her. She tearfully explained that her much loved son had been showing extensive behavioral problems that had been flagged by the school. This had not surprised her as she knew Salim had found it difficult to make friends and also had "many worrying behaviors" at home. She then explained that Salim had "a major eating problem" and that he could "never be alone by himself in a room," which meant she always had to be with him, including sleeping in Salim's bed every night. She went on to say that Salim took many hours each day to do his homework, that "he often cries like a baby," and that he was generally very demanding. Mrs. G said she and her husband felt absolutely exhausted and were concerned about Salim's future.

Systemic and mentalizing approaches have a lot in common: Above all, they view many emotional and behavioral problems as being essentially relational in nature. This book views systemic work through a mentalizing lens. It intends to inspire systemic practitioners to expand their work in ways similar to the ways in which mentalizing therapists have been inspired by systemic concepts and practices. The aim of mentalization-informed systemic therapy (MIST) is to enhance mentalizing in order to open a person to improved social communication and interaction, within the family as well as in other social settings, and

thus to increase openness to learning, epistemic trust (Fonagy, Luyten, Allison, & Campbell, 2019), and resilience. By epistemic trust we mean trust in the information about the social world that we receive from another person. The ability to take in what others communicate to us as having personal relevance greatly enhances our ability to adapt in the face of challenging situations. This is why we have suggested it is a potentially powerful protective factor in mental health and social functioning (more on this in the section below in this chapter, "Why Is Mentalizing Important?"). The therapeutic focus is on encouraging the natural process for solving social problems by genuinely considering each other's experiences and points of view. After all, it is the experience of feeling one's perspective of reality aligned with another's that generically improves confidence in the value of engaging with perspective taking as a whole. In addition, this experience potentially opens the mind of each family member to the possibility of learning and discovering something relevant to them, thus improving trust in social learning as a whole.

THE MENTALIZING LENS

Mentalizing is an imaginative activity that interprets human behaviors in terms of intentional mental states. It is important to emphasize the word *imaginative,* as it is imagination that underpins mentalizing: It enables us to intuit the thoughts, feelings, and intentions of those around us and so to make sense of their actions, just as we organize our own subjective experiences. Mental states refer to a person's needs, desires, feelings, beliefs, fantasies, goals, purposes, and reasons. Mentalizing is mostly preconscious, but it can also be a deliberate activity of reflection. It is crucial for representing, communicating, and regulating feelings and belief states linked to our wishes and desires, whether they are being met, threatened, or frustrated. The same psychological and neural mechanisms we use to understand ourselves are also used to understand others. In this way, the foundations are laid for our social interactions.

The acquisition of the ability to mentalize is evolutionarily protected and modulated by the environment in ways similar to those by which language is acquired and developed. The capacity to mentalize emerges as essentially a nonconscious, reflexive appreciation of others' intentions, emotions, and perspectives (Seyfarth & Cheney, 2013). The nature of our mentalizing skills is shaped by our social environment, just as the particular language we first learn as children depends on our mother tongue. The predominance of family as a basic social unit has made it the primary context for acquiring and shaping social understanding.

This and other reasons (some of which may be genetic) account for the fact that the ability, willingness, or appropriateness to adopt a mentalizing stance varies between individuals and families. Our wider cultural environment may also encourage a stronger focus on mentalizing the self over the other, depending on how strongly individualism is valued (Aival-Naveh, Rothschild-Yakar, & Kurman, 2019).

Mentalizing is a fundamentally bidirectional or transactional social process (Fonagy & Target, 1997). It develops in the context of early attachment relationships and interactions with others, and its quality is very much influenced by how well those around us are able to mentalize. This experience of being mentalized by others is internalized and enables us to enhance our own capacity for empathizing and engaging better in interactive social processes. The relationship between attachment and mentalizing is also thought to be bidirectional in that difficulties with reflecting on mental states are likely to adversely affect close relationships; a poor attachment relationship—the experience of not being responded to in a sensitive way—may undermine the natural development of the capacity to mentalize, which, after all, depends on having been understood oneself. We need to understand others to appreciate others as understanding us. Think of how we learn a language by being spoken to, and then, being brave, we engage in conversations with others. Mentalizing is just the same process. We learn it by doing it. The problem is that some of us, for one reason or another, do not do it terribly well. We misunderstand people; we make assumptions about why they do things; we act before thinking about what we are trying to achieve; we know precisely how we should not behave, yet find ourselves doing the very thing we abhor; we spend endless hours ruminating on what our friend meant by saying something, only to discover that he or she was not even aware of having said it; we feel overwhelmed by emotions for reasons we do not understand, or we feel nothing when something upsetting happens; and so on. Failure of mentalizing, or to put it more appropriately, ineffective mentalizing, is what most of us do quite a bit of the time, especially when we are upset. One insight that we have had as therapists working with individuals, couples, and families is that making ineffective mentalizing just a little bit more effective in most families improved their situation and sometimes removed difficulties they presented with altogether. This is how MIST was born. It is our contention that more effective mentalizing builds both individual and family resilience: A better understanding of the mental states of others and self leads to a freeing of more meaningful communication. And this is what MIST tries to promote.

Not everyone agrees with the view we present of how mentalizing comes about in the course of a child's development. There are those

who propose that mentalizing (theory of mind) is an innate module in the brain that requires little more than maturation (Leslie, Friedman, & German, 2004). Many cognitive psychologists believe that mentalizing emerges through a process of quasi-scientific deduction in which the child evolves in order to create a plausible account of the social reality (Gopnik & Wellman, 2012). Some have put forward convincing arguments that mentalizing is taught by adults more or less explicitly (Heyes & Frith, 2014). However, in this book we will take a social-developmental approach and suggest that mentalizing is a uniquely human-evolved capacity that emerges in each mind, a capacity that is triggered by the interpersonal environment and wider social system the person finds themselves in. Radically, we maintain that were it not for others around us making us focus on our subjective experiences, mentalizing would not emerge—any more than a child of 18 months would begin to speak easily unless spoken to.

THE FAMILY SYSTEMS LENS

The other lens through which we work with families is the systemic one. Viewing the family as a system is useful, for it permits describing families as, for example, having "homeostatic tendencies" and specific properties such as hierarchies, boundaries, subgroups, as well as overt and covert communication exchanges and coalitions. For therapists, it can be helpful to view family members as behaving according to a set of hypothesized explicit and implicit rules that have developed over time, and often over generations, governing the relationships and communications within "the system" (Watzlawick, Bavelas, & Jackson, 1967). If specific features of the system, thought to contribute to the presenting problem(s), can be discovered or uncovered during therapy, then the system can perhaps be changed by questioning those features, such as established rules and relationship patterns.

Since the 1950s, systemic practitioners have developed a range of conceptual frameworks and interventions aimed at treating different types of problems and presentations. Some of these are particularly relevant to a mentalizing approach. Salvador Minuchin's ideas (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) are especially helpful in elaborating a mentalization-inspired approach (Asen & Fonagy, 2012a, 2012b). Minuchin introduced a focus on "dysfunctional" interactions that can evolve spontaneously in the here and now of the session. If these interactions do not occur, he suggests making them come alive in the session by encouraging deliberate "enactments" of typical problematic patterns (Minuchin, 1974). Such enactments allow intense thoughts and

feelings to emerge in each of the participating family members so that they may be immediately utilized to promote change. The technique of "circular and reflexive questioning," originally developed by the Milan team (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978), is an example of how long-established systemic tools powerfully promote the process of mentalizing. "Interventive questioning" (Tomm, 1988) tunes into the mental states of the individual family members. We have noticed that many systemic practitioners employing this approach tend *not* to inquire explicitly about the individuals' current feeling states. Instead, they are likely to focus more generally on how each person's actions and beliefs affect another's, and how family patterns and other contextual factors account for people's actions and interactions (Boscolo, Cecchin, Hoffman, & Penn, 1987). The mentalizing principle is "always focus on and work with current thoughts and feelings."

The classical systemic approaches tend to focus relatively little on the subjective states of family members when, for example, heated interactions take place. Traditionally, there was little interest in exploring how an individual's experience in such sessions may have altered their understanding of a relationship. The mentalizing approach, by contrast, retains the family members' focus on the specific episode and each person's experiences in the "here and now" of the session. It pays specific attention to how family members feel and think about acute social experiences. Mentalizing, the understanding of others' understandings, can change fundamental assumptions. It can change the mental states that appear to drive actions and the behaviors of other family members, and it can also alter how the family as a whole may think or feel about specific issues.

MENTALIZATION-INFORMED SYSTEMIC THERAPY

We refer to the approach put forward in this book as mentalization-informed systemic therapy (MIST). It not only harvests concepts and techniques from the systemic field, but is also enriched by mentalization so that all family members can see and experience themselves and others in new and nuanced ways that open up a multiverse of possibilities and experiences. The mounting evidence base for the effectiveness of mentalization-based therapies (see, e.g., Bateman & Fonagy, 2008, 2009, 2019; Blankers et al., 2019; Byrne et al., 2019; Fonagy et al., 2014; Keaveny et al., 2012; Rossouw & Fonagy, 2012; Smits et al., 2020) lends this approach increased legitimacy. MIST is not a new model of therapy—it is an integrated way of working with couples and families. The mentalization-informed therapist does *not* aim primarily

at helping families to find pragmatic solutions to problems, but rather to remove temporary—or not so temporary—blocks in family relations. Such blocks can, for example, include suddenly and unexpectedly refusing to answer a question, going "blank," or inadvertently or deliberately misunderstanding what another family member has said. The removal of blocks can, however, help a family to find its very own solution(s) to perceived problems.

Why Is Mentalizing So Important?

We have an evolutionarily unparalleled capacity to learn new information and pass it on to those who learn from us, particularly our children. We spend the first years of our lives learning how to do things, how to use an extraordinary number of words, how to use tools, how to learn the millions of rules that we have to follow, and so on. But we cannot learn everything by observation alone— life is simply too complicated. We have to be taught, and over millennia we have evolved extraordinarily efficient ways of passing on information to our young, so that they know exactly what they should absorb, pick up, and make their own. When children are addressed directly, when eye contact has been made, when they have been called by their first name, when they have been smiled at, or were just looked at with a raised eyebrow, or someone said a warm "hello" to them—all these little gestures are cues for children to know that whatever is coming next is important for them to remember. These cues, also referred to as *ostensive cues* (see Chapter 7), serve to make the child feel that they are being recognized as important, as respected social agents. They counteract the natural "epistemic vigilance" we all feel—the self-protective suspicion toward potentially damaging, deceptive, or inaccurate information (Sperber et al., 2010). Ostensive cues appear to make the child drop their guard and listen and absorb what they have heard. Being recognized in this way makes it more likely that we can trust what we hear—that is, we develop *epistemic trust,* a trust in knowledge. Adults also will respond to feeling recognized, just as little children do. The only difference is that, for an adult, a raised eyebrow or a smile may not be enough. In an adult, these ostensive cues tend to be more signals that indicate to the listener that the communicator "gets" them: recognizes their agency, the possible complexities of their state of mind, and shows validation and support in relation to these states. In essence, the communicator demonstrates through word or action that they are able to view the world from the other's perspective. In a systemic context, it is awareness of the idiosyncrasies of the family (e.g., particular family traditions, known demarcations and boundaries) that can serve as an ostensive cue to the system of the trustworthiness of an individual.

Mentalizing comes into this because understanding someone else's state of mind can in itself, if communicated appropriately, constitute a powerful ostensive cue. Mentalizing has the capacity to generate epistemic trust. If I mentalize someone, I recognize them as an agent. However, in order to establish epistemic trust via this route, I need to be able to mentalize the other well enough for that person to see themselves as accurately mentalized.

As human beings, we have evolved to be able to communicate and to employ dedicated mechanisms of communicative mind reading to enable us to collaborate effectively in productive social systems (Tomasello, 2019). The family is perhaps the most obvious example of the systems that benefit from this remarkable capacity. Of course, it is also the context where the malfunctioning of communicative mind reading becomes most obvious. What we try to do in MIST is to slightly retune this part of the social mind–brain. We do not try to replace bad thoughts with good ones or to generate good feelings in place of bad ones; we simply offer opportunities for communicative mind reading to be restored to its natural state; we try to remove blocks in the way of the spontaneous processes of thinking and feeling.

Getting Started: Mentalization-Guided Systemic Telephone Conversations

Let us return to Mrs. G and Salim.

The therapist asked how urgent Mrs. G felt the issues were and how soon she wanted to have an appointment. She replied, "As soon as possible . . . I could come to the clinic any time to explain more about Salim and his difficulties." The therapist inquired who, in her view, should attend the first appointment and asked her to consider the advantages and disadvantages of bringing her son, as well as the pros and cons of her husband accompanying her. The therapist also encouraged her to contemplate whether there was anyone else who might helpfully attend the first meeting. This was done via gently posing a number of questions:

- "Why do you think it might be more appropriate for you to come on your own?"
- "How might your husband feel if he is not present for the first appointment?"
- "What might be the disadvantages if Salim is there and hears about your worries directly?"
- "What might you not be able to talk about if Salim is in the room—and would this be a good thing or a bad thing?"

Mrs. G patiently answered all the questions put to her, frequently hesitating before replying and prefacing many of her answers with, "I'm not sure," or "I don't really know." The therapist continued, and asked Mrs. G about her preferences regarding where to have the first meeting: in the clinic, the family home, at the health center (as the referral had been made by the general practitioner [GP]), or somewhere else. Where would she feel most comfortable, and where might Salim and her husband like to meet? How might they decide? And would her husband agree with the referral and what Mrs. G had described as the problems—or would he have a different take on it? At the end of the telephone conversation, which lasted approximately 20 minutes, Mrs. G said she would like Salim to attend the first appointment together with both parents. The therapist validated her decision and added that, if after giving the matter further thought or discussing it with family members or friends, she wanted to change the appointment or who was going to attend, this would be fine.

Readers may query the wisdom of a therapist subjecting a potential client to a barrage of questions before the first therapy session. Mentalization-informed systemic work starts the moment a referral is received. In this way, the therapist signals from the outset what might be expected from the therapeutic encounter: the opening up of multiple possibilities and perspectives. In this first encounter the referring person, be that a parent or a professional, is encouraged to mentalize themselves as well as other members of the system, be that the family, the care system around the child, the school, or the child and adolescent mental health service.

But what does that mean in practice?

The questions the therapist put to Salim's mother during the telephone conversation could be described as *interventive* in the sense that the questions aim to help her—and the therapist—to look at issues from more than one perspective. Similar phone conversations can take place with a social worker, teacher, GP, or other professional (though bear in mind that regardless of the source of referral, the preference in mentalization-informed systemic family work is to talk to a family member first before having conversations about the family with professionals).

Systemic therapists tend to consider the context(s) in which the request for help arises. It is helpful to think of doing this at different levels of the system: the level of the individual client, of the referrer, of significant others, as well as the level of the neighborhood and friendship network, their faith-based connections, the schools and work settings family members relate to, the culture or subculture the family belongs to, and the overall sociopolitical context. Bronfenbrenner's (1986) ecological

approach is relevant here. Such multilevel *context reading* allows therapists to consider multilevel interventions. Should they just work with the family? Do they need to include other professionals or the family's own network? How can the family's faith-based or other cultural connections become involved to help with the presenting issues or problems? Does a child or a parent need to be seen individually? When viewed from a systemic perspective, clinicians have plenty of choices, as there are many possible contexts within which the work can be carried out. Mentalizing is not just the product of the dyadic mother–child or the triadic mother–father–child relationship. Rather, it is the product of a social group, a culture that the child experiences as focused more or less on their concerns, fears, and pleasures (Asen, Campbell, & Fonagy, 2019; Fonagy et al., 2019). The global aim of MIST is to enhance mentalizing within the entire wider system. Problems, we claim, arise because mentalizing stops or gets sidetracked, if not derailed, in the family's ecology.

Co-Constructing Therapeutic Contexts

After *context reading* comes *context making*: How can one make relevant therapeutic contexts that provide a response to the request for help? The question for therapists is, "What are the contexts that I need to use—or make—to address the presenting problems and issues?" Context matters! When answering this basic question pragmatically, it is helpful to consider four types of context: person, place, time, and activity (Asen, 2004).

The Person Context

The question of *who* should be concretely present in a meeting or session opens up many possibilities—from children, parents, and members of the wider family to significant others, be they friends, religious figures, or other professionals. In this way, the therapeutic system remains open for new persons to join or others to leave in future sessions. Mentalizing is an intensely interpersonal business. We have to remind ourselves that mentalizing occurs in the space *between* people, where we imagine the reasons for others' actions (or indeed our own) or imagine who we are in someone else's mind. So the person context determines the mentalizing context; feelings and thoughts will alter with the change in context.

The Place Context

There are a number of options for *where* the work is carried out: the clinic, home, school, hospital ward, supermarket, court, mosque, com-

munity center, town hall, and corridors of the court, to name a few. Working with a child and family in a naturalistic setting, a setting where the problem manifests itself concretely, can be more effective than confining all clinical work to sterile offices or other agency-based interview rooms. Instead of sitting-down talking therapy, *walking therapy* may loosen the minds of the clients and therapist. Just as with the who, the where determines the content and shape of the work. Mental states and family dynamics arise in the spaces between places as well as between people. The child's problems at school may be about conflict between the school and the home, so place matters. Feelings and thoughts can be buried in locations. Visiting these locations or choosing not to can both be wise options. But probably the wisest option is to question why certain places are immediately ruled out.

The Time Context

The *when* can be defined in terms of length, frequency, duration, and actual time of the session(s). Therapists of different persuasions tend to create discrete time slots lasting between 45 and 90 minutes, with a set number of sessions (6 or 12) that often take place over a period of 3 months to 1 year. Are there optimal therapy session minutes? Sigmund Freud probably invented the 50-minute hour more for his own convenience of note taking than in order to determine the optimal consultation period. Similarly, the 90-minute session systemic therapists tend to allocate for families may be born out of habit rather than need.

Context can often inform, if not dictate, the duration of sessions. In a pressurized clinical service, it may be realistic to offer 30 minutes per family. Family sessions lasting 10 or 15 minutes may be the appropriate time frame for carrying out family work in a family doctor's office, as this fits the very specific primary care context (Asen, Tomson, Young, & Tomson, 2004). At the other end of the spectrum, we may want to offer more time for multiproblem families when difficulties are chronic. Families are not likely to make the necessary changes if they receive 60-minute sessions at two-week intervals. Here we may have to consider longer interventions. These tend to be undertaken in multifamily settings (Asen, 2002), as it is more economically viable to work with six to eight families over such a time span rather than just with one.

The contextual parameters of timing should be guided by pragmatism. But pragmatism in the interest of what? Here MIST offers what we hope is a clarifying perspective. The pragmatic aim is to optimize the system's capacity to generate mental state understanding, that is, to increasingly see behavior as the expression of underlying beliefs, wishes, needs, desires, and intentions.

The Activity Context

What is actually taking place during the course of therapeutic work? The activities families are involved in can vary a great deal. This context includes, of course, therapeutic conversations or discussions that tend to be word-focused. In our view, manuals often overspecify and try to dictate what is talked about, which can limit mentalizing. MIST uses many playful activities, some of which are nonverbal or paraverbal, such as role plays, sculpting, collages, and exercises. The therapeutic activities are fitted to the presenting issues and may change from session to session.

Why is MIST more playful than many other therapies? It is not out of disrespect for our clients, and it is certainly not to sidestep the severe pain they sometimes bring to our door. MIST brings play into the therapeutic encounter to empower imagination for a deliberate reason: Mentalizing and in particular flexible mentalizing require an imaginative openness. Mentalizing involves imagining the internal states of another human as well as oneself. Some degree of self-awareness is required for this. We have to imagine how we might feel in order to attribute meaning to someone else's actions. So MIST is about shamelessly encouraging imagination, and we could happily call our approach MSTI: Making Systemic Therapy Imaginative.

The contextualizing questions Who? Where? When? and What? need to be asked not only at the beginning of taking on new work, but throughout the whole process of treating a family. By regularly involving individuals and families in this questioning process, it becomes possible to co-construct ever-changing relevant contexts for change, opening up new ways of seeing and experiencing. There are therapists who argue that too much flexibility—too much making and changing of contexts—is confusing to families. Other therapists maintain that too much predictability and routine are antitherapeutic and can kill natural curiosity and spontaneity. From a mentalizing perspective, it is important that therapists, together with their clients, try to think and rethink continuously whether the established *who, when, where,* and *what* contexts are still helpful.

Of course, being reflective is preferable to its opposite. But that is not central here. What is central is the shared or joint attention to a problem or issue that is considered important by all participants. It is the jointness of the process of continuous questioning and shared reevaluation that contributes to healing. It allows for the process of shared collaborative reflection, which is MIST's primary focus. Of course, flexibility also allows for the therapeutic system to remain open, so much so that the composition of who attends sessions can change, as well as

where, when, and for how long sessions take place. Yet it is not flexibility that heals, but the curiosity and surprise that it can bring that actually does the heavy lifting.

Generating a Focus and Considering Therapeutic Interventions

When the G family attended their first session, the primary aim was to create a jointly negotiated and agreed-upon focus for the work. In this case, the therapist opted for a problem-oriented approach, encouraging the family members to list all the worries they had and to specify what they wanted help with.

Session 1

Salim's mother quickly started listing the many different worries she had about her son, while Salim and his father busied themselves with a computer game. She repeated what she had said on the telephone and provided a long list of concerns: Salim's eating issues and anxiety states, his often very demanding behaviors, the lack of friends, hyperactivity, babyish and clinging behavior, temper tantrums, and many other worries. She talked for 10 minutes without any remarks from her husband or child. The therapist noted this process but did not comment on it.

Once Mrs. G had finished, the therapist thanked her and asked the father whether he wanted to add anything else. He said his wife had explained things well, much better than he could, and he added that he was also worried about Salim but less so than the mother. When Salim was asked whether he knew why his parents had brought him to the clinic and whether there was anything that he himself wanted help with, he shrugged his shoulders and then resumed his play. The therapist turned to both parents and asked them which of the issues the mother had mentioned they felt should be tackled first. Salim's father pointed at his wife and said, "Let her decide, she is the boss." The therapist encouraged the parents to discuss together which particular problem to tackle first. The mother replied that the most urgent issue was Salim's "eating problem . . . it takes him 3 hours to eat his lunch and 1½ hours to eat his breakfast. . . . It's driving me mad." The father added, "It would drive me mad, too, but I am out at work all day. I manage a restaurant and that means long hours. My wife has to help Salim eat most of the time." The parents were asked when they wanted to come for an appointment to address the issue. The mother said, "As soon as possible, how about next week!" and the father agreed. The therapist suggested that the next session should take place at lunchtime, with food being supplied by the parents, and that it should last some 3 hours so that the "eating

problem" could be fully studied. After some discussion, the parents decided that only Salim and the mother should attend, as it was almost exclusively she who was engaged in the daily struggles over eating.

During this first session, the therapist immediately noticed specific relationship patterns, such as how the mother played a dominant role and how the father seemed to feel he had to agree with his wife, and observed that Salim was oblivious to the parents' repeated requests to stop playing the computer game. However, the therapist refrained from commenting on these interactions. Instead, he decided to leave open the possibility to return to his observations at a later stage. Why did he not challenge Mrs. G or Mr. G? There is an important technical issue here for MIST. Following the principles of the intervention, the therapist endeavored to place himself in the shoes of all the family members. He considered, if he were Mrs. G, whether any intervention that questioned her behavior would be likely to enhance her capacity for interpersonal understanding. Then he did the same for Mr. G and Salim. In doing so, he became aware of the shame and embarrassment that any or all of them may have felt by attention being drawn to a specific interaction he had observed. It seemed the therapist knew little, and even polite questioning could generate shame or embarrassment, or a feeling of being misread or misunderstood. MIST recognizes that feeling misunderstood or misread is an experience that generates pain. Thus, the stance that is gently curious and is experienced as being open and inquisitive rather than knowing is far more likely to be productive in enhancing reflection.

Session 2: MIST in Action

One week later, Salim and his mother attended for the second session, as agreed. Mrs. G had brought lunch for both Salim and herself. They sat down at a table in a large consulting room. The therapist came in and out of the room at 5- to 10-minute intervals, observing the family briefly and commenting occasionally. He observed that Salim had hardly begun to eat and was chatting with his mother, pleading with her to feed him or stating repeatedly that he was not hungry. The mother responded by telling him that he was a "big boy . . . you can eat yourself . . . you said you were hungry . . . " and repeating these phrases endlessly. Salim continued to behave in ways much younger than his biological age. The mother frequently made encouraging noises and accompanying actions, more befitting a 1-year-old infant than a 6-year-old child. There was a lot of "gootchie gootchie" and small talk, and the mother paid a lot of attention to Salim's not eating. The

therapist eventually asked the mother how, in her opinion, the eating was progressing. She pointed at the full plates and commented that it was "not going very well." She said this was "typical of how it is at home—it takes ages for him to eat anything." The therapist asked the mother whether she felt that Salim was too thin. She replied, "No, he has a normal weight, but he wouldn't if I didn't work so hard to get food into him." When asked to speculate on why Salim was so slow at eating, she was at a loss. The therapist said to the mother: "Maybe you should leave the room and come back when he has eaten his food." The mother looked shocked but left the room together with the therapist. Salim seemed even more shocked; he said: "What?! No!!" and began to scream louder and louder and then banged on the door through which his mother had left. This went on for 2 minutes, with Salim repeatedly screaming, "I'm dying!" Meanwhile, Mrs. G, in an adjoining room, became extremely agitated and began to hyperventilate. She said her son could not bear to be in a room alone and that he would be in a panic.

The therapist went back into the room where Salim was continuing to scream for his mother and said to him: "Your mom will be back when you have eaten some more food." Salim was beside himself and speechless. He made an attempt to swallow some food. The therapist encouraged him to eat a bit more. Salim complied, and as he was eating, he was unable to scream, but he still produced tears. The therapist called the mother to return to the room. She looked emotionally drained, and she immediately went up to Salim to dry his tears, which interrupted his eating. He dropped the spoon and leaned back. His mother continued to fuss over him, wiping his face and taking the spoon out of his hand.

The therapist asked the mother to sit down, away from her son, and watch his eating. Salim started again to put some food in his mouth. The therapist knelt next to him and put his ear playfully on his belly, pretending to listen to the food entering his stomach and exclaiming, in a somewhat silly voice: "Hurrah hurrah, says your tummy, I am happy to have some food down here . . . thank you, thank you." Salim laughed, his mother laughed. The therapist was serious when he turned to the mother: "You know I somehow knew that Salim could cope with being in the room by himself and could eat by himself, with me and even without me. I think he would have been able to eat the whole lunch—and pretty quickly . . . but I was worried about you . . . I was worried that you might crack up next door—I was worried that you might not be able to cope with being out of sight of your little boy, but he is quite a big boy . . . and see how well built he is, these muscles, he is much bigger than perhaps you think he is."

The mother had by this stage calmed down a bit, and, after listening to what the therapist had said, she had a smile on her face. The therapist,

now standing close to Salim, asked the mother to imagine what Salim was feeling and thinking then and there, making a physical gesture of imaginary thought bubbles coming out of the child's head: "If there were thought bubbles coming out of Salim's head, what might be written in there?" She smiled and said: "He is thinking, 'I am not coming back here.'" The therapist checked with Salim whether his mother got it right. He hesitated, then looked at his mother, and he nodded. Therapist: "So will your mummy have to drag you back here?" Salim smiled and shook his head.

The therapist asked again to listen to his "tummy," and Salim clearly enjoyed it when the therapist exclaimed, again in a rather silly voice: "I want more, come on feed me, I am still really really hungry." Salim proceeded to eat at a good pace, with a big smile on his face. When the therapist left the room to attend to another family with "eating problems," Salim turned to his mother and said: "Feed me mommy, if you love me." The mother responded: "Do you think I don't love you? Why do you say that? Why do you say I don't love you?" Salim: "Because you are not feeding me." This went on for a time, with the mother pleading again with Salim to eat. When the therapist reentered the room, he said: "I think—but I may well be wrong—that Salim thinks he needs to behave like a baby to be loved by you. I know he is a clever boy and I bet that he can eat all the food in 10 minutes or less—but as long as you don't think he can, he won't. He probably needs to know that you know he is 6 and not 1 year old." The therapist left the room again and when he returned 10 minutes later, Salim had finished all the food. The mother reported that all she had done was to tell Salim repeatedly that he was 6 years old and not 1. The therapist commented: "You can probably behave older than 6—the way you ate all that food and so quickly, that was so impressive—only older children can do that."

He turned to the mother and said: "Well, we had scheduled 3 hours for this, so there is another 1 hour and 40 minutes left . . . is there something else you'd like to use this time for?" The mother said: "Yes, it's to do with his homework—it always takes him 1 hour or more, and the school says he should do it in 10 minutes . . . but he won't. I need to sit next to him and help . . . and then we end up arguing and I have to do it basically because Salim says it's too difficult to do on his own." Therapist: "Well, why don't you both have a go now, and I'll be back in 1 hour or so." Ten minutes later, Salim came out from the room in search of the therapist. When he found him, Salim said proudly, "I'm finished—and my mom didn't even help me." The therapist asked Salim what he thought she might be feeling. "Proud," he replied. The mother confirmed that Salim was right, and she was then encouraged to speculate about what thoughts and feelings might have been going on in Salim at different stages over the last 2 hours.

EXPLAINING THE SESSION

This session—which was being video recorded—could not be described as a typical example of either purely systemic therapy or purely mentalization-based therapy, as described by Bateman and Fonagy (2016). A range of different techniques were employed, some from behavioral, structural, mentalizing, and other approaches. The therapist's position was central, and he was rather interventive, generating stress in both parent and child. This is why we call the approach MIST: It is essentially a systemic approach with a mentalizing focus.

From a mentalizing perspective, what happened could be described as follows: The therapist observed nonmentalizing interactions between mother and son; he blocked these interactions dramatically by asking the mother to leave the room; this immediately increased the levels of arousal in both mother and child, and their capacity for mentalizing completely shut down; they both were in a state of panic. Once the mother had returned, the therapist tried to help both to regain the capacity to mentalize by engaging Salim in a playful way, using pretend techniques and involving the mother in these interactions. This decreased the arousal of both mother and son, and they gradually regained their ability to think and be aware of feelings. This evident increase in mentalizing capacity then led the therapist to get the mother to speculate about the child's state of mind then and there, trying to explore his actual experience rather than her imagined picture of his mind. He did this because he became acutely aware that the anxiety between mother and son was unbounded, that the anxiety of each resonated with the anxiety of the other and rapidly became uncontrollable for both. As they had said accurately in the first session, they had the capacity to drive each other mad. Meanwhile, the therapist communicated his belief in Salim, including that he was older than he had chosen to act. Salim felt recognized by the therapist and was able to come unstuck, which assisted the mother to view him differently. This led to developmentally more appropriate interactions and communications between them.

Session 3

When Salim and his parents returned 2 weeks later for the third session, they reported that Salim now ate properly and that he was also keeping up with his homework. The mother then explained that she and her husband wanted help "for another big problem—he cannot be in a room on his own, not a minute, not a second." The therapist asked the parents' permission to see Salim on his own. They gave it, and Salim had no difficulty separating from them and following the therapist to another room. The therapist

spoke with Salim about his fears of being on his own and then suggested they play a little game; the therapist would leave Salim in the room for fractions of a second to see how long he could tolerate being alone in a room. Salim suggested 5 seconds. The therapist left the room for precisely 5 seconds and returned. He asked Salim whether 10 seconds was doable and Salim agreed. This was followed by a 15-second absence, and over time it went up to 2 minutes. The therapist then pretended to be a TV reporter and interviewed Salim about what he had thought and felt during each of those absences. Salim spoke directly into the running camera, explaining that he was worried before, but doing it was okay and almost fun. The therapist then handed the camera and microphone to Salim and suggested that he should leave the room for increasingly longer times and then interview the therapist about what he thought and felt in Salim's absence. Salim managed the task well, and both therapist and Salim went back to the room where the parents had been waiting. Salim explained what he had been doing with the therapist over the past 30 minutes, and both parents seemed not to believe him, prompting Salim to say: "You all go out of the room and I will show you." The parents and therapist left the room. In the corridor, the therapist asked each parent to put themselves into Salim's shoes and imagine what he was thinking and feeling while he was alone in the room. When they were reunited with Salim, the therapist asked him what he thought the parents would be thinking and feeling in their absence. Salim was spot on when he imagined that his mother had been full of worries about him, including that he might hurt himself badly in the consulting room or go too close to the window and risk falling out; he thought his father would "not be so worried," and, as to the therapist, Salim said: "Oh, he was not worried, he knows I can do it." The therapist got the family to remember the previous session. As the father had not been present, some of it was shown on a laptop. All three family members watched intently, and when it came to the point when the mother left the room and Salim had screamed that he was dying, he burst out laughing and said, "It's so silly." The mother, with tears in her eyes, was visibly moved. Salim went to her to reassure her and put his arms around her, seemingly in an effort to comfort his mother. The therapist drew attention to this interaction and asked the father: "What do you think is going on in your wife? And what might your son be thinking and feeling right now?" After listening to the father's speculations, he asked the mother to look at the segment of the previous session and reflect on her own feeling state and that of her son.

The behavioral technique of "exposure *in vivo*" is rarely part of a systemic approach, but it is perfectly compatible with a mentalizing one when done for the purpose of enhancing the range of thoughts and

feelings that can be brought to an issue. Here it was employed to provide Salim with a novel experience in a playful manner, with a subsequent use of a prop (video camera and microphone) to focus on the mental states of self and others. Once he had metabolized this experience, Salim also used his newly gained confidence in a playful interaction with his parents. At that point, they started seeing him through different lenses, and correspondingly he came to be aware that they also experienced him as being different. Naturally, this rapidly translated into new ways of seeing himself too. The use of video material from a previous session allowed Salim to look at himself and his parents to look at him from an external perspective: Seemingly unable to mentalize himself and his mother at the time she had left the room 2 weeks earlier, he was now thinking it quite funny. However, the mother's stressful experience was revived even when she had experienced her son's newly gained confidence only minutes before.

The focus of the first session was, by parental consent, the eating problem. The intervention tried to concretely address this issue in order to remove one of the barriers inhibiting mentalizing: the mother's sense of her son being a little baby who needed to be fed by her. During the course of the intervention, the mother gradually saw and experienced both Salim and herself differently. Of equal importance, Salim felt temporarily recognized by the therapist as an agent, a 6-year old boy with a mind of his own, rather than as a helpless baby. Removing this barrier temporarily kick-started effective mentalizing, and it allowed mother and child to move away from an intensive over-preoccupation with feeding.

Once the eating issue had been resolved (temporarily) in the session, the therapist invited the mother to consider working with the next layer—and Salim's difficulty with doing his homework was nominated. This was followed in session 3 by addressing another problem layer—Salim's seeming inability to be in a room by himself. This way of working could be termed the "onion layer" model of working. Preparing an onion for cooking, slicing into and then chopping it, is usually a rather tearful enterprise, so much so that one's vision can become blurred. Similarly, when working with families, getting too quickly into the core—or the "nodal point" (Selvini Palazzoli et al., 1978)—may be theoretically desirable but is usually unwise as an opening gambit: It can generate high levels of arousal among family members. The aim is for the family to be able to return to manageable levels of arousal and resume mentalizing in the stressful context that normal family life can come to represent. Furthermore, parents often say that "we have not come here because we have relationship problems, but because our child has serious problems. It's him and not us you should focus on." It is wise to go with what the

parents believe the most difficult problem is and start there, collaborating *with* them as it were. Only peel the next layer if or when invited by the parents or other significant family members. This way of proceeding is often more acceptable to clients and needs to be done at a pace the family can tolerate in harmony with their increasing capacity for mentalizing. At the opening stages of family work, the therapist carefully monitors the capacity of the family to absorb content that requires mentalizing. Even later on in therapy, during moments of high arousal, the therapist will stop short of explicitly offering accounts of interactions that require mentalizing when it is likely that these cannot be absorbed.

Another session took place some 6 weeks later; only the parents arrived this time. They reported that Salim was functioning "pretty well" now, both in school and at home. On top of this he had made a good friend, and the friend had come to visit him at home; it was a first. The father then said that his wife had always been anxious about Salim—he was a precious child—even before he was born. Three miscarriages had preceded his arrival, and he was gravely ill when born and was in and out of hospital during the first year of his life. "I think my wife still thinks of him as a baby who needs to be watched all the time. . . ." Two parental couple sessions followed.

This is an example of how, step by step, session by session, therapeutic work can get closer and closer to the "nodal point"—with the onion being peeled layer by layer until family members—in this case the mother—are willing and able to address difficult issues that are at the heart of the matter.

CONCLUDING REFLECTIONS

This brief introduction to Salim's family illustrates both the simplicity and the complexity of the MIST approach. Mentalizing is of a moment. It is the current understanding of each agent's mental state. It is therefore rapidly changeable, even ephemeral. Yet it can become rigidly held and is apparently impervious to external influence. Salim's mother's belief that he was a baby in need of being fed by her was exactly such a robust, yet ephemeral, construction—ephemeral in the sense that Mrs. G did not truly believe that Salim was a baby, yet her actions could only be understood as reasonable in the context of that evidently mistaken assumption.

What makes such ephemeral attitudes so tenacious? The nature of mentalizing makes change difficult if there is heightened emotional

arousal. Salim's capacity to generate anxiety in his mother undermined the potential for mature thinking and, from the perspective of her experience, made the fleeting impression feel like an incontrovertible truth. Naturally, being treated like a 1-year-old was not easy for Salim, though he accommodated it rather well. But in so doing, he made himself in all respects dependent on the ministrations of an all-attentive caregiver and resonated powerfully with her feelings of anxiety—as indeed almost all 1-year-olds would be expected to do. The same emotion-driven process that can make ephemeral beliefs concrete was also at work for him—his status as a baby was made quite real for him by his anxiety. The system where poor mentalizing in Salim triggered anxiety and poor mentalizing in his mother, which in turn generated anxiety and even more inadequate mentalizing in Salim, became a system that can only be described as rigid. It certainly did not feel in the least ephemeral to anyone.

Yet, breaking such an ineffective mentalizing cycle is relatively simple. In most average family contexts, resolutions are found every day, spontaneously without professional intervention. Why revealing beliefs to be ephemeral rather than totally compelling can require external intervention in some families and not others is indeed a complex question that we will try to address in this book.

But the complexity of that question should not be mistaken for the sophistication required to address problems of inadequate mentalizing in any particular instance. Attributing even complex family problems to suboptimal mentalizing can liberate the therapist to identify easy, playful, and relatively painless processes that encourage a rapid return to more acceptable patterns of family interaction. The reader might wonder why the simple intervention of listening to Salim's tummy appeared to have been such an appropriate and effective way of tackling this family's problems in relation to Salim's chronic eating difficulties. From a MIST perspective, the answer is that by adopting a playful, slightly humorous stance, the therapist mentalized Salim's tummy (not a part of the body normally regarded as capable of having thoughts and feelings). Yet, creating a mentalizing tummy could encourage Salim to mentalize his mother's excessive anxiety and let her reflect on the realistic concerns she might have in relation to Salim's physical well-being.

Throughout this book, we will consider simple interventions that have tremendous influence merely by reigniting the natural processes constantly available to all of us to modulate affect and stabilize interpersonal interaction.

Chapter 2

Effective and Ineffective Mentalizing

Ms. Jones had been known to Social Services all her life, as had her mother. Both had suffered physical and emotional neglect from infancy onward, and both had spent significant periods of their childhoods in foster care. More recently, at the age of 18, Ms. Jones had become a mother herself. Her baby, Tracey, was only 3 months old when neighbors alerted Children's Services because they were concerned that Tracey was screaming a lot and that Ms. Jones was screaming back at the baby.

A parenting assessment was requested, and Ms. Jones turned up for her first appointment in a somewhat belligerent mood, launching immediately into a tirade: "I don't know why they always pick on me, why don't they leave me in peace? I bet they don't have children themselves and they are just jealous that I have. That social worker I have, she is an old woman, she looks like a witch, no surprise that she can't have any children, and that's why she wants to have my child . . . well, she can't. Tracey is mine, I am a good mom, I know what to do. She should go and see some of the other families on the estate, that's real child abuse what they do there. . . . I am different, I bring my Tracey up the proper way, so she can have discipline and respect for me and all that . . . they never let go these social workers, they are evil. . . . "

At this point, the assessing therapist felt the need to interrupt Ms. Jones: "Thank you for explaining this so clearly. May I just ask you, what is it that your social worker might be worried about, from her point of view?" Ms. Jones's reply was prompt and delivered in an impatient tone: "I've just told you—there is nothing wrong with me, there is nothing wrong with Tracey. There is something wrong with the social worker. She should see to

me having more money, that my flat is fixed properly, you should see the state of the kitchen—that's what they should do, the social workers, make sure that people live in better homes. Then they would have time to look after children. You can't expect us to be perfect—I mean, with the leaks and the damp . . . the time I have to spend cleaning, and there is no one at the Council who is interested, they are just lazy and incompetent, couldn't run a piss-up in a brewery, they couldn't. . . . " The therapist, thinking about his objective for the session, made a second attempt: "When you think about yourself as a mother, is there something that you think you do really well? And is there something that you feel you could do even better?" Ms. Jones replied: "Nobody is perfect, particularly when you can't pay your bills, when you have to shoplift to feed yourself and your kid. Give me money and somewhere proper to live and I'll be a more perfect mother!"

In our work we have come across many a Ms. Jones. They face many hard challenges in their lives. Sometimes we feel a little overwhelmed in listening to them. Would we be able to do better given the multiple stresses they face? What can make life even more challenging for them is an impaired and at times almost absent mentalizing. They do not engage with us in trying to see the world in an even slightly different way from how they see it. The apparent absence of mentalizing is not only a feature of families with members who have suffered abuse and neglect. As we said in Chapter 1, all of us have times when we do not mentalize well, when simplistic and concrete thinking takes over. On such occasions, we cannot seem to imagine that it could be any different from how it is, how we *know* it to be. We are convinced that there is no reality other than our own. We might ask ourselves how come other people are not able (or, more likely, not willing) to see things in the obvious way we see them. Are they being obtuse? Perhaps they are being deliberately obstructive?

In the above segment of the first encounter between the therapist and Ms. Jones, she appears to subscribe to only one reality: her own. She portrays herself as a victim of Social Services' injustice, "they" have "picked" on her, she says; she feels that her life would be better if her flat was in a reasonable state, and Social Services is to blame for all of that. This all seems very one-sided, yet attributing one's own difficulties to the failure of others is something we all find ourselves doing from time to time. The question is this: If mentalizing is as important as we said it was, ensuring that we all fulfill our evolutionary function as social collaborators and that we hunt together for that proverbial stag (Bullinger, Wyman, Melis, & Tomasello, 2011), then why do we sometimes fail to mentalize well? What does mentalizing well look like?

TYPICAL SIGNS OF EFFECTIVE MENTALIZING

There are various signs (see Box 2.1) that would suggest that effective mentalizing is taking place, be that in relation to oneself, to another person, or to being relational (see Chapter 6 for further elaboration and the systematic categorization of these signs as "facets of effective mentalizing").

Openness to discovery is akin to the stance of curiosity (Cecchin, 1987), meaning that the person is genuinely interested in other people's thoughts and feelings and respectful of the perspectives of others, particularly when these perspectives are different from their own. This may often require an *empathic stance*. The reluctance to make assumptions or to hold prejudices about what others think or feel is called the *not-knowing position*. Related to this position is the stance of *humility,* a willingness to be surprised and to learn from others, regardless of status. *Perspective taking* is characterized by the acceptance that the same phenomenon or process can look very different from different perspectives and that these tend to reflect the individuals' diverse experiences and

BOX 2.1. Typical Signs of Effective Mentalizing

- Openness to discovery
- Empathic stance
- Not-knowing position
- Humility
- Perspective taking
- Playfulness and self-deprecating humor
- Turn taking
- Focus on mental states and ability to distinguish between feelings and thoughts
- Reflective contemplation
- Inner conflict awareness
- Managing affect and arousal
- Impact awareness
- Capacity to trust
- Capacity for collaboration
- Belief in changeability
- Assuming responsibility and accepting accountability for words and actions
- Forgiveness
- Autobiographical/narrative continuity/developmental perspective

histories. *Playfulness and self-deprecating humor* gently force alternative perspectives and can also favor *turn taking*—the ability to "give and take" in interactions with family members and significant others. The *focus on mental states and the ability to distinguish between feelings and thoughts* is an important facet of effective mentalizing. *Reflective contemplation* is a mentalizing attitude that conveys a flexible, relaxed, and open, rather than a controlled and compulsive, pursuit of how others think and feel. *Inner conflict awareness* is a specific aspect of self-reflectiveness. Being able to *manage one's affect and arousal* ensures that effective mentalizing can be recovered or maintained during stressful interactions. *Impact awareness* refers to the appreciation of how one's own thoughts, feelings, and actions may affect others. The *capacity to trust* is an important mentalizing strength, and it is in marked contrast to a paranoid, fearful stance. The capacity to trust affects the *ability to collaborate* with others in joint tasks. The *belief in changeability* implies some degree of optimism and embodies the hope that minds can change minds, as well as, and often thereby, physical situations. The stance of *assuming responsibility and accepting accountability* for words and actions entails recognizing that one's actions are generated by one's own thoughts, feelings, wishes, beliefs, and desires—whether or not one is fully conscious of them at the time of the action. *Forgiveness* is a mentalizing strength that bases the comprehension of the actions of others on the understanding and acceptance of their mental states. *Autobiographical/narrative continuity/developmental perspective* implies the ability to make sense of how the present may be affected by experiences and events in the past.

MENTALIZING: STATE AND TRAIT

Plenty of reasons explain why the capacity for mentalizing can fluctuate. For convenience, we can separate them into two categories: trait or state. It is probably the case that both biological and environmental factors influence an individual's developing capacity to mentalize. This capacity can be seen as a long-term trait. For example, infants who are born blind are markedly delayed in the development of mentalizing for the first 2 years of their lives. Infants who do not experience a secure attachment relationship may also be delayed in their ability to acquire robust mentalizing. Furthermore, early privation or trauma appears to impair the ability to develop mentalizing appropriately.

Certain contextual factors temporarily block effective mentalizing in individuals, both in those with well-developed and those with

developmentally less robust capacities for mentalizing. These contextual factors function to produce shorter-term states. This is most likely when we feel we are under stress, such as when we are very frightened, angry, and frustrated, or when we feel humiliated and ashamed. At these times we all need validation of our position because we have momentarily lost our capacity to see ourselves as agentive beings, in charge of our destiny, motivated by what we think and wish for. Our sense of identity is threatened. The mentalizing apparatus becomes disconnected from the rest of how we think, and we revert to simpler modes of seeing ourselves, others, and managing our world.

This may help explain why Ms. Jones talks the way she does to the therapist. She perhaps feels she is under siege, and therefore she enters into a kind of fight–flight mode. When she feels accused of being a bad mother, she becomes very defensive; she sheds any doubt and adopts an attitude of almost unnatural certainty about what her social worker might want or feel. She experiences herself as not being meaningfully responded to, and she appears unable to appreciate the concerns others might have about and for her. She has no confidence that her feelings and needs will be recognized, and she demands something more than words to "make the therapist see" her position, to achieve recognition for herself, which of course is all our natural right. However, this intensification of her stance can have a paradoxical effect: It is likely to limit the other person's capacity to mentalize her and see things from her position. The protagonists in this common enough scenario are quite likely to end up in a vicious cycle of nonmentalizing self-assertions and poorly reasoned arguments. In other words, the ineffective mentalizing expressions of Ms. Jones's understandable emotional arousal (the unnatural certainty, the accusations, the demand for resources) are likely to compromise her potential helper's capacity to provide the understanding. Ms. Jones craves psychological validation in her situation of isolation, sleeplessness, breast feeding her infant every 4 hours. She is trying to manage on very inadequate welfare resources, which have been unacceptably delayed.

Ms. Jones continued: "I know that you are all the same, you helpers, you therapists, you social workers. You don't understand us; you don't understand people like me who have tough lives. You live in posh houses, you drive expensive cars, and you can eat what you like. You think I am rubbish, not good enough, just got pregnant to get social care, not good enough to look after her child, just trouble and a lost cause."

While Ms. Jones may well accurately mentalize a specific social worker or therapist when she imagines that she is considered a lost cause or is being looked down on, it is her global, significantly overgeneralizing assumption that *all* helpers are more or less the same and the black-and-white nature of her interpersonal judgments that characterize her stance as ineffective mentalizing.

Mentalizing is important for representing, communicating, and regulating feelings and belief states linked to one's wishes and desires. When stressors interfere with the relatively high level of brain function required, mentalizing weakens or stops. This is likely to be a temporary phenomenon, or, at the more severe end, it can be the expression of a habitual way of coping (perhaps at times thoughts and feelings can be too painful to bear). What we see in place of mentalizing are characteristic modes of thinking that fill the gap mentalizing should occupy. We are describing these modes in some detail to alert therapists to the notion that what they are hearing cannot and should not be taken at face value, as an indication of who this person is. Before we make judgments about these persons, we should ensure that they are able to express their thoughts and feelings to us in the way they would wish to when not upset. Ms. Jones's mind, when she is stressed, becomes temporarily closed to seeing herself and her child from a perspective other than her own. But this may not be the way she normally is. Typical signs of ineffective mentalizing are contained in Box 2.2.

BOX 2.2. Signs of Ineffective Mentalizing

- Inability to consider both self and other perspectives
- Unjustified certainty about the internal mental states of self and others
- Focus only on concrete external factors
- Unfounded attributions about the thoughts or feelings of others
- Dominance of automatic unthought-through assumptions
- Apparent lack of interest in mental states
- Accounts of own thinking or feeling at variance with reality
- Excessively overdetailed accounts of events
- Accounts of thoughts and feelings that have little or no connection with reality
- Idealizing or denigrating discourse
- Overfocused on or stuck in just one of the dimensions of mentalizing (For more on the mentalizing dimensions, see Box 2.3)

PREMENTALIZING MODES: THINKING AND EXPERIENCING

Three specific forms of ineffective mentalizing have been suggested: psychic equivalence, teleological, and pretend modes. These modes of functioning characterize children's thinking before the age of 5, and they can re-emerge in older children and adults under certain circumstances. This kind of regression to prementalizing modes of functioning can undermine the social mechanisms that enable human collaboration: negotiation, turn-taking, creativity, and respect for the mental states of others.

Psychic Equivalence

The concept of psychic equivalence (Fonagy & Target, 2000) refers to a developmentally immature form of mentalizing in which mental states are experienced as having the same status as physical reality. In the psychic equivalence state, only what is observable in the real world is experienced as being of significance (Fonagy, Gergely, Jurist, & Target, 2002). Psychic equivalence is a normal developmental stage for preschool children whose fears cannot be assuaged by reassurance that they are unfounded. It is a stance that, in adults, could be paraphrased as "everything in my mind is out there (i.e., is true), and everything out there is in my mind (i.e., known to me)." The toddler seemingly "knows" everything there is to know, and everything the toddler knows is by definition "true," from their point of view—the only point of view as far as they are able to discern. Psychic equivalence is more likely to re-emerge beyond toddlerhood if effective mentalizing is insufficiently supported in the family, and it can momentarily return for adults when emotional arousal prevents effective mentalizing. At these times, one's own thoughts and feelings override those of anyone else. It is this momentary inability to entertain alternative explanations and perspectives that gives mental states in psychic equivalence such immense force. Ms. Jones "knows," as she repeatedly emphasizes, what the social worker and people like her think and feel about her. Similarly, she has a fixed view of other support organizations. Alternative explanations do not appear to be possible to contemplate.

Teleological Mode

Ms. Jones continues: "There is something you can do for me. If the housing people gave me a better place, I would be a better mother. Honestly, I don't need social workers, I need a bigger flat where my baby is not coughing all the time, if I can sleep and I am not tired I can look after my baby. I would

have no problems with Social Services or with anyone if my baby and I had a proper place to live in."

This is an example of another prementalizing mode kicking in: the teleological stance. Here, only behavior that has physical impact is considered meaningful. It is a form of quick-fix thinking. The individual can recognize the potential role of mental states, but this recognition is limited to very concrete, observable outcomes. Concrete results and solutions in the form of "deliverables" in the physical world are being looked for and uniquely valued. In this state, it is assumed that only actions can change mental processes: Only "what you do and not what you say" counts. It leads to urgent demands for physical acts that often are for rescue; to be saved is the physical demonstration of benign intent by others. A new apartment, a payment, acts of subservience, retributive justice, and so on will tell me I matter, I am valued, I am respected, I have suffered. When individuals are in this state, they have already suspended doubt (psychic equivalence), and there is absolute certainty about what needs to be done to solve the particular issue. There is unique recognition of real, observable goal-directed behavior, as well as a focus on objectively discernible events that may potentially constrain these goals. Ms. Jones appears certain that there is only one way to address her distress and psychological needs, and this involves changes in her living circumstances and in the physical world.

Pretend Mode

The therapist made another attempt: "Let us imagine you were given a new flat by the Housing Department, and all was well and the social workers left you in peace. What would your relationship with baby Tracey be like? What would you be doing, how would you be spending the day? Whom might you see, or who might help you?" Ms. Jones replied, much more animatedly than before, speaking quite rapidly: "All would be fine. She thinks the world of me. I can tell. When I pick her up in the night she trembles, she is so excited to be with me. We have a real bond. She knows I am her mom and I love her, and I would do anything for her. And if we had a flat that was in the other estate, where I asked to be, not where we are, which is horrible, but the other one, then we would be near my mom. And my mom would help me; I'd let her help me. She means well, she wasn't a good mom, but she means well. She wants to be a nan and do things better than she did for us. I will help her to be a good nan. She could look after Tracey if I go to work. Tracey needs to have a good relationship with her nan. I never knew my nan. And my boyfriend, Joe, could come to the house whenever he wants. Now he is just

too far. But Tracey could have a relationship with him because she needs a father. It is not like all children should have someone who is like a father. The guy who got me pregnant was no good, but Joe is different . . . he comes from a good family, he had proper parents. At the moment he can't visit me, he doesn't like the flat, I don't blame him. I think he is just not comfortable with the cold. So you see. . . . Tracey is missing out on having a proper dad . . . but at least she has a mom . . . and my own mom is okay really. . . . I know my sister and I both had times in care when she could not cope but she came back and showed up for us in the end and she just behaved like that with us because she had no loving herself . . . her mother was a right old cow,. . . . She was very abusive. So mom was abused and she treated us badly because that was the only way she knew how to treat children. I am different, I have learned from experience. . . . I can see how my mom was affected by her experience and I will not let that happen with Tracey."

The pretend mode is a developmental mode through which young children decouple their own world from external reality; it is often joyous and rewarding. We see it in their pretend world of play, where they talk to imaginary friends and create make-believe games. In this prementalizing mode of mental functioning, the child at play knows that internal experience may not reflect external reality. The little boy can believe that his wooden stick is a sword, without expecting them to actually harm his opponent. Children can create imaginary mental worlds that they are able to sustain as long as the boundaries around it are maintained and they are not confronted by actual reality (Target & Fonagy, 1996). Or, to paraphrase it, imagining is real but not reality. Playful interaction with a significant adult or older child who takes his pretend world seriously helps the child to represent and manage his feelings. The capacity to explore and think about mental states can develop in this dissociated play world. With development, this world of imagination is applied to the real world, and a comprehensive sense of the real state of self and others develops. However, when adults relapse into pretend mode, as Ms. Jones did above, they create a glass bubble around their thinking that is as delinked from physical reality as the cops and robbers game of 5-year-olds. In this space, the deepest sounding conversation is in reality inconsequential. There are references to mental states, but these have no substance that can be followed up and relied on. Often the emotions that one might expect to follow from beliefs are simply absent, and statements are not accompanied by congruent affect. Body and mind are decoupled. A conversation can go on for a long time; thoughts and feelings are discussed, but the narrative reaches no resolution, like a wheel that is spinning in sand, obtaining no traction. Ms. Jones's conversation above

could be described as a kind of pseudo-mentalization, the adult continuation of the young child's pretense. Her narratives appear to contain elements of mentalizing, but they fail to connect with any reality and therefore they fragment and achieve no coherence. She describes how Tracey feels, but the bond she alludes to is hardly compelling. The insight into her mother's experience hardly provides an account of her mother's past behavior. Joe's role as a father to Tracey does not seem ensured from her descriptions. These contributions may come across initially as somewhat thoughtful, as reflecting partial understanding of how people might feel in the situations described, but ultimately they have a "canned," predictable character. Ms. Jones's account has the hallmark lack of recognition of the inherent uncertainty that should accompany speculating about the contents of someone else's mind. Thoughts and feelings in others or the self are marshalled to support the interest of the speaker. Thoughts about mind-states can become more convoluted than they need to be, intruding into places where they are not needed. Overactive mentalizing can turn into hypermentalizing (Sharp et al., 2013), becoming increasingly inaccurate in the process. Some people invest a lot of energy in thinking or talking about how other people in the family think or feel, but with little or no relationship to the other person's reality.

DIMENSIONS OF MENTALIZING

It would be both unrealistic and undesirable for human beings to be always in a state of effective and explicit mentalizing. If we were, life would be very dull indeed. Spontaneity, inspiration, creativity, and originality might all become severely hampered. Well-functioning individuals, couples, families, and wider social systems probably work best when an ever-changing balance is achieved, moving continuously and flexibly between different ways of mentalizing. There are probably many polarities of thinking, but for us four main dimensions of mentalizing are particularly important (Fonagy & Luyten, 2009; Sharp et al., 2013; see Box 2.3).

The first dimension, implicit versus explicit mentalizing, is an aspect of everyday life, and we almost always tend to mentalize implicitly quite automatically. Such reflectiveness allows us to get on with the mundane and ordinary tasks of living. It tends to be fast and underpins activities like anticipating the next move of a person walking opposite us in the street or maintaining a conversation while bearing in mind the information that our conversation partner possesses and what we might have to explain. We do this automatically, without conscious effort. From time to time, we then focus on a particular issue arising in ourselves or

BOX 2.3. Dimensions of Mentalizing

Implicit	versus	Explicit
(automatic)		*(controlled)*
Affective	versus	Cognitive
External	versus	Internal
Self	versus	Other

in another person or the family, and we then explicitly consider mental states (i.e., deliberately reflect on them). This is a slower process (Kahneman, 2011).

The second dimension, emotion versus cognition, manifests itself when we sometimes direct our attention predominantly to thoughts (the cognitive) rather than feelings (the affective), but sometimes, as when, for example, watching another person suffer physical injury, we focus on an emotional reaction with little concern for beliefs. Some of us will at times find it easier to have a cognitive understanding of mental processes. At those times, we are less connected with accompanying emotions. Some people may be able to tune into feeling states better than others but may find it difficult to relate these feelings to thoughts or beliefs. Again, this is a dimension that we all move along according to context, but that we all have natural, varying default positions on.

At times, we prioritize the mental states of others and do not foreground our own thoughts and feelings—the fourth dimension of mentalizing. But that is not always the case. Discomfort and pain make us focus on ourselves to the exclusion of concern for others. At other times, we resonate with how others feel and have an intuitive understanding of their experience. There are times, too, when we try to figure out what others are feeling by placing ourselves in their shoes and trying to see how they might be seeing the world. To get a better understanding of how a child may feel, for example, a therapist may kneel on the ground to try to see the world from the child's height.

All the above are different ways of mentalizing, and the effective mentalizer moves along these different dimensions as he or she best suits the situation. Is, for example, an argument with one's partner about who will do the dishes entered into in a state of preoccupation about oneself (self rather than other on the self–other dimension), perhaps while carefully accounting for when and by whom the washing-up was last done (cognitive rather than affective on the affective–cognitive dimension)? Does one ignore the partner's furious look (ignoring the external on the

external–internal dimension) and prioritize an impulsive (automatic–implicit rather than reflective on the implicit–explicit dimension) automatic response and sulk? Would the outcome be better if one slowed down and reflected, not ignoring the partner's angry expression but instead addressing the upset and the other's possible feelings of injustice (emotion in the other)?

Effective mentalizing, as described above, reactively moves along the four dimensions and does not become stuck at either end. Some of us may find it easier to speculate on what goes on inside people, ourselves and others (internal), rather than on how people's actions, faces, and body language appear (external). Some may tend to intellectualize and stay preoccupied with cognitions, while those who are more prone to experiencing intense emotions may be far more comfortable with the feelings side of things. There are some people whose concern appears almost uniquely with themselves, and there are others who invariably sacrifice themselves and place other people's points of view first. Some people find reflection hard, are impatient, and need to feel they can act, while others spend too much time reflecting without arriving at a conclusion that might be of practical help. Reasonably well-functioning individuals, couples, families, and other social systems tend to move continuously between the poles of these four dimensions, establishing a steady state despite some transitory fluctuations.

As we have said, often people function less well because they are stuck at one or more polarity of the four mentalizing dimensions. For example, in the therapy setting, an externally fixated client may be convinced that a particular facial expression of the therapist can only mean that the therapist hates her; the client is not able to reflect that there could be different reasons for the expression. By contrast, a therapist with a predominantly internal focus who sits behind the client on the classical couch will almost inevitably miss reading any external cues of mental states. A man who wants to solve all relationship issues by adopting a reasoned and evidence-based approach is likely to encounter considerable difficulties in responding to his partner's emotional needs. A father who can only think of his own needs and feelings will find it difficult to establish strong bonds with his children, whom he feels are a mystery to him.

In summary, achieving an overall balance across these polarities is important for effective social functioning. A major goal of MIST is not just for family members individually to achieve balanced mentalizing but for the system as a whole, with all its members, to be balanced. The system as a whole, through the combination of the actions of its members, shows a balance between reasons and feelings, intuition and reflection, each thinking about their own reactions and being concerned

about the experiences of others, as well as a balance between looking inward to mental states and outward to each other and the situations the family faces. Therapeutically, this is relatively easy to achieve. It can be prompted by strengthening the pole opposite to the one the discourse appears to be stuck on at any one time. For example, family discussion characterized by an excessive reliance on cognition needs to be balanced by helping family members to focus on the emotional impact of firmly held ideas on each family member. A lengthy narrative about how one person feels or thinks prompts a natural inquiry about how others might experience the same constellation.

Balanced mentalizing is a sign of effective mentalizing, allowing shifts between cognitive and emotional mentalizing, between action and reflection, between mentalizing others and self, between mentalizing the past and the present moment, and between implicit mentalizing and explicit mentalizing. How do we know if the rebalancing has been successful? The mentalizing family dialogue is not too difficult to recognize. There are six main indicators that the therapist can look out for: (1) genuine curiosity about the mental states of family members, (2) a tentativeness that reflects respect for the opacity of other minds, (3) keen awareness of the impact of affect on self and others, (4) perspective taking, (5) narrative continuity incorporating complexities, and (6) a shared sense of agency and trust.

Misuse of Mentalizing

Effective mentalizing can at times be used to further a person's self-interest at the expense of the well-being of the family or one of its members. For example, in a high-conflict postseparation family, a child's current mental state (despondency and sadness) is not infrequently used to provide ammunition in an interparental battle. A mother may say: "It is not good for you to continue to have contact with your father; whenever you come back from seeing him, you are irritable and sad and don't want to do your homework or even see your friends. Don't you think it would be better if you stopped going to him every other weekend? Perhaps once a month would be better." This example suggests that the child's feelings may be deliberately distorted or exaggerated, perhaps even misrepresented, by a parent for their own purposes. Because being mentalized occurs in the context of being manipulated into an impossible position in relation to parental contact, the child may come to experience mentalizing activities as aversive—it may feel safer to be dismissive in relation to difficult feelings. It's easier to abandon the mentalizing level altogether and reduce social experience to its least psychological, most concrete, and least nuanced form.

ASSESSING MENTALIZING

Given that a major aim of MIST is to enhance effective mentalizing in individuals, couples, and families, it is important that it is accurately assessed. What are the signs of effective mentalizing, and, equally important, what are the signs of ineffective mentalizing, operating in prementalizing modes, or plain nonmentalizing? There are formal and informal tools for undertaking this task, particularly when assessing reflective functioning (see, e.g., Fonagy et al. 2016; Duval, Ensink, Normandin, Sharp, & Fonagy, 2018; Ensink, Leroux, Normandin, Biberdzic, & Fonagy, 2017).

As most therapists working with families do not have the time or training to use sophisticated research instruments to formally assess the presence or absence of specific aspects of effective mentalizing, more pragmatic methods may need to be employed. A first step could be to look at each individual family member and rate them informally in relation to the four main mentalizing dimensions described above. Is the person functioning:

- More in the affective or cognitive domain, or are they functioning in a balanced way?
- More focused on self or others, or are they functioning in a balanced way?
- More automatically or explicitly mentalizing, or are they functioning in a balanced way?
- More internally or externally focused, or are they functioning in a balanced way?

Provisional answers to these questions can provide an initial orientation and begin to inform potential therapeutic interventions.

Once having listened to how individuals or family members explain the issues they have come to seek help for, the therapist can also consider these other questions:

- Do conversations focus primarily on concrete concerns, such as who did what, and on explanations of behavior in terms of physical circumstances and influences—or is there also a focus on underlying feelings, needs, thoughts, and other mental states?
- Are there difficulties in emotion recognition?
- Do feelings get confused with thoughts?
- Do family members manage to look at their own thoughts and feelings?
- How aware is everyone of how their specific thoughts, feelings, and actions impact others?

- Do people overgeneralize from mental states?
- Are family members able to think about situations flexibly, from more than one perspective?
- Does a family member act without thinking or avoid thinking?
- Does this family member have certainty and rigid beliefs about what goes on in other people?
- Does one person tend to answer for others?
- Do the caregivers make genuine efforts to help and support the child and come to an understanding of their experiences?
- To what extent do family members spontaneously seek out the point of view of other members of the family?
- Do family members mention different perspectives or the possibility that they might be wrong about how others think and feel?
- Are descriptions of family interactions or the target problem dominated by concrete, nonpsychological, all-or-nothing explanations?
- Are there playfulness and humor in the interactions among the family members?
- Is there freedom to talk about a full range of thoughts and feelings, or are certain feelings or thoughts avoided or result in noncommunication?

Further questions therapists can pose to themselves may be informed by looking at the list of the signs of effective mentalizing (Box 2.1) and thinking about which facets might be present in whom. Trait or state reasons may be responsible for the temporary or patterned absence of effective mentalizing in particular domains. As already observed, difficulties in mentalizing arise in situations of stress. If balanced mentalizing cannot be restored, emotionally charged interactions tend to evolve, leading to a temporary loss of the capacity to think about the thoughts and feelings of others and the self in a balanced way (Fonagy & Luyten, 2009).

In arriving at their assessment, therapists can also look out for particular phrases or words that might suggest an absence of effective mentalizing or the presence of prementalizing modes. Words such as "always" or "never" are often typical in this way of talking, suggesting excessive certainty and generalizing. For example:

- "You always take my brother's side against mine."
- "It irritates me when his mom comes home late, so I know it must upset him too."
- "You would be glad if I was dead."
- "It's because he's been drinking those sugar drinks that his dad bought him that he behaves like that!"

- "I know you don't care because you pull that face when I speak to you."
- "I think that you are refusing to eat because you're angry with me."

As alluded to in Chapter 1, mentalizing is a stance characterized by being inquiring and respectful in relation to everyone's states of mind. It is being curious about what others' feelings might be and what thoughts, meanings, and related experiences could be attached or attributed to them. Effective mentalizing is thus not only the capacity to read one's own or another's inner states of mind and feelings more or less accurately, but also a way of approaching relationships with the expectation that one's own thinking and feeling may be enlightened, enriched and changed by learning about the mental states of other people (Fonagy & Target, 1997).

CONCLUDING REFLECTIONS

In summary, mentalizing is fluid and involves movement across the poles on different domains, but in some individuals, couples, or families mentalizing is more likely to become stuck at a particular point on one or more of these domains. As these moments of "stuckness" become more persistent and less flexible, the individual can reach the state of being in a prementalizing mode. A helpful heuristic for recognizing inadequate mentalizing is looking out for excessive certainty or the apparent meaninglessness of discourse. The therapist's subjective experience of the family interactions he or she is witnessing can be an important indicator of what is happening. The insistent demand for action that accompanies teleological thinking will make most of us anxious and leave us feeling pressured to provide a quick solution. The excessive certainty that comes with psychic equivalence will often generate frustration when our wish to engage in simple reasoning appears to have foundered. The pretend mode is sometimes the most challenging to spot as it can be hard to know when feelings described are not truly felt and when thoughts advanced do not reflect genuine belief. Ultimately, the lack of reality comes through in an experience of absence; it is hard to attend; one's mind wanders and in general one does not feel that the person one is talking to is really present in the room despite appearances.

The questions about the quality of mentalizing listed above are helpful, primarily because they point to action. If genuine mentalizing is inherently balanced and carries with it an awareness of its own limitations, then addressing inadequate mentalizing can almost be formulaic, strengthening the opposite end of the dimensional pole.

The following is an excerpt from Jane Austen's *Emma* (1815). Austen did not know or use the term "mentalizer"; she called the character of Emma an "imaginist." Yet, her descriptions of Emma's thought processes are an exceptional anticipation of what has now become known as "mentalizing."

> A very little quiet reflection was enough to satisfy Emma as to her agitation on hearing this news of F.C. She was soon convinced that it was not for herself she was feeling at all apprehensive or embarrassed; it was for him. Her attachment had really subsided into a mere nothing; it was not worth thinking of; but if he, who had undoubtedly always been the most in love of the two, were to be returning with the same warmth of sentiment which he had taken away, it would be very distressing. . . . He had misinterpreted the feelings which had kept her face averted, and her tongue motionless . . . she was reproaching herself for . . . making no acknowledgment, parting in apparent sullenness, she looked out with voice and hand eager to show a difference; but it was just too late. . . .

Emma, across the course of the novel, is able to link her attempts to understand the minds of other individuals with an inner search for her own thoughts, feelings, and desires. The object of her love, Mr. Knightley, makes her aware of how her own conduct is being viewed by others and how, by seeing herself through their eyes she becomes aware of her own longings. It is her *imagination* that triumphs and allows Emma—and of course Jane Austen—to be such an outstandingly effective natural mentalizer.

Chapter 3

Setting Up Mentalization-Focused Interventions

THE MENTALIZING STANCE

MIST therapists aim to increase the mentalizing capacity of the individuals, couples, and families they work with. As outlined in Chapter 2, mentalizing is context dependent, and its different dimensions require that it be used flexibly and in balanced ways. The therapist adopting a mentalizing stance is an intervention in its own right, not least because it role-models effective mentalizing. Below are key recommendations for adopting a mentalizing stance.

1. Maintain and, when it is lost, regain mentalizing (in all parties)!
2. Before questioning, accept without qualification the perspective adopted by the client(s) and genuinely consider the emotional implications of holding those sets of beliefs and experiencing those feelings (empathy).
3. Use an active, curious, inquisitive stance that does not involve feigning understanding.
4. Direct joint attention to mental states—children, adults, key professionals, and therapists all look at the same assumptions about the thoughts and feelings of protagonists.
5. Always use ordinary/nonexpert language, avoiding the guise of privileged knowledge about clients' minds.
6. Focus and place emphasis on perspective taking and on marking

discrepancies between perspectives as well as exploring their sources.

7. Adopt a "not-knowing" stance: Eschew certainty, mark what isn't obvious but is presented that way, indicate when you do suspect you "know."
8. Model active, intentional effort to find out about the opaque mental life.
9. Show humility: Acknowledge your own (ineffective mentalizing) errors, accept agency, express regret where relevant, model interest in being corrected and having your mind changed, as well as displaying the capacity for self-deprecation and humor.
10. Show doggedness when exploring misunderstandings once these have arisen.
11. Engage in self-disclosure in the interest of transparency by acknowledging confusion, puzzlement, and self-reflection.

Adopting a mentalizing stance will inform specific MIST strategies and interventions that address facets of effective mentalizing that may be underdeveloped or absent altogether in family communication.

EFFECTIVE MENTALIZING IN THREE PRIMARY AREAS

The four mentalizing domains can feel like rather ornate, academic constructs, particularly for a therapist who is in the midst of demanding and complicated processes at work in the here and now of family therapy. Therefore, as a kind of clinical shorthand, we will now describe some of the key signs of effective/ineffective mentalizing as they typically appear in the course of working with families. In particular, it is mentalizing in three areas that are often most salient: mentalizing about oneself, mentalizing about the other, and "relational" mentalizing about the whole family system. Therefore, we will now focus a little on mentalizing in these areas in a family context. But a note of caution is in order: All mentalizing is essentially a recursive process. Thus, in the jump-starting of mentalizing, whether to do with the self, other, or relationally, any change will have an impact on the process in which it is embedded. A changed view of a partner will impact the relationship with that partner, which in turn will have the potential to bring about further changes of perspective. There is also a recursiveness between mentalizing domains. Some of the facets of effective mentalizing are particularly relevant when *mentalizing other people,* like "perspective taking." Other facets, like "turn taking," are important for *relational mentalizing,* and perceiving oneself in the mind of the other (the "self-inquisitive stance") is an

essential aspect of developing representations of one's own thoughts, feelings, hopes, and wishes.

These categories can only be separated notionally as they are constantly in interaction. The extent to which individuals will experience being able to mentalize the self will depend on how they are treated by others, which, in turn, will be crucially dependent on how well they are able to see others' perspectives. If a person withdraws from relationships, they will not need a great deal of interpersonal or relational mentalizing capacity. They are of course more likely to find themselves in that situation if they have felt consistently that others did not see them in the way they perceived themselves. This may have been because their self-narrative was so poorly elaborated that even accurate depiction of their internal state felt unreal and irrelevant or because the social environment (e.g., a prison or a residential school) was so little concerned with the subjectivity of its members that no one belonging to that system would sensibly prioritize the enriching of self-narratives.

The processes that enhance mentalizing in the three primary areas—self, other, and relationships—are of course also massively overlapping, as we shall see. See Box 2.1 in Chapter 2 for many of the typical signs of effective mentalizing.

Effective Self-Mentalizing

We identify 10 specific facets that the therapist can use to help pinpoint where intervention may be most helpful.

1. *A focus on mental states* in an account of one's actions in preference to identifying convenient aspects of the social and physical worlds in those accounts. However, this includes an ability not to focus excessively on mental states to a point where we may be caught up in a world of imagination with little connection to social and physical reality.

2. *The not-knowing position* (Anderson & Goolishian, 1992) or the stance of *safe uncertainty* (Mason, 1993). This implies that one can never know for sure, but at best one can intelligently guess the needs, wishes, thoughts, and feelings of another person. We are in no greater privileged position in relation to understanding the reasons for our own actions as they relate to our mental states (Nisbett & Wilson, 1977; Ross & Nisbett, 2011). The term *safe* may be appropriate to describe this stance in that suspending the need to know for certain averts the risk of being overwhelmed or befuddled by the putative reasons for the behaviors and actions of other people. The sense of safety also links to

an underlying confidence that one finds one's own reactions, at least to some extent, predictable.

3. *Self-inquisitive contemplation and reflection,* which have much in common with the popular meditational approach of mindfulness. Reflecting on one's own thoughts and feelings as internal states quite separate from reality, with no implication for action, has turned out to be a valuable adjunct to many therapies. Lack of the capacity to achieve such a stance may indeed characterize individuals who are concrete thinkers and can only deal with how things (allegedly) are.

4. *Perspective taking,* in relation to self-states, which is a complex achievement. It incorporates acceptance that multiple explanations can account for the same behavioral phenomenon, but also that a dominant emotional state, like a strong feeling or prejudice, may have multiple layers of explanation—some good, some bad.

5. *Inner conflict awareness,* which relates to the above and incorporates not just the multilayered quality of subjective accounts but also the possibility that they are not compatible with one another and that internal contradictions and opposing forces are at work in each of us. In particular, being able to recognize that ambivalence in ambition, wishing for both something and its opposite, is a pervasive feature of each of us.

6. *Managing emotion,* increasingly recognized as a key underlying indicator of effective intra- and interpersonal functioning, the absence of which is associated with (a) most mental disorders and (b) their common causes (Beauchaine & Cicchetti, 2019; Beauchaine & Crowell, 2018). Intense affect disrupts mentalizing, and the enhancement of the capacities for emotion regulation is increasingly incorporated by most therapies. The generally accepted view identifies four component processes of emotion-regulation strategies: (a) An emotional reaction is triggered by a specific situation; (b) attention is given to internal or external aspects of the trigger and its context; (c) cognitive processes of evaluation are undertaken, resulting in an appraisal of the situation; and (d) a response is organized, which aligns the emotional reaction with concurrent goals and the situational appraisal (Gross, 2014).

7. *Taking responsibility for words and actions,* based on the assumption that actions are largely driven by an individual's internal states, even when the person was not aware of where these originated. Effective mentalizers resist the temptation to not assume agency and accountability in order to reduce shame and preserve self-esteem.

8. *The ability to distinguish between feelings and thoughts* while respecting their different propositional logic. This ability is important in

avoiding psychic equivalence. Being able to move flexibly between feelings and thoughts is essential to effecting a rounded human experience, which necessarily entails both.

9. *Self-deprecating humor.* The willingness to laugh about our own shortcomings and see the humorous sides of our predicament helps us cope with difficult situations, mistakes, and imperfections and enhances self-acceptance.

10. *The ability to establish autobiographical or narrative continuity,* which refers to the coherence of our self-narratives. This facet of self-mentalizing is fundamental not only to our sense of agency (Ryan, Deci, & Vansteenkiste, 2016), but also to our capacity to recognize ourselves in the depiction that others may make of us. This, of course, underpins relational mentalizing. The coherence of our own narrative underpins our sense of personal continuity (self-identity) maintained by past and current experiences and our capacity to envision what we will think and feel in the future. The historical aspect of the narrative will incorporate a *developmental perspective,* recognizing that the person has experienced various phases with their characteristic challenges in the course of their life trajectory.

Effectively Mentalizing Others

A mentalizing approach cannot consider the mental world of the self separately from the mental world of others. We gain our sense of who we are from experiencing ourselves through others, and we get to know others by finding points of connection between potential interpretations of others' actions and our self-awareness. But such a dialectic only gets us to a certain point. From the perspective of daily clinical challenges, we need to separate our clients' mentalizing of others and the ways they think about themselves. Next we identify nine facets that the therapist can use to identify places where intervention within the "other" domain may be necessary.

1. *Seeing mental states as motivating action in others* presents a problem for some people when they appear reluctant to contemplate mental states as underpinning the actions of others around them. At the other extreme, with their imagination unbridled, are those who may make excessive and unnecessary assumptions in relation to mental states—a stance we have referred to as *hypermentalizing* (Sharp et al., 2011).

2. *The not-knowing position* in the context of mentalizing others implies a genuine respect for the ultimate inscrutability of the mental

states of other people. This position has been referred to as "the opaqueness of mental states" (Leslie, 1987). It is an open acknowledgment that one can never know and only guess the needs, wishes, thoughts, and feelings of another person.

3. *Humility* implies an absence of arrogance in relation to the beliefs and attitudes of another person, an openness to a range of views significantly beyond that which persons themselves hold. It implies an unpretentious modesty about one's own capacities and the willingness to be surprised and learn from others regardless of status.

4. *Perspective taking,* in this context, is considered by many the pivotal human mentalizing capacity underpinning social cooperation and joint intentionality (Tomasello, 2019). This is sometimes considered in a uniquely cognitive domain, although the emotional facet is probably closely linked.

5. *Empathy* is often seen as the emotional side of perspective taking, although it probably has a form that precludes an understanding of the other's position and simply evidences an emotional resonance. Beyond this, empathy entails experiencing key facets of the emotional state of the other, particularly emotional pain, and being able to map the implications and give voice to this emotional understanding in a manner that the other can perceive and appreciate.

6. *Curiosity about other minds* is a benign form of curiosity (Cecchin, 1987). It describes an attitude of genuine interest in other people's thoughts and feelings. It includes an expectant attitude that one's own understanding of the other (and beyond the other) can be elaborated or expanded by what one can learn from another mind. Thus, this facet implies an openness to discovery and sustained holding of the "not-knowing stance" to prevent the person from making the errors of prejudgment, excessive introduction of assumptions, or frank prejudices about what others may think or feel.

7. *Reflective contemplation* is a relaxed and open attitude toward how others think and feel rather than a controlled and compulsive pursuit to figure them out. The attitude ensures an openness to reflective resonance where the individual allows him- or herself to resonate with an other's experience and then comes to reflect on the feelings this experience has generated within.

8. A *developmental perspective* allows the person to see and begin to understand other people with changing priorities and with humility as they travel through their life trajectory, and to create biographical bridges between experiences and states of mind.

9. *The stance of genuine forgiveness* is based on a person's capacity to understand an agent, for example, a parent or a sibling, in terms of the mental states that have underpinned that person's historical or current action. The action is normally contextualized. It is the integration of beliefs, emotions, and associated situational constraints that helps explain a behavior well enough for the person to accept what happened and consider it as falling within the boundaries of being reasonable. This facet must be carefully distinguished from notional forgiveness, which is not based on an understanding of circumstances and related mental states. In such instances, the wish to forgive may be genuine, but it is not backed up by genuine comprehension of the actions of others. Genuine forgiveness follows from acquiring greater familiarity with the internal drivers of others' actions when curiosity and reflective contemplation have generated new understandings.

Effective Relational Mentalizing

Relational mentalizing refers to the shared thinking and feeling within a family or other group. While thoughts and feelings about relationships are usually addressed in relation to mentalizing about others or about the self in relation to others, there is a higher level of interactive process that MIST must also address. This concerns intentional states that individuals in the system assume to be joint or shared by everyone. Tuomela (2005) has named this category *jointly seeing to it* (*jstit*). Improvement in relational mentalizing is at the heart of what MIST is trying to achieve.

It has been argued that mentalizing has a somewhat special "we-mode" (Gallotti & Frith, 2013); it assumes that the social context (the mere presence of others) improves a person's potential for mentalizing by broadening their awareness of the options for action and generating new solutions. Relational mentalizing concerns thoughts and feelings that drive options for doing things that one could not do on one's own. To put it plainly, other people being around makes one think differently and better. This involves co-representing the other's viewpoint, which is a precondition for acting jointly. When people (families or just any other collection of individuals) decide to *be and act* together, to join forces, there is a sense in which no member of the group can be assumed to be doing it on their own or can be appropriately considered as thinking or feeling in isolation from others in that "psychological collective." This sense of we-ness, of shared minds, has an irreducibility, which means that it must be addressed separately from individual mentalizing of self and others. This is because joint actions are experienced in a qualitatively different way and involve shared or "we-intentions." Relational mentalizing relies on underlying, mutually accepted, yet often

implicit conceptual and situational presuppositions. It does not necessarily involve agreement-making to generate joint intention (Tuomela, 2005). Below we consider signs of effective and ineffective relational mentalizing.

1. *Joint intentions* can be more or less shared. When they are, we are working in the *we-mode*. Developing such shared perspectives is at the heart of relational mentalizing. Explicit awareness of nonshared joint intentions paradoxically makes for a strong we-mode. Assuming a we-mode that is actually far from joint is quite common. Declaring intentions to be joint is a frequent indicator of its direct opposite. Assumptions about joint actions can be grossly inaccurate and self-serving.

2. The *acceptance of an emerging, fresh joint perspective* is best indicated by joint action. If a family initiates a plan and then acts as a coherent unit, with all members actively participating, then we may talk about effective relational mentalizing. Merely acknowledging awareness of others' perspectives is not enough. This is not complex. How about watching a football match together on TV, or going to the zoo, or playing a board game?

3. A *relational not-knowing stance* about joint intentions can foster relationships and open exchanges of thoughts and feelings. It is part of the process of working toward and exploring the potential for we-ness in the family unit. "Where are you in relation to the zoo-idea?" Communication in relation to this movement is of course mostly implicit, not explicit.

4. *Nonparanoid responsiveness* suggests a basic assumption of a benign background to relational mentalizing. Acknowledging one's potential for making unfounded assumptions about others' social actions can facilitate joint action. By contrast, attributing nonbenign intentions to relational overtures can generate a paranoid or overreactive response. The expansion of effort to see the other's internal state and perspective can enable the other(s) to feel "seen."

5. The *ability to take turns* furthers give-and-take interactions with others and provides evidence of effective mentalizing. This includes the ability to make oneself available for being understood and to extend one's understanding by taking on board the other person's thoughts and preoccupations.

6. *Impact awareness* implies an appreciation of how one's own thoughts, feelings, and actions may affect relationships with others and how one's behavior with others may be affected by their mental states. Impact awareness in relational mentalizing is awareness of the shared

experience of the group or of a couple, not of a single individual within it. It is an acknowledgment of personal agency (the impact one has) on a relational context.

7. *Playfulness* is a state of mind that permits transgressing the physically palpable world and entering the arena of make believe. It opens up the mind to experimentation and imagination. Joining with others in playful exploration of shared understandings and feelings can indicate effective mentalizing. Playfulness may be important in relation to both self and other mentalizing, but it comes into its own in creating shared mental states. Playfulness can lift some of the inhibitions that prevent shared intentionality. For example, the vulnerability of a family member's sense of self can block arriving at a shared experience in the family, but playing may take away self-consciousness sufficiently for a community of minds to be formed.

8. *Belief in changeability,* or a hopeful and optimistic outlook of family members, implies a general assumption that minds *can* be changed. It imbues the system with a sense of optimism, of "never giving up." In this context, changeability refers to the family's shared experience of optimism in relation to *jointly seeing to it* (*jstit).* "We have had difficult situations before and we dealt with them; we are not sure what the solution is this time, but we will sort it somehow."

9. The *capacity to trust* refers to the openness of the system or to attachment security within the family system (Hill, Fonagy, Safier, & Sargent, 2003). While trust within dyadic attachments is primarily driven by sensitivity, here we are concerned with a systemic sense of trust that may be a vital ingredient for forming and sustaining meaningful relationships. A network of trusting relationships is quite different from an overarching sense of trust, which is the basic assumption of the family.

We will return to these different facets of mentalizing in Chapter 6 and pair them with specific interventions. The following example further illustrates how to set up mentalizing-focused interventions.

STARTING TO WORK WITH JANE AND HER FAMILY

The referral consisted of a long and detailed letter, written by the social worker who had been working with Jane and her now 3-year-old daughter, Michelle, ever since the child's birth. The letter stated that Jane had been addicted to heroin and crack for many years and that Michelle had to be

treated for severe withdrawal symptoms immediately after being born. Both Jane and Michelle then recovered in a mother-and-baby unit, and after 6 months Jane was clean and ready to leave the unit. She moved back home with her little daughter, and over the following year she was regularly tested for illicit substance use. Health visitors and social workers visited mother and child frequently and monitored their welfare. Twelve months later, Michelle's name was removed from the child protection register.

It was at this stage that Jane asked to see her two boys, John and Ben, now aged 7 and 9, who had been removed from her care when they were 18 months and 3 years of age, respectively. At that time, Jane had been heavily addicted to class A substances, and she was prostituting herself to pay for the drugs. Many of her clients came to her flat, and the children were at times directly exposed to their mother's sexual activity and volatile behaviors. They also witnessed violence between their mother and father, who occasionally turned up. For long stretches of time, the mother had been emotionally and physically unavailable to her boys. It all came to a head when one of her clients attacked the boys and caused serious injuries to both of them.

Child Protection Services intervened and the children were placed in foster care, as neither the father nor members of his or the mother's family were willing or able to care for the children. Both boys were diagnosed with severe attachment disorders and proved difficult to manage in foster placement. They were moved into another placement within 3 months of being taken into care. This proved to be a pattern for these boys. By the time they were 7 and 9 years of age, respectively, they had been in 16 different foster placements, as well as in a therapeutic boarding school and two children's homes. When Jane asked to have contact with her boys, they had just been moved to their 17th foster placement. Supervised contact was arranged and it went well; the boys were well behaved and said they wanted to live with their mother. Another contact 3 months later went equally well, and this is when Jane officially requested to be considered as their primary caregiver. This request prompted the referral to the clinic, with a call to assess the mother and the boys and to provide opinions and recommendations with regard to whether or not the boys could be returned to their mother and half-sister.

The Social Network Meeting

When dealing with seemingly complex referrals, it is often best to first convene the professional and family network. This meeting is attended by the parent(s), members of their own network, as well as the various professionals involved. The aims of this meeting are:

- to understand the minds and mindsets of everyone involved
- to engage in an open dialogue about hopes and fears
- to compile a map of the people in the family's life and of their respective views
- to understand the relationships between the professionals and the family
- to jointly agree on the areas of work and timescale issues

The bringing together of many minds for therapeutic purposes was first pioneered by Ross Speck, who started what he and his coworkers termed *network therapy*. This approach subsequently also became known as social network intervention (Speck & Rueveni, 1969, Speck & Attneave, 1972). Clients, their relatives, and other key members of their social network were invited to address issues together, an approach that bore distinct similarities to tribal healing practices in indigenous societies. A network of relatives, friends, and neighbors was mobilized and was collectively involved in developing new options and solutions for dealing with a difficult crisis, increasing "bonds" and decreasing "binds" between people. The Milan team (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980) critically examined the role of professionals, particularly that of the referring person, and produced a range of techniques and interventions that can be employed in actual network meetings. In a further development, Seikkula et al. (2003) suggested that all discussions, including assessment and treatment decisions, should be held openly in the presence of the client and family, with the aim of generating a collaboration that tolerates the uncertainty that often occurs in crisis situations. "Dialogicity"—promoting "open dialogue"—is the primary focus here, and the promotion of change in the client or family is seen as secondary. Dialogue is viewed as the forum and medium through which families and clients are able to acquire more feeling of agency in their own lives, as new understandings are generated in dialogue (Andersen, 1995). This position is compatible with the process of holding mentalization-focused conversations—be those dialogues, "trialogues," or multiples thereof—to promote change through sharing multiple perspectives.

Communication, which is at the heart of such meetings, requires that each person come with a mind open to learning something new and relevant to them, which they can use in other situations. For communication of this kind to be effective, there has to be trust between those bringing expertise and those listening and learning. Of course, in genuine open dialogue the roles of "instructor" and "learner" are not fixed and in fact are purposefully left open. Notwithstanding who is in which role at which time in a communication sequence, trust by the

learner in the genuine commitment of the instructor to lead and not to mislead is absolutely critical. But how does the learner know if he or she can trust the instructor? We have suggested that mentalizing is critical in the process of establishing effective communication (Fonagy, Luyten, & Allison, 2015). If the learners experience the situation as one where their personal narrative is understood, where they feel seen as effective agents by the instructor, they will lift their natural suspicion and open their minds to learning. What they hear in the network will be encoded as relevant to them, to be remembered and to be used in other contexts. As we shall see, the alternative to this healthy pattern of open dialogue is one where the participants experience the exchange of information as pertinent to that situation alone. They will be able to understand and repeat it but will not allow their mindset to be influenced. As therapists, we have experienced many frustrating consultations when clients were able to clearly appreciate what we were trying to communicate, only to behave in exactly the way they had been behaving prior to our efforts at persuasion. More on this later in this chapter.

How can the therapist identify a network? The following questions may help to get the individual to think about her or his network: Who is concerned about the situation or problem? Who has been involved? Who could be of help and is able and willing to participate? Who should issue the invitations? It is certainly consistent with the MIST principle of encouraging agency and respect for personal narratives to involve the client family centrally in determining the membership of the initial network meeting.

The personal and professional network Jane wanted in the initial network meeting included her own parents, a close female friend, the health visitor, two social workers, her substance misuse counselor, and her GP. The network meeting was chaired by the clinician, who welcomed everyone and then invited Jane to explain her current situation as well as her hopes and fears in relation to the boys living with her and its impact on her and her young daughter. All members of the network meeting listened attentively and without interrupting her. Once Jane had finished, the clinician inquired whether anyone wished to comment or ask any questions. Jane's father said that he and his wife had not had any contact with their daughter for some 10 years because of her drug taking and the company she associated with, but that in recent months Jane had gotten in touch with them and that they were now reestablishing their relationship and getting to know their granddaughter. Jane's mother added that she wanted to help her daughter to be a mother to three children and that she would want to help as much as

her daughter allowed her to. Jane responded by stating that she had let her parents down and that she felt very bad about this. She became tearful and her mother got up and hugged her. The clinician asked Jane's father what he thought was going on for his wife and daughter, and he replied, "I don't know, I am not good with feelings . . . you have to ask them." His wife commented, in a somewhat dismissive tone: "I wish he was happier that people have feelings."

The discussion returned to the children and how each might feel about living with their mother and what the risks might be. Jane's counselor spoke and explained that Jane had made a remarkable recovery but that there was an increased relapse risk if the process of returning both boys to her care was too quick; the resulting stresses and strain might be too much for Jane. The GP agreed and added that Jane might fall back on using drink and drugs unless she was given a lot of help and perhaps some medication. Jane objected, emphasizing that she was now strong and needed no medication.

It was now her friend's turn to join in the conversation. She said she would support Jane as much as she could and said that she had three children herself, that her experience might be helpful, and that her support might be acceptable to Jane. The social worker was cautious and warned against giving the boys unrealistic hopes about living with their mother and that one needed to be sure that Jane could really cope with them and their fragile emotional states. She emphasized the importance of being "as certain as possible that Jane can put herself into the children's shoes and understand what they have gone through and whether she can cope with the challenges they will pose for her."

In a discussion that involved everyone in the room, all eventually agreed that before any family work could be done involving the children and the grandparents, individual work with Jane had to take place. The term "viability assessment" was used to describe the first phase of the work: to assess whether the mother could, in principle, be considered to care for the boys and, therefore, for three children. Or, to put it somewhat differently, to assess Jane's ability to effectively mentalize the boys, her daughter, and herself.

The network meeting sets the context for an encounter of minds, all focused on addressing specific issues and finding joint ways forward. Having the perspectives of different persons—family, friends, and professionals—can lay the foundations for a more nuanced appreciation of the multiple perspectives on the problem at hand. The membership of the group is as critical as the process that the group undertakes. The primary function is to open a dialogue for a system to be created where

there is a shared narrative that the client (in this case Jane) can see corresponds to her personal narrative. What was critical in this encounter was not who took which view about the children being taken back into Jane's care, but rather Jane's feeling that all the participants of the network meeting understood her wish to have the children back and could elaborate on this narrative from their respective points of view. The social worker, who was very negative, could nevertheless give expression to John and Ben's desire to be with their mom, which undoubtedly helped validate Jane's wish for the same thing. Although the social worker expressed discomfort about the excessively rapid progression, she also identified Jane's attempts to mentalize the children as the primary objective. A MIST network meeting should have the clear statement of personal narratives as its focus, with the modeling of a mentalizing interaction as the key vehicle to achieve this focus.

In this way, even individuals from the client's wider social system who cannot be present can be included in the network meeting. Those present can be asked hypothetical questions, such as, "What would your best friend have said if she had been present in this meeting about this issue? What might your reply have been? And what might have been her response?" A member of the network meeting can be given the task of contacting them after the meeting and relaying the absent person's comments to the next joint network meeting; this meeting may take place 3–6 weeks later and has the task of reviewing progress. The same can be done in relation to professionals whose views need to be represented. The presence of some professionals, such as social workers, is crucial when working with families where there are child protection concerns.

Mentalization-Stimulating Questions

A major aim of mentalization-focused work is to stimulate effective mentalizing via a range of specific questions. These questions are sequenced, and one usually starts with a set of questions that focus on mentalizing others (*first-order mentalizing*), progressing to *second-order mentalizing* questions that center on mentalizing one's reaction(s) to others. *Third-order mentalizing* questions are preoccupied with mentalizing the reactions of others to one's own state of mind. When asking these questions, one can do so in three time dimensions: past, present, and future. This process is termed *diachronic prompting*; it is a circular process of literally flipping backward and forward in time and thereby connecting past, present, and future experiences. Future-oriented questions will address likely hypothetical scenarios, as a kind of preparation for all eventualities.

Below are some examples of *first-order* mentalizing questions:

- What do you think this felt like for Ben at the time?
- If something similar happens once he lives with you, what do you think might go on inside him?

Second-order mentalizing questions might be:

- When Ben had these experiences, what sort of thoughts and feelings did that trigger in you? Do you remember?
- When you think about Ben's reaction here and now, what thoughts do you have about it? Are they any different?
- Do you think Ben remembers any of it now? If he brought it up, how would you respond?
- If Ben asked you about why you let all this happen, how might you feel? And what would you say to him?
- Turn the clock back to the time when Ben got attacked by your partner all these years ago. You said that you felt paralyzed. What do you think went on in Ben when he saw you were in that state?

Third-order mentalizing questions:

- If Ben was in the room right now and heard what you said, what might his reaction be?
- I can see that you seem very upset when you talk about what happened then. What do you imagine I think and feel when I think about your reactions to Ben's feelings?
- Let's imagine the court allows Ben to live with you and one day he is really angry and blames you for having taken drugs, neglected him, and not protected him from being injured; you feel really upset and maybe even guilty. What effect might this have on him?

The asking of questions should not become excessive, mechanistic, or turn into what may feel like a cross-examination. It is not the obtaining of answers that the MIST therapist is after. The questions are meant to stimulate effective mentalizing, like exercising and strengthening one's mental biceps in a gym. Genuinely engaging with the questions can be painful but can generate new perspectives that for the therapist are more important than the content of the answers.

A dialogue assumes open communication, which means that both parties have to be open with each other about their experience of the communication. The worst thing about dialogue not being open is the failure to state that it is no longer a dialogue. We have noticed that

sometimes therapists do not make clear when the dialogue, from their point of view, has ceased to be a dialogue and has become a monologue by the client or professional. It is important that therapists begin to reopen the dialogue by declaring that they no longer feel they are part of the conversation.

When MIST therapists do not understand the client or one of the professionals, or gets lost in someone else's—or their own—train of thought, they need to ask for clarification: "The last bit I understood was that you felt . . . and then I got lost and confused. Can you help me?! When I raise my hand, it means that I have stopped understanding, and I would then like you to stop so that I can try to catch up." When a person talks too fast, the therapist ought to say: "You are saying so much and so fast. I need baby steps, baby elephant steps." Particularly when it concerns misunderstandings, the therapist's stance is characterized by honesty that enables the opening of dialogue. Owning up to not understanding is thus critical. When therapists realize that the client is perturbed or upset by something they have said, the therapists can say: "I got something wrong here. Can you help me? What did I get wrong? I seem to have made you a bit cross, a little angry even . . . I am really sorry that I have said something that seems to upset you this way. . . . That really was not my intention. Can you help me understand what I got wrong?" And if it happens again:

"Why is it that I keep misunderstanding you or that you feel misunderstood? I hate being misunderstood. It's a dreadful feeling for a person not to feel understood when they want to be. The idea that is dawning on me is that you have been struggling with a lot of people who you feel don't actually understand you. How do you cope with the awful feeling of not being able to get people to understand. . . . If I was in that situation and was the person who was consistently left feeling misunderstood, I would feel so annoyed, so I guess I am surprised you appear to manage your feelings so much better than that."

Managing Increasing Arousal

Remember what has been said about emotion and mentalizing: The therapist has to manage the client's arousal within reasonable bounds. This is hard to do because the very situation of being in a therapeutic relationship increases arousal, especially for people for whom close relationships represent an emotional trigger. Those with a history of trauma often find individual therapy a threat, although they may also see it as an opportunity to recover their capacity to manage their emotions better.

Managing a client's increasing levels of arousal is a frequent challenge when working with individuals. Here the therapist focuses on the client's mind and not on acting-out behavior. When the client says, with an angry voice, that she "didn't want to come today; there is no point. Talking is useless," the therapist responds by saying: "I am pleased you came to tell me this—I think this is good. Because if I had found someone unhelpful, I would have difficulty getting myself to come for yet another session." The client responds with a "Hmmm." The therapist adds: "I am impressed you came. So, when did you start thinking that, just last week or for some time?" The client says: "Last time!" The therapist elaborates: "If you did, I wasn't aware of it. Am I just a bit stupid? Did you give signals and I didn't get them? What should I have noticed?" By talking in this way, the therapist puts his mind out there, enabling the client to watch how the therapist mentalizes aloud; the client can observe, so to speak, the therapist's mind in action.

Effective mentalizing is incompatible with high levels of arousal. When the client's arousal increases further and she begins to shout, the only thing the therapist can do is to bring down the arousal. The therapist will have to say: "I cannot think when people shout at me, my mind just goes blank. . . . I do want to listen very much—but it is quite hard when you shout." This or similar statements may need to be repeated a few times for the client to respond by downregulating her affect.

There are times when a client will ask rather personal questions, and, when faced with these questions, the therapist may be torn between answering them, as he would like to be seen as normal if not transparent, and blocking them, as these questions tend to be nonmentalizing fillers. It is possible to address personal questions by answering them briefly and then exploring the client's state of mind that informs these questions. When, for example, the client asks: "Are you married, doc?," the reply can be, "Yes, I am . . . but would it be easier for you if I was or if I wasn't?"

INDIVIDUAL WORK WITH JANE

Jane agreed to attend once-weekly sessions lasting about 1 hour each over a period of 6 weeks. The work focused initially on her own experiences of having been parented and how this might have informed—or not—the way she parented each child, replicating or correcting her parents' practices. She was asked to describe each parent and provide concrete examples of their caregiving behaviors, including times when she had been ill as a child and had felt upset at school or with friends. She began to compare her parents'

behaviors and responses with her own maternal actions and conduct and make some connections. She spoke at length about her struggles as a teenager, getting into, as she put it, "wrong company" and severing all ties with her parents, whom she perceived to be very critical of her and favoring her younger sister.

As she repeatedly talked about her adolescent struggles and her psychological turmoil in those years, the therapist attempted to redirect the focus onto her children. She was asked to put herself in the minds of her children when they last lived with her: What was it like for an 18-month-old baby and a 3½-year-old child to live in a situation that seemed chaotic? What did the children observe? What could they make of what they saw, and what might they have felt? Jane initially found these questions difficult to answer. Gradually, encouraged by further questions, including, "What sort of a mother did your boys see?" and "Looking back, what sort of a mother do you think you were?" she developed a narrative. Her eyes filled with tears, and when asked to talk about what was going on "inside you right now?," she replied, "I feel that you must be thinking I am the most awful mother you ever met . . . neglecting my children in that way. . . . I don't deserve to be a mother." Jane missed the following scheduled session, but with some encouragement she attended a week later. She spoke about how she had been emotionally unavailable to her children, how she just lived from day to day without making any plans. The therapist asked her to look at herself through the eyes of her own mother and how she might have felt about Jane then and now. Jane spoke about breaking off all contact with her parents because she could not cope "with being criticized by them all the time." She was able to think about what it might have been like for her parents during those years. She realized that, while they were not actively critical, she felt that they were but just did not say, and that was even worse. In the end, she agreed that she could not bear to see herself through their eyes. The last three sessions focused on the boys' states of mind, both when they lived with her now and possibly in the future. The latter involved asking her to consider a range of hypothetical scenarios, including the boys challenging her, failing in school, and engaging in delinquent activities.

When undertaking viability assessments within the context of court proceedings, it is essential to cover a whole range of topics and themes. Although courts may not formally see it this way, a mentalizing approach can assist the court's decision making, for example, by demonstrating that a parent does, or does not, have the capacity to mentalize both the child's experience of being parented and the parent's own reactions. If the court is concerned about a parent's ability to take responsibility for past parenting shortcomings, then assessing this parent's capacity to

mentalize parenting from the child's perspective can be helpful. Mentalizing is similarly helpful when the court asks about the parent's ability to empathize with their child's predicament in their current situation. Another area to explore involves determining the person's capacity to connect past events and experiences with present ones—what is termed *autobiographical continuity*. This facet of effective mentalizing (see Chapter 6) is maintained by connecting with thoughts and feelings from the past and recognizing these mental states as originating within oneself. All these are *content* issues that have to be addressed. However, from a mentalizing perspective, it is even more crucial to focus on the *process,* namely, the way in which this is actually done.

The Trajectory of Mentalizing Interventions

What should the therapist be doing during these sessions to assess and enhance mentalizing in Jane? We have already described various aspects of adopting a mentalizing stance (see above), and in this case Jane's therapist employed an empathic, inquisitive stance, repeating and clarifying what Jane had said. He was alert to the many aspects of what Jane explained that he might not have understood or might have misunderstood. Rather than being focused on biographical facts, he took an inquisitive, benignly curious (Cecchin, 1987) stance on her subjective experiences, including her impression of others' subjectivity. He took a not-knowing position, thereby displaying humility and modesty. He felt under no obligation to pretend to understand the nonunderstandable. He allowed Jane's narrative to unfold, but with his questions he attempted to focus her attention increasingly on the mental states of her children and her reactions to them. He explored Jane's world in the interpersonal realm and not just the subjective. He intervened when she ran into nonmentalizing, politely stopped her, and then rewound the dialogue to a point where effective mentalizing had still been intact. The trajectory of mentalizing interventions is summarized in Box 3.1.

FROM INDIVIDUAL TO FAMILY WORK

Another meeting with the family and professional network was held after 6 weeks, at the end of the viability assessment and therapeutic intervention work. Jane gave an account of her sessions with the therapist. The therapist elaborated on what Jane said and expressed concern as well as a sense of being impressed by the range of issues that had been at least touched on

BOX 3.1. Trajectory of Mentalizing Interventions

- Validating what the person says (*"It is important that you are telling me that. . . . "*)
- Checking for understanding (*"I heard this . . . am I understanding this correctly?"*)
- Spotting and exploring effective mentalizing (*"I really liked when you explained to me why your mother might have been so distant. . . . "*)
- Provoking curiosity about psychological motives for actions ("*Wow, what was that about?"*)
- Identifying an automatic response to something because of a break in mentalizing (*"Can we just pause here? So you said that 'of course he shouted,' but it was not clear to me why he did."*)
- Rewinding to the moment before the break in subjective continuity (*"Can we just go back to. . . . ?"*)
- Identifying affect (*"What were you feeling at that point?"*)
- Exploring the emotional context (*"What other situations come to mind when you feel this?"*)
- Defining the interpersonal context (moment-to-moment exploration of problematic episode, identifying affect: *"What happened just then?"*)
- Explicitly identifying and owning up to the therapist's own contribution to the break in mentalizing (*"What have I done for us to be at that point now?"*)

during the six sessions. Jane's progress was reviewed and there was agreement that she had the potential to progress and consider the next phase of work. Jane said that she had been thinking a lot about her boys, but a lot of it had been speculation: "I don't really know them . . . when I have seen them a few times over the past year during the contact sessions with the social worker, they seemed happy, but I do not know what they are really feeling. . . . They won't let on . . . I can't read them and they probably cannot read me very well either. We need to get to know each other." The social worker said, "The boys do not feel safe to talk about their feelings, they can only act them out," and she explained that both had been very violent in school, leading to their exclusion from four schools to date. She added that matters had not been any different in the foster placements, and this was why they broke down repeatedly. The current foster carers explained that their approach was to leave the boys in a "safe place" to cool down, just by themselves, and only talk to them about what happened hours later.

All agreed that the mother should be given a chance to see whether she could have them live with her. Six once-weekly sessions were arranged for the children and their mother, with her deciding if or when other members

of the family or network should be present. She said she would like her three children to come to the first session, together with her parents, "because I will need their help if the boys live with me in the future." When asked what she would want to focus on, she replied that she wanted to find out what they felt about her, the past, and the possibility of living with her again, "but I want to know their true feelings, not just being nice to me."

The first family session took place, and the boys seemed very happy and exuberant when meeting their mother, grandparents, and little sister in the waiting room. The therapist invited the family into the consulting room and, after a brief introduction, asked each child whether they knew what feelings were and whether they could name some. Ben and John were quick to answer, listing "aggressive," "angry," "happy," "sad," and "aggressively happy."

Jane and her parents then added a few more, including "considerate," "thoughtful," "jealous," and so on, altogether some 20 feelings. The therapist wrote all these on separate cards, and each family member was then asked to draw a card and, without telling anybody what the feeling state written on it was, had to display it without using words, with the other family members having to guess what the card in question was conveying.

Both boys initially read almost every single emotion displayed by other family members, including their maternal grandparents, as angry or aggressive. They were genuinely surprised when their mother, for example, said that they had mistaken her showing sadness for feeling aggressive. The ensuing discussions between the family members about the affect snapshots generated a variety and range of emotions that helped all to become more sensitive to nuances in their emotional expression.

There was much guessing and laughter. This was followed by discussions about how feelings can be correctly identified or not, and how—if different family members had drawn the same card—each might have displayed that feeling differently. Throughout this "reading the mind behind the face" game, the therapist took photographs of the faces of each displayed feeling state on a digital camera. After several rounds of this, there was a collection of 20 photographs. These were quickly printed and placed on the wall of the consulting room, like exhibits in an art gallery, and were then viewed and discussed. Each family member was asked about times when they felt the way they were depicted in the photograph and whether anyone else in the family had spotted their "state." This prompted the mother to remember how kind and protective Ben had been to his younger brother; she gave a few examples. Both boys looked quite moved and a picture of the boys was also taken and given to the mother. At the end of the session, the boys asked whether they could take the photos home and put them up on the walls of their foster home.

Putting feelings on the map, as it were, is particularly important when working with families where there is poor emotion recognition, as there is almost inevitably with traumatized children (Pollak, Cicchetti, Hornung, & Reed, 2000). When a photograph of a child who is described as "always aggressive" has been taken that depicts him as being (temporarily) "loving" or "kindly," this photo may be a significant exception to the dominant narrative and will encourage more nuanced and therefore mentalized ways of viewing him. Providing family members with prints of photographs taken in sessions, as a kind of "take-away," not only acts as a reminder of perhaps significant interactions in the session but, more importantly, can continue to stimulate intersession curiosity about mental states.

The context of court-mandated work, at least in part, determines the content of sessions. Here a major question is: Can this mother assist her children to recognize their own emotions and those of others, so as to regulate these better? Games like "reading the mind behind the face" are tools to facilitate this.

Jane returned with her boys for the next sessions—without her parents and without her young daughter. This was her decision alone, and she explained that she wanted to talk to the boys about their memories of living with her—but not in the presence of anyone who had not been there at the time. Ben and John were very active as they entered the room; they wanted to tell their mother about an exciting trip they had undertaken with their foster caregiver. For the first 15 minutes Jane was barely able to get in a word. She then broached the subject and asked them straightforwardly whether they remembered when they lived with her. Ben simply said: "no" and busied himself with his mother's mobile phone. No further probing got him to expand on the "no." When John was asked the same question, Ben answered on behalf of his brother, stating laconically: "He was too young when it all happened; he was only a baby." This prompted John to say: "I was only a baby, I couldn't even defend myself." Jane took the hint and decided to change her approach. She took a board game from her bag and placed it on the table, stating: "Let's play a game." Ben seemed to recognize it and said: "I remember that game . . . we used to play it. John, you were too small." Jane asked John how to play the game and he obliged. He evidently had remembered the rules, and he moved the pieces expertly when explaining the rules of the game to his brother, adding repeatedly: "You were too young then, Mom and I played it." The three of them started playing the game, and, after a few minutes, Ben asked his mother whether she remembered a man named Fred: "You remember he played with us, he was nice, but you said you did not want to let him come to the house anymore. He was nice, not like Andy, he

was not nice, he hurt us." The mother seemingly focused on the board game and asked very gently, "so you remember that?" Ben immediately replied: "No, I don't! Mom, please concentrate, we are playing a game."

Helping children to remember painful memories in order to create autobiographical continuity (see Chapter 6) is particularly difficult when children have suffered severe trauma. Trauma has destructive effects on cognition, with feelings not being effectively mentalized. This can lead to a return to prementalizing modes of cognitive functioning, manifesting themselves above all in dissociation and physical acting out. There is a considerable risk that the experience of childhood neglect will be reenacted and trigger ineffective mentalizing responses as an adult. In this case example, Jane needed to be prepared to wait until the children were ready, at their own pace, to connect with past experience(s). Games often achieve this objective more quickly and effectively than asking endless questions, which children may experience as a form of cross-examination, as if they had committed a crime or offense.

Over the subsequent four sessions, attended only by the boys and their mother, Ben—and later also John—produced a few memories of what had happened all those years ago, and they slowly began to probe their mother about why she had been unable to look after them. The mother answered truthfully, though she did abstain from embroidering her accounts with too much detail. After much further work, they were both eventually reunited with their mother and, on follow-up 2 years later, were still placed with their mother and both attending mainstream schools.

CONCLUDING REFLECTIONS

Systemic therapy is often considered coterminous with family work. MIST also focuses on the family as well as beyond the family and on individual work. The focus of the intervention is determined by pragmatic considerations, but its global aim is to enhance mentalizing within the wider system. This can be seeded by making a key actor within the system better able to mentalize. Inevitably, the entire system will be impacted because the individual's concerns will spread to others in the system. We assume that Jane's individual therapy, recommended by her network, affected not just the way she thought about the task of reuniting with her children, but also affected her parents, her sons, her daughter, and the professionals in her network. Over a relatively brief period

of 6 weeks, she was enabled to ask herself questions about her sons' experiences under age 5 and to start considering not just how they might think and feel about such memories, but how she might reflect on their reactions and how her sons would in turn experience her reactions and attempts to reassure them. As we emphasized above, it is not the content of these reflections that is material; rather, it is the mixture of confidence and humility with which Jane is able to entertain first-, second-, and third-order mentalizing that is critical from a systemic perspective.

The system benefits little from an individual who from a standing start becomes a mind reader. If this had been the case, Jane would have remained alone as the single "mentalizer" within what was at best a partially mentalizing system. Jane's mother had strong motives to assist but was poorly supported by a husband evidently too bruised by past experiences of expressing emotional concern. There was also limited support from fellow professionals who were understandably fully preoccupied with the boys' need to manifest their emotional experience in action rather than words. Jane's move to accept a more mentalizing stance toward the family trauma she had to some degree engineered was critical in providing a foundation for more traditional systemic family work.

Recognizing and verbalizing emotion was at the heart of moving the system toward an acceptance of the past and a realistic contemplation of a shared future. The board game that the family played was in a sense the entry ticket to the community that the family endeavored to create on the back of Jane's ambition to reunite with her sons. All the members of the group, including Jane's daughter, had to believe that feelings could be expressed, would be recognized, and would not be mistaken for unhelpful and disruptive communication. It was not that members of the family had to learn how feelings were expressed. In a sense, everyone in the family knew all too much about that, notwithstanding Grandad's protestations. The necessary progress was at the level of communication, a sense of safety in relation to communicating about feelings. The implicit rules about emotional expression had to be reset within the system. Feelings could be experienced and expressed, and the consequence would not be catastrophic.

The small-family group sessions between Jane and the two boys were of course critical to ensuring that the memories of all three of them could be talked about. Again, it was not that these experiences had to be worked through. Such a process may take years, and perhaps it will never be achieved. The aim of the mentalizing-based approach in this context was to enable communication about experiences that had been unspeakable before the intervention. Jane did well to contain an initial phase of this process, well enough to ensure that the new family group could function as a system. We understand that the system remained

relatively stable, though obviously not without its problems. Mentalizing has a gyroscopic function.

As long as communication within a system remains mentalizing, it is accompanied by a reasonable level of stability, essential for social collaboration. The importance of trauma work is rarely insight; it is the management of arousal in the presence of trauma. Remaining able to think and feel, notwithstanding the activation of past memories, was a tall order for John, Ben, and Jane. MIST worked to ensure that the capacity for effective mentalizing was strong enough in each protagonist to be able to produce thoughts and feelings interwoven with the traumatic experience into the family discourse. None of them could have engaged in an open family dialogue with one another unless there was a safe way of knowing that each could appreciate the other's personal narrative. It was a tall order. But it was achieved.

Chapter 4

Not Going Around in Circles

Mentalizing Loops

Rose was 32 years old when she was referred for therapy. Again. At that point, she had a long history of child, adolescent, and adult psychiatry behind her—26 years to be precise. She saw a child psychiatrist first when she was 6 years of age because of what was then diagnosed as depression; she then received individual and family therapy for approximately 4 years. As a teenager, Rose self-harmed and also made several suicide attempts. She received medication, cognitive-behavioral therapy, and various other interventions, including a 1-year admission to an adolescent unit. By the time she was 18 years of age, Rose was diagnosed with chronic depression, and over the following 10 years she was prescribed practically every available antidepressant. Altogether she had had six hospital admissions, each lasting several months and usually associated with suicide attempts or severe self-harm.

Rose's relationship with her parents had never been close. Her father left her mother when Rose was only 2 years of age, and she never saw him again. When her mother remarried, Rose was 4 years old and she was initially very happy to have a "new father." However, her stepfather turned out to be an alcoholic with a violent temper, and Rose witnessed significant domestic violence. She also reported that her stepfather had made a few attempts to have a sexual relationship with her. Being admitted to an adolescent unit in her midteens seemed a welcome escape from the home situation, and after her discharge she did not return home but instead chose to live with friends in an abandoned squat. Rose then had a few relationships with men who

were often violent toward her. She met the father of her son, Johnny, when she was 22. Johnny was born 2 years later. Rose suffered a severe depressive episode after giving birth, lasting some 8 months. Rose sustained facial injuries when her partner attacked her. She decided to separate from him and bring up Johnny on her own. This proved more difficult than Rose had anticipated, and she had to rely on the help of Social Services, with a succession of social workers providing practical child care and financial support. At the age of 29, Rose met another man, David. He was a few years younger than she was and, as she put it, "different . . . he is soft, he is kind, he really loves me." They had a little girl soon after and, for the first time in many years, Rose felt happy. This lasted about 2 years, but in recent months she had felt irritable, and this led to arguments with David. She thought she needed help, fearing that her mental health issues were adversely impacting their relationship. Rose requested to be seen together with David for couple therapy. At the beginning of their first session, Rose said, "It's my problem and not his, I've been like that all my life . . . and I don't want to ruin our relationship." David nodded: "I love her, but it can't go on like this."

When seeing an individual, couple, or family for the first time, it is important to delineate their personal narrative. To establish a relationship characterized by trust, the therapist has to start by showing they have an accurate view of the client's perspective of the situation. The therapist shows curiosity and respects *the client's* problem definition, including which member of the couple they believe "has the problem." Some therapists might be tempted to immediately challenge Rose's assertion that she alone has the problem and to respond with a riposte, such as "Don't be so sure." The rationale for such a response might be to create an interactional framework from the very outset. A mentalization-informed therapist, however, would regard this intervention as premature, believing that supportive and empathic validation needs to precede any form of challenge if trust is to be established. This allows the client to experience the therapist as someone who sees the world through *her* eyes and therefore the kind of person whose words can be relied on and taken seriously. Ideally, this happens before introducing any other perspectives.

Challenging Rose's depression and reframing it as an interactional event—however accurate this might be—is likely to create a feeling of alienation that follows when clients feel they are being bulldozed by a well-intentioned clinical preconception. It is likely that over the past 26 years depression has become part of Rose's identity and personality; such designations are not mentalized, and the meaning-making behind

her experience of herself as "suffering from depression" is unclear. Nevertheless, within MIST we assume that diagnostic labels, however inadequate and misconceived, are often helpful to individuals with long-term conditions, albeit for reasons that rarely correspond to what the diagnostician intended. The idea of depression may have even become an important companion for Rose in her life, like a friend who could explain her experience and make sense of what happened to her. Without "depression," she may feel herself to be the defenseless victim of horrendous life circumstance or, even worse, the guilty agent who generates her own adversity. Such a sense of responsibility can generate shame and embarrassment. However unpleasant and disabling, depression can have a kind of value; this is what David hinted at. Rose has lived *with* depression for years, serving almost like another partner for her. Maybe at present depression is *the third person* in their relationship. Giving it up might come at a cost. But MIST has an approach for taking on long-standing mental friends who are perceived as crucial to the person's existence. A shift can be achieved through mentalizing.

MENTALIZING A WELL-REHEARSED NARRATIVE

Let us take Rose's example further. Various techniques can be used to mentalize Rose's idea of depression or any other embedded belief for that matter. The crucial step is seeing how the mind is treating a long-held comforting belief, as if it were a real person. Beliefs that come to be embedded can acquire a status of incontrovertibility (they are accepted in a state of psychic equivalence). To be able to shift them, they have to be mentalized—recognized, respected, validated, explored, clarified, and literally brought back to life.

An empty chair can represent depression and can be used therapeutically by questioning it, moving the chair closer and further away. However, the timing of such techniques is crucial. When individuals have a diagnosis which they—and those close to them—fully embrace, absolute respect is required. This may seem a potentially counterproductive start, as sticking with the diagnosis tends to favor the production of problem-saturated narratives: long and circumstantial accounts of what happened, accounts that have been given repeatedly to professionals and sound well practiced. A way of dealing with long explanations while retaining mentalizing may appear to be paradoxical: Slow it down. The stance of pausing and repeating what the individual has said allows the therapist to maintain a mentalizing therapeutic stance of curiosity, and to remain connected and alert. Disrupting a well-rehearsed narrative by

slowing it down and asking questions, including questions about how other persons might have viewed what went on, can be an effective tool to kick-start effective mentalizing again.

After thanking David for accompanying Rose to this first session, the therapist explained that he would be guided by what Rose wanted to talk about and that he did not expect David to say anything unless David himself wanted to do so. Rose nodded and said: "This is about me and my depression, and I have had it many years, long before I met David." The therapist encouraged her gently: "Well then, please tell me about your depression." Rose immediately launched into a detailed account of how it started, going back to her childhood. It seemed to the therapist that Rose had told this story many times before, and, after listening respectfully for about 2 minutes, he asked her to pause and check that he had fully understood. He briefly repeated what he thought she had said and then continued, "Now, can I just check this—if at that time and when all this was going on, you had put yourself in the mind of your mother, how do you think she saw this, from her perspective?" Rose paused and thought for a few moments before she replied: "I don't think my mom knew what was going on. She was always busy with my little brother, she didn't have time to think about what I wanted . . . or what I needed." Therapist: "And what was that like for you?" Rose: "I felt lonely . . . " and she began to cry. The therapist turned to David: "Is it okay if I ask you a question? Yes? Well, thank you. I don't know whether Rose has told you before what she has just said now, but if you had been in her position, how might you have felt? And can you understand what might have been going on in the mother?" David: "I am not a therapist . . . but I would have felt very lonely, maybe also very sad . . . and I would feel annoyed with my mom for not paying as much attention to me as to my brother. Thank God my mom was different." Rose continued to cry; this prompted David to get up and put his arm around her. She did not seem to want this and pulled away. David returned to his seat, and this was followed by a tense silence, interrupted only by Rose's intermittent sobs.

REMENTALIZING AFTER INTENSE EMOTION

When intense emotions develop during a session, the therapist is faced with a dilemma: to let the emotions run or to pause, to intervene or not to intervene. Therapists can bookmark an episode of interactions, such as that between Rose and David, and return to it later when things have cooled down. Or they can deal with it here and now by getting all participants to mentalize the moment. Which path therapists choose will

depend on the context. In this case, the context is a first session with Rose, who sees herself as the problem carrier, and with a partner who prefers to be in an observer position. Remaining in the here and now may not work, as Rose's arousal makes effective mentalizing a difficult task. A better option may be rewinding to the point before the breakdown in mentalizing and finding ways of bringing down the arousal level by moving on from where it all got stuck.

The therapist spoke calmly to Rose, "You talked about what it was like for you as a young child and that you felt neglected by your mom. Let us skip a few years . . . I'd be interested to get an impression of how things were when you were 10 years old. What worked well in your family and what didn't perhaps go so well?" Rose took a deep breath, "There was a good time . . . my father had gone and John arrived and I was happy, I had a new dad and I wasn't teased at school any longer." She wiped her tears away and her face brightened up. Rose then recalled a few anecdotes from her teenage years, with the therapist asking clarifying questions from time to time. These questions focused on how other people might have perceived Rose at the time or how they may have viewed specific relationships. The therapist also turned repeatedly to David and asked him whether he knew what Rose was talking about and whether any of it had been new or surprising. He continued, "David, when you first met Rose, do you think Rose was worried about letting you know her history of depression?"

Including David in the Session

We should remember that the aim of MIST is for the system to be mentalizing effectively. It goes without saying that David is part of the system, and without his active involvement in the process, Rose's mentalizing will not be sustained. The task is to enhance David's mentalizing without alienating him by undermining his personal narrative as Rose's support person, her protector.

Faced with the difficult problem of how to include David in the session, the therapist first placed David in an onlooker position, observing the interaction between Rose and the therapist. By asking David gradually about what he had noticed—past and then also in the present—David became a participant-observer and commentator. Turning an individual session into a couples session can be a subtle process. To avoid alienating David and to go with his personal narrative, the therapist does not ask David about himself and his life but about his perspectives on Rose. David perceives this query as consistent with his role in Rose's therapy and his stance that he wants to assist his partner rather than

be treated *with* her. Yet, by offering Rose an opportunity to observe David mentalizing her, the therapist creates an alternative perspective that Rose can integrate with the other (better established) perspectives she holds. In this way, David is making a direct and active contribution to MIST. In mentalization-inspired couples therapy (Bleiberg & Safier, 2019), the role of the partner is most important in maintaining the mentalizing process, particularly when it is challenged by the intensification of emotion in one of the parties.

THE MENTALIZING LOOP

A mentalizing loop is generated when the therapist's follow-up to his questions is to draw attention to Rose's immediate reaction and to get both her and David to *mentalize the moment*.

The therapist asked David about his observations of Rose's depression—what made it better and what made it worse? How did he explain the fluctuations? After pausing for a minute or two, David replied that he had noticed that whenever he returned from a business trip—lasting an average of 2 days—Rose seemed particularly depressed. She would then tell him that she finds it difficult to cope without him and that during his absences both children are very demanding. When thinking further about it, he observed that Rose is very reluctant to go with him to any business dinners and other social commitments to do with his job. "She always says she is not feeling well and that she is too depressed to come with me . . . it feels like an excuse, at least sometimes." Rose looked alarmed at what David said, and tears welled up in her eyes. The therapist drew attention to this: "David, look at Rose, what do you think is going on for her right now?"

Here the therapist deliberately brings David into the position of mentalizing Rose in the here and now. The sequence of triggering effective mentalizing is best described as the Mentalizing Loop (Asen & Fonagy, 2012a), and its first phase is illustrated in Figure 4.1.

This loop is like a route map that shows ways to facilitate the emergence of effective mentalizing. However, it is not a traditional route map in that there is no specific destination at which the couple or family are meant to arrive. The mentalizing loop is above all a pragmatic tool for navigating the here and now and helping to find new directions out of a current impasse. It does so by drawing attention to specific interactions and communications, and it focuses explicitly on specific states of mind by first *noticing and naming* them and thereby putting them temporarily

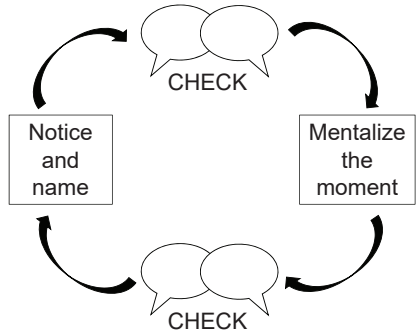

FIGURE 4.1. The Mentalizing Loop (phase 1).

on hold, for further inspection. In our case, the loop is started when the therapist notices and names by observing that "I notice that when David talks about Rose's depression and how it fluctuates, she looks alarmed." Highlighting this interaction sequence has the effect of halting what could turn into a cascade of nonmentalizing statements, reactions, and counterreactions. However, before he can proceed any further, the therapist needs to check whether both Rose and David can connect with the description named: "Maybe I got that wrong—or do you see it that way, too?" In this way, the therapist's observation is presented for mutual examination and consideration. If Rose and David show some recognition, the therapist can explicitly focus on what is going on that very moment, in the here and now, and get each *to mentalize the moment*. "Can you imagine what Rose might have been thinking or feeling that made her look so alarmed? What do you think went on for her at that point?" This is an invitation to mentalize the partner, in this case Rose. When David speculates about what might have gone on in Rose's mind at that very point—mentalizing the moment—the therapist can then follow up with inviting Rose to comment on David's speculations, thereby creating a circular motion of brainstorming, or indeed mindstorming, checking whether matters are being viewed similarly or differently. The process of continuous checking—which includes the therapist—creates a loop: What has been noticed is named and what has been named is questioned, with perceptions being checked continuously.

Generalizing from a Loop

By mentally rewinding and reviewing a specific sequence in this way, a series of metaperspectives can be generated, which can further promote

effective mentalizing. At some point, the therapist may ask an individual to link the here-and-now mental states to other situations that may have arisen in the course of ordinary family life situations. This is the second phase of the loop, and it is illustrated in Figure 4.2.

Linking the specifics of acute interaction to more general interaction patterns unfolding at home or in other contexts is key to stabilizing mentalizing within the system. MIST assumes that changes can only be achieved if these are available phenomenologically, to working memory; otherwise the risk is a drift into pretend mode. The downside of this insistence is the ephemeral nature of the moment of mentalizing. Only the most optimistic therapists assume that insight coming from such experiences is retained longer than the session in which they were experienced. It is therefore essential that the therapist make an effortful link (slow and deliberate) to interaction patterns that the couple might have noticed and perhaps remained puzzled by. Asking generalizing questions links the ephemeral insight to a long-standing significant pattern in the life of the couple and can be achieved by a simple open question: "Have you noticed whether things like this are also sometimes happening at home or elsewhere?" This question may trigger memories or associations that are significant and could be relevant to presenting issues. For example, David's reference to Rose getting out of unwelcome social engagements by claiming to be depressed may well be such an instance.

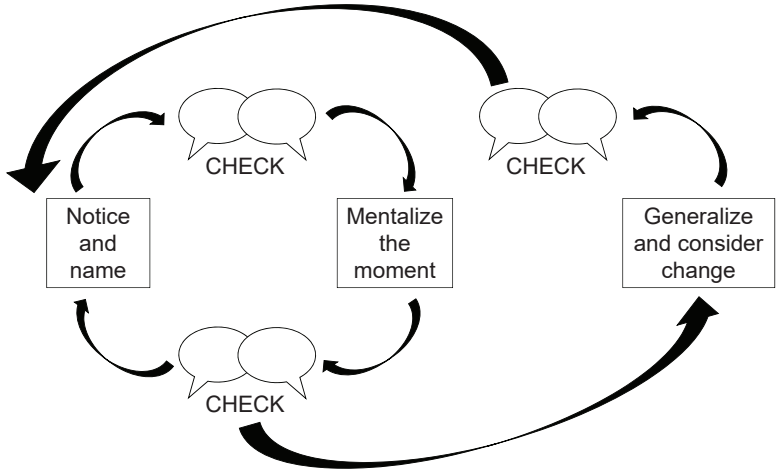

FIGURE 4.2. The Mentalizing Loop (phase 2).

Forward Loops

The therapist can create a "forward loop" by projecting a situation into an imaginary future: "Let us imagine that another social engagement has been issued and Rose does not feel like attending it, how might you both manage this—the same way or differently? And if David says that you are using depression as an excuse, how might you respond?" It is this move that takes us from just *generalizing* to *considering change*. At the risk of being repetitive, MIST is not a problem-solving approach. The purpose of this part of the loop is to generate alternative thoughts linked to possible actions. The point is for mentalizing to lead to solutions but not to persuade the couple to adopt a specific solution. The expected mechanism of change is not teleological, namely, choosing a strategy based on its outcome. It is to internalize and adopt the overarching approach of creating solutions to problems through considering the thoughts and feelings of all those involved in both the problem and its potential resolution. The MIST therapist undertakes this next phase of mentalizing the proposed solutions by spelling out the thoughts and feelings of the protagonists. Thus, a suggestion is (again) *noticed and named* by the therapist: "I can see that Rose thinks that she should be allowed to come clean about not wanting to join you, David, and that you should accept this. And I can see that David believes it is important for his work that he is seen together with his partner on important occasions. Have I got that right?" It is worth noting that here the "checking" part of the loop starts again, and, if both partners feel that the therapist has portrayed their respective positions accurately, further effort to embed the mentalizing stance can be undertaken: "Why don't you talk about that now . . . how you might manage this next time round?"

Many solutions to any problem are possible. MIST has its own criteria for an adequate solution. This may be formalized as the creation of an environment in which multiple perspectives are able to engage with each other in a meaningful, mutually respectful way; it is a context within which two minds look at themselves and each other in new and nuanced ways, opening up different possibilities and experiences. We consider the process of continuous "looping" to be the major therapeutic ingredient, and not the arrival at a specific solution. Of course, one must not ignore the subjective experience associated with finding solutions. It is highly gratifying and rewarding for all those involved, including the therapist. But this should not be the aim. Rather, the objective is ongoing mentalizing—namely, finding a position where multiple perspectives can be simultaneously and productively entertained.

Therapists have various choices when investigating couple or family issues. They can quietly listen to descriptions of problems, and they can

also ask questions about specifics. Much of the traditional systemic work with families tends to be based on words and to be "dialogic" (Seikkula et al., 2003) or "conversational" (Anderson, Goolishian & Windermand 1986), with a well-tested question and answer format. However, talking about problematic issues is one thing; observing them *in vivo* is another. When a problematic interaction occurs in the here and now of working memory, all that is required is for the therapist to focus on it. When such an interaction does not occur spontaneously, family members can be encouraged to "enact" one (Minuchin, 1974), demonstrating live how things go wrong between them and how matters can escalate. Enactment techniques lend themselves to *mentalizing the moment,* as illustrated by the example above ("Can you imagine what Rose might have been thinking or feeling that made her look so alarmed? What do you think went on for her at that point?")

Video Recording of Sessions

MIST freely uses photography, video, and audio recordings. Audiovisual recordings of sessions are considered useful to promote effective mentalizing. They are particularly valuable when arousal is high in a session and mentalizing capacity has gone out the window. For example, Rose may have been so upset by David's suggestion that she used her depression as a strategy that she burst into tears. David may then have felt equally upset that she did not understand him. The emotion would run so high in the therapy room that any attempt by the therapist to get either partner to mentalize the other or themselves is bound to fail. It may prove impossible for the therapist to bring down the arousal levels sufficiently to kick-start effective mentalizing during the remainder of the session. These are situations when the mentalizing is overly stuck at the implicit pole of the implicit-explicit domain, to such an extent that words are unlikely to shift it.

Encouraging reflection through reviewing video recordings of what has been going on can be a solution here. The principle of "striking the iron when it is cold" (Omer, 2004) can perhaps be employed in the subsequent session. The audiovisual recording (video or DVD) of a very emotional episode can be replayed, placing the partners in an observing position. The therapist can pause the recording frequently and impose an "other" or a "self" focus, as seems appropriate. The therapist can ask each party to put themselves in their own mind at the time or that of their partner, from this different historical vantage point: "When you were starting to cry, let us just focus on that moment on the video, what do you think went through your partner's mind?" This question can be

followed up by asking Rose to check with David as to whether this was indeed the case.

In these contexts, nothing gets mentalizing going better than a helpful misunderstanding. If David feels misunderstood, this misunderstanding can be used in the here and now to activate Rose's capacity to mentalize both partners. "So when you get it wrong how he felt then and when you look at his face now—what might be going on in David's head?" Viewing and re-viewing of significant episodes of problematic interactions permits the diachronic exploration of states of mind—past, present, and future. The latter can be addressed by looping forward to *generalize and consider change* with questions such as: "Supposing this happened again next week, how might each of you react?" Again, the solution is not what is important; it is the journey that Rose and David have undertaken in understanding what went on between them. It is not the getting there that gets one the sense that one has arrived.

BALANCING CHANGE AND MENTALIZING THE MOMENT

A major aim of MIST is to promote and enhance effective *balanced* mentalizing so that it adapts flexibly and creatively (moving along the different mentalizing domains) to the context and involves all participants. To be continuously reflective, mentalizing self and others explicitly at all times is not only completely unsustainable, it would also kill spontaneity. As we have described in Chapter 2, the therapeutic aim is to achieve appropriate movement along the different dimensions of mentalizing: between cognitive and emotional mentalizing (i.e., thinking and feeling), between action and reflection, between mentalizing others and self, and between implicit and explicit mentalizing (Fonagy & Luyten, 2009). The risk that a mentalizing focus carries is a bias toward explicit and sometimes cognitive mentalizing. This is a risk that must be avoided. In the course of therapeutic work, family members should not feel the need to reflect on actions excessively or compulsively, but should instead be encouraged to find a balance between intuition and reflection, reason and feelings, looking inward to mental states and outward to situations, thinking about one's own reactions and the experiences of others. This state is usually achieved, as we described above, by strengthening the pole opposite to the one the discourse appears to consistently favor. Also important in this context is therapeutic unpredictability. Most of us as therapists get into habits, be these verbal (e.g., asking the same question) or physical (e.g., always sitting in the same way, with our posture communicating a consistent attitude). The predictability of the therapist

inevitably interferes with balance because it favors a specific stance (pattern) in relation to the polarities. It matters little what that locus is. The point is that the therapist should not be in a predictable place in relation to these positions. For example, an excessive therapeutic reliance on cognition needs to be balanced by helping family members to focus on the emotional impact of firmly held ideas. The reflexive demand of some therapists for family members to constantly reference emotions ("and how did that make you feel?") can be as nonmentalizing as the total absence of reference to feelings (Siegel, 2015). What therapy manuals rarely capture is the need for the therapist to model mentalizing by showing a dynamic process of movement between polarities. This may be best encoded in the physical position of the MIST therapist as sitting at the edge of the chair—balanced between sitting and leaning forward, almost as if getting ready to stand and definitely not looking comfortable. While this may seem irreverent in relation to the seriousness of the cases we are describing, there is an important link between physical flexibility as expressed by location choice and posture and the avoidance of embedded modes of thinking and feeling.

RESTORING BALANCE THROUGH PAUSE AND REVIEW

The therapist tries to adopt a stance that carefully balances the need to allow the couple or family to interact naturally—observing their habitual ways of interacting around problematic issues—and intervening at critical moments to open up new perspectives. If arousal increases too much, the capacity to mentalize can fall dramatically (Bateman & Fonagy, 2016), with mental states becoming unbalanced. The therapist's task is to slow down or pause the speed of interaction and attempt to restore the balance of mentalizing across all four mentalizing dimensions. This *pause and review* approach, with the sequence of (1) action, (2) pause, and (3) reflection, is an integral part of the mentalizing loop. It aims to permit each partner or family member to gradually resume effective mentalizing, with emotion becoming integrated with cognition and equal weight being given to self and others.

As often referred to in the systemic literature, the distance between protagonists in a family can be concretely expressed in terms of physical distance. The polarity between avoidant and enmeshed is often cited to describe this form of embedded expectations. MIST regards such positional challenges as opportunities for cross-modal reflection. Bridging modalities, such as between the tactile and the cognitive or the visual and the vocal, points to and enhances awareness of the mental. In fact,

before verbal reflection has meaning for an infant, the mother's physical positioning of her child indicates her sensitivity and what is called embodied mentalizing (Shai & Fonagy, 2014). Thus, manipulating the physical position of protagonists creates space for embodied reflection even without words.

In another session, some 2 months later, Rose spoke about her son, Johnny, now age 8. She explained: "He is such a loner; he has no friends and at home he is always in his room, in front of the computer and playing games. . . . He doesn't eat with us; he cuts himself off. . . . He is going to a special school because he has problems with learning . . . I am really worried about him, I don't want him to end up like me." The therapist asked Rose whether she might bring him to one of the sessions. She was eager to do so, and 2 weeks later Johnny came with her—without David—to a mother–son session.

Johnny placed himself as far away as the room permitted. He said he was "bored . . . I don't know why I am here." The mother explained to Johnny that she was worried about him, "You are always by yourself; you won't do nothing for yourself; you are all day and night on your computer. . . . We want you to be part of the family." Johnny shrugged his shoulders, and Rose did the same. The therapist commented on the space between them and then asked Rose: "When was the last time Johnny sat on your lap?" The mother replied, "A long long time ago. . . . He just doesn't like closeness . . . and maybe he is too old to sit on my lap." Therapist: "Would you like to sit on your mom's lap?" Johnny shrugged his shoulders and said nothing.

The therapist turned to Rose and asked her: "If you invited him to sit on your lap, would he do so? Why don't you ask him and see?" Rose said in a half-hearted way to Johnny: "Do you want to sit on my lap?" Johnny got up immediately and placed himself on his mother's lap, with a big smile. Rose looked surprised and then spoke about how, "He won't do nothing by himself, he can't do his shoelaces, he won't brush his teeth."

Johnny made himself comfortable on his mother's lap. At one point he leaned backwards to rest on his mother's chest and she pulled away. Johnny moved forward as if to come off his mother's lap. Therapist: "I noticed that Johnny was leaning back—and that you then pulled away. . . . Did I see that right? Was his closeness uncomfortable for you? Or was there another reason?" Rose replied: "I can't get close to people . . . I don't know why. . . . Johnny, he can be very violent." Therapist: "Is he violent now?" Rose: "No, not now, but he often is. . . . " Therapist: "How would you describe Johnny now? What might be going on in his head as he is sitting on your lap?" Rose: "He likes it, I don't know why. . . . It never occurred to me that he wants to be close to me."

At this point, Johnny snuggled up to his mother, who looked quite perplexed. Therapist: "I think that is what he wants. . . . I may be wrong, but it looks as if he really wants to be close to you. . . . If you were to pull him in, pull him toward you, he'd snuggle up to you even more than he does now. . . . Johnny, what is it that you want? Maybe you can show your Mom." Johnny put his arms around his mother and held her tight. Therapist: "Isn't it great how he can show you, without words, what he wants and maybe even needs?"

In this interaction, the therapist employed enactment techniques to create an emotionally charged event between son and mother. He encouraged and facilitated physical closeness between a child, defined by Rose as being distant and not seeking affection, and a mother who finds it difficult to get close to others. An intense experience develops between them where they actually "*feel*" each other, with the therapist attempting to narrate the state of Johnny's mind—what he might be feeling. In this way he becomes temporarily the voice of the child, attributing to him feelings, desires, and wishes in relation to his mother. This resembles the "voice-over" format of a TV documentary, but here the mother is both audience and participant, experiencing live her narrated child's states of mind via physical contact. But beyond the voice is the physical experience of both. We may get some clues about this by watching a video replay, but this is ultimately superficial. What is changing in this process is physical proximity: a sense of being cared about that has its best expression in being held and feeling safe. While it could be argued that this process is beyond what the concept of mentalizing can capture, we would claim that the experience of physical closeness is at the very root of mentalizing. The metaphors of mentalizing all play to this proximity theme (being close to someone in one's views, bringing ideas closer, knowing someone intimately, the nearness of perspectives, ideas being adjacent to each other etc.), which in turn hint at the origin of shared perspectives as arising out of closeness (Lakoff & Johnson, 1999).

How mentalizing the idea of depression can assist with the secondary effects of depression is beautifully illustrated in the interaction between Rose and Johnny. Johnny is unable to mentalize his mother's withdrawal from him, which results from her intolerance of intimacy when she is depressed. He feels rejected and withdraws. Rose is resentful as she feels she needs to do everything for him, and yet he gives nothing in return. His hostility is born of his (natural) inability to understand his mother's condition, and this creates deep anxiety in Rose. Poorly

mentalized, Rose sees 8-year-old Johnny's hostility as scary. She feels vulnerable, and, in a mode of psychic equivalence, she is reminded of her father's brutality and pulls back. The dyadic relationship threatens to break into a chasm of unmentalized misattributions of mutual experience. The therapist is inspired at this point and breaks down the barrier of nonmentalizing by enforcing physical proximity between mother and son.

What then takes place is a piece of embodied mentalizing. It is to a point narrated by the therapist to explicate the language of physical gestures, but we can assume that much deeper physical thinking is also going on in the two body–minds. Rose's suspicion of the potential depth of Johnny's need makes her initially respond almost with hostility to Johnny's gesture of affection, which he can physically give, although he is unable to put words to his feelings. Rose moves away slightly, and Johnny's body reacts almost with panic. The therapist steps in, mentalizing the moment and explaining to both about Johnny's need to cling, to hold on and not let go. Subsequent events fully justify the therapist's leap of intuition, recognizing the mutual terror of rejection. He normalizes clinging for both mother and child. Paradoxically, this helps Rose, it turns out, not just in terms of reconnecting with Johnny but also by recognizing and tolerating David's intense need of her after periods of separation.

Two weeks after this session Rose returned with David. She reported that "It's like a miracle has happened, Johnny is hugging me all the time; he is so tender, so different from his father. He likes to sit on my lap; he puts his arms around me. . . . It is as if I have a new baby, a big baby, and as if he gives me another chance to be his mom. . . . I know it sounds silly, but Johnny is kind of teaching me to be close to people. . . ." At this point, a loud sigh from David was heard. The therapist asked Rose what she thought this might be about and, without any hesitation, she replied: "He also wants to be my baby . . . my very, very big baby." Both laughed as Rose put her arm on his shoulders and drew David toward her.

CONCLUDING REFLECTIONS

How are we to understand what is happening between Rose and David? What can be the aim of a brief treatment that follows 26 years of a wide range of relatively unsuccessful therapeutic interventions? Obviously, the alleviation of Rose's depression is not a realistic therapeutic

aim, given that her depression has resisted a range of therapies. Yet Rose is asking for help when she feels her moods and the behaviors that tend to follow might undermine the relationship she values with David. The appropriate mentalizing aim with a long-term condition, such as chronic depression, is to establish the unmentalized aspects of the experience for the family system. Teleological thinking, however, can make it seemingly impossible for depression to be meaningfully talked about in a dyadic relationship. Mental disorder, when it is severe and chronic, can, and frequently does, have the secondary effect of disturbing the quality of social communication which all individuals seek within their relationships (Fonagy, Luyten, Allison, & Campbell, 2017). Unfortunately, mental disorders such as depression, whatever their cause, strain an individual's capacity to mentalize. Anyone who has experienced depression will talk about how it is harder to think while depressed. The nonmentalizing aspect of Rose's depression is quickly drawn to the therapist's attention when David assumes that Rose uses her depression to avoid interpersonal experiences she finds disagreeable. David's attribution is understandable but profoundly lacking in mentalizing. He attributes intent where none belongs. He feels, to some degree, persecuted by Rose's depression, as if the depression were a person. When the therapy highlights this aspect of the couple's relationship, Rose feels upset, as if she is being accused of an act of sabotage for which she actually experiences no responsibility.

MIST is not proposed here as a cure for Rose's depression, but rather as a method for removing temporary or not so temporary blocks in family relations. Mentalizing impaired by a family's experience of mental illness is a common and readily addressed problem. The focus of intervention is not the disorder but its experience for those in the family. That is precisely what the therapist was able to deliver in this instance, enhancing mentalizing through the dyadic process of questioning as part of the mentalizing loop. Mental disorder inevitably brings greater emotional intensity than ordinary social interchange can easily accommodate. One might say that MIST is not a cure but has the potential to help relieve, with sometimes dramatic consequences, the problems that emerge secondarily to mental illness.

Awareness that the intensity of emotion can create problems needs recognition and revisiting in a state not dominated by distress. This was illustrated by the therapist waiting till the iron was "cool" before introducing reflection. The principle that mentalizing cannot be straightforwardly introduced to address ineffective mentalizing is clear, albeit harder to follow in practice than therapists might think. The therapist must work to get mentalizing active or wait until it spontaneously reemerges before bringing reflection to bear.

In the mentalizing loop, the therapist creates a space where thinking can once again become productive. The link can be made to loss and separation, clearly a potent trigger for Rose's depression, but also perhaps a moment of vulnerability for David when he is more sensitive to Rose's actions than he might otherwise be. There is no magic here, but simply a recognition that mental disorders have secondary effects that can aggravate the consequences they bring for relationships unless the experience of the disorder is mentalized for all concerned.

Chapter 5

Teaching Families to Mentalize without Explicitly Teaching Them

Sergio was 14 years old when his mother asked for help. She explained on the telephone that she was a single parent and that she and Sergio had always had a very close relationship until he hit puberty approximately 1 year ago. According to his mother, Sergio then became "very self-conscious and secretive. . . . I feel I no longer know him . . . and he cuts himself off from everybody, he has no friends, and he always worries about how he looks. When I ask him why he does not want to go out, he says that it is to do with his face and that's why he doesn't have any friends. I keep telling him that he looks fine and that there is nothing wrong with his face, but that makes him angry. . . . he explodes, I have no idea why . . . and then he screams, punches the walls and doors. . . . it can take hours for him to calm down . . . and then he locks himself in the room and I hardly see him for days. He won't go to school . . . it's about his face he says . . . that his eyes are too small and his cheekbones stick out and so on . . . and he is now saving money to have plastic surgery." After some discussion she agreed to come together with Sergio for a first meeting. Sergio asked to be seen on his own, with his mother remaining in the waiting room of the clinic.

Sergio presented as a sullen-looking teenager with no abnormal facial features; in fact, he was a rather good-looking young man. Sergio was monosyllabic initially—he did not talk spontaneously and answered questions with shoulder shrugs, "hmms," grunting noises, and a very occasional "yes" or "no." When asked whether there were any issues he wanted to discuss, he pointed at his face, saying merely "that." The therapist gradually

learned, by asking questions, that Sergio was convinced that his face was deformed, so much so that he was saving money to have plastic surgery. "I would have friends if I had a different face . . . my life would be good if I looked better." When the therapist said that he thought Sergio was good looking, Sergio replied: "Look at my cheeks, they are crap, look at the shadows under my eyes . . . and look at my teeth—they are all wrong. I can't smile because of my teeth." Any further reassurances given by the therapist were met with shoulder shrugging and occasional grunting noises.

The therapist decided to change tack and asked Sergio whether it would be all right to examine his face, together with him. He produced a large mirror, and, sitting next to Sergio, he asked him to look at himself and imagine what his friends or other people thought of the face they saw in front of him: "rate that face as a whole on a scale from 1–10." Sergio obliged and scored it as "2" and explained why this was: "Look at my cheeks; they are crap . . . and the shadows under my eyes. . . ." When Sergio was asked how he thought the therapist might rate his face, he replied "maybe a 3 or a 4" and when requested to explain why there might be this difference, Sergio replied that he thought the therapist wanted to be "nice to [him], but you don't think that really."

The therapist acknowledged what Sergio had said and then asked him whether he could take a series of photographs of Sergio while they were talking, "so that we can examine your face further." He placed himself in front of Sergio, engaging him in a wide-ranging discussion about various topics, such as school, football, lost friends, his mother, and some questions about his father. During this discussion, which lasted about 10 minutes, the therapist took some 20 photographs on his smartphone. He then got up and sat next to Sergio, both studying each picture in turn and with Sergio being asked to rate his face on each of them. The scores now ranged between 1 and 4. Being asked why on some photos his face got a higher or lower score, he attributed the higher scores to happy moments, above all in relation to watching football matches and seeing his favorite team win. For example, he said: "When you asked me what result made me most happy. . . . It was when Arsenal beat Man United 5:0."

Therapist: "So your face can change a bit. It looks a bit better when you are happy about something . . . have I got that right?" Sergio shrugged his shoulders. The therapist went a bit further: "Do you think you could become your own plastic surgeon—at least for the next 2 years until you are 16 years old when you can give consent to have a face operation? Maybe I can help you to change your face a bit, just a little bit. I'd like to make a suggestion and see whether it works. I suggest you take about 50 selfies between now and the next time we meet in different situations, and then we can look at them together and we can work out what makes some faces look worse and some a bit better. Maybe you need to put on your favorite music

when you take the selfies, or when you watch TV, or when you feel really down, or when your mom has a go at you."

EMOTIONAL PLASTIC SURGERY

Feelings are generally experienced as rooted in the self and in the body. When this is the case, they are not open to doubt and challenges by others. They just are, they are immediate, born of bodily experience, rapidly capturing subjective reality. When we feel something intensely, that experience is not open to doubt. The very nature of emotional experience is inseparable from its compelling and consuming character. A problem arises if thoughts begin to be caught up in emotion, if ideas and beliefs about self and others become part of the logic of feeling. Thought, by its nature, is a tentative process. If I know that something is a thought, then I am simultaneously aware of the possibility that it might reflect a misapprehension or even an error. When the logic of emotion captures my thinking, all signs of such tentativeness disappear from my cognition. Ideas become definite and clear, beyond doubt and second thoughts. Thinking becomes black and white huge generalizations and prejudices take over, and I am ready to dismiss all alternative points of view because they *feel* wrong. But *thoughts should be thought and not felt*. As described in Chapter 2, psychic equivalence is the state of mind where the intensity of affect has hijacked a thought; an idea that should be subject to the rules of a cognitive proposition has become totally compelling because of the intensity of emotion that surrounds it. It is now treated with the deference we would normally reserve for physical experiences verified by our senses. It is not that thoughts and feelings should be kept separate, but the mind must know which is which.

Sergio's deeply entrenched beliefs about his facial appearance could be said to have reached a delusional intensity, a condition also known as "dysmorphophobia." The therapist initially felt tempted to address Sergio's ineffective mentalizing attitude by adopting a mentalizing stance as if to compensate for Sergio's lack in that domain. He found himself questioning Sergio's self-perception, engaging in a Socratic dialogue about appearance, encouraging Sergio to critically examine and reflect on his beliefs and consider the evidence along with alternatives to his entrenched views. This approach did not work. As described in Chapter 4, mentalizing will never trump nonmentalizing, so one will not be able to "reason" (mentalize) a person out of a position of psychic equivalence. This led the therapist to consider another path, and the alternative approach was, somewhat paradoxically, nonmentalizing.

A nonmentalizing intervention can serve to reduce emotional intensity sufficiently for a person in psychic equivalence to be coaxed into adopting symbolic approaches to thinking. Of course, not all nonmentalizing interventions will serve this purpose. The therapist has to join the client first and look at the world together from the same standpoint and—like it or not—validate Sergio. The use of a mirror and of the photos assisted in looking at the same images and developing a conversation about the potential states of mind informing Sergio's facial features and expressions. Presenting a perspective consonant with Sergio's, the therapist reduced the emotional tension generated by his mother's and others' well-meaning but dissonant perspectives. Then, as arousal is reduced, it becomes more possible to start to mentalize.

Taking this stance jointly was essential to achieve affect regulation. Further, the nonmentalizing (somewhat teleological) concrete rating of the face in each photo established a rudimentary language of how to talk about the relationship between mental states and their manifestations in the physical world. Physical appearance can be regarded as a potential representation of mental states and therefore as the foundation for subjectivity. The origin of subjectivity is likely physical and is rooted in the caregiver's recognition of intentionality in the baby's physical gestures (movements, expressions, vocalizations, distress signals, etc.). As Sigmund Freud (1923, p. 16) put it, "the ego is first and foremost a body ego." The mind is, so to speak, placed in the physical body, with the aim of facilitating the transition from physical to psychological language. In this way, somatic and affective states become gradually accessible to mentalizing. In time, Sergio became curious about how his "entrenched face" seemed to be more flexible than he assumed and how this was related to the content of his conversation. The last part of the session described above consisted of an unusual and perhaps challenging framing of Sergio's belief: the notion that one could be one's own plastic surgeon—mentally altering physically unchangeable features.

Sergio returned for his next session a week later, on his own. He had done his homework and had taken more than 50 selfies on his mobile phone. The therapist and Sergio sat down together and looked at the photos, one by one. Sergio was asked to rate each selfie, and, from time to time, he turned toward the therapist and asked whether he agreed. Sergio's rating fluctuated between 1 and 7, the latter for a series of selfies taken when he did online chats with a group of what he called "football-mad mates." When asked what a girl who saw this photo might think or feel about him, Sergio replied: "She'd say 'wow.' " Therapist: "If you want one or more girls to say 'wow' when they look at you, what might you need to think and feel at the

time, so that you'd get that sort of reaction?" Sergio thought for a long time before he replied: "I need to have happy thoughts . . . maybe I need to think about good football results. . . ." While Sergio talked, the therapist continued taking photos of Sergio, and Sergio then examined and scored these as well. To his surprise Sergio found two photos where he said: "Look at that, that's a 5 . . . maybe a 6."

Two weeks later Sergio returned, this time with a friend. He burst out: "I have 263 followers," referring to a social media platform. He said the response to his online images had been "Amazing; they say I am 'cool.'" His friend confirmed this and added that "Sergio is just different . . . he was really depressed and now he laughs a lot." Sergio then proceeded to show the therapist his latest selfies, pointing out three that he rated as "10 . . . well, or maybe 9." His friend said that he had always told Sergio that there was "nothing wrong with his face" but that Sergio simply didn't believe it. When the friend was asked why he thought Sergio had "this thing" about his face, he replied: "I think it's something to do with not having a dad . . . he never talks about it, but I know it bothered him." The therapist turned to Sergio and inquired: "Is there something in what your friend said?" Sergio replied: "I don't know my dad; he lives in Argentina, and my mum said he was horrible." In the subsequent conversation in which both boys participated, the topic was "fathers"—whether one needed them or not, whether fathers were bothered about their children, how similar and different one might be from one's parent—and so on. Sergio said he knew practically nothing about his father, and this prompted the therapist to ask whether maybe his mother should come to the next session and talk to Sergio about his father.

When Sergio arrived for his first session, he was very stuck with one singular rigid view of himself as ugly. *Ugly* was equivalent to *not liked*. The emotional impact of feeling disliked and the intense negative emotions this thought generated in a tender adolescent mind intensified the reality of his experience of himself as unattractive. This gave way to an extremely vicious cycle of ever deeper convictions and increasingly intense reactions to feeling not likeable. It is possible that complex personal and family dynamics and other issues contributed significantly to a young person with normal looks starting to form a distorted picture of himself. Yet at the most immediate level, it was the interaction of a bodily experience generating an emotional reaction that repeatedly reinforced and deepened a belief; each reinforcement of misery turned into a conviction, which in turn deepened the bodily experience, having the potential to further deepen the conviction. Looking for causes and reasons to explain this phenomenon would have required exactly the kind

of mentalizing capacity that Sergio was not able to bring to this experience. With this realization, the therapist eschews the pursuit of insight. Paradoxically, the MIST therapist joined Sergio by getting alongside him in his psychically equivalent world. The therapist built on this joining together of their minds by gently expanding their perceptions rather than challenging them to facilitate the recovery of mentalizing. Tackling Sergio's view intensified affect and further amplified his conviction born of psychic equivalence. Validating his views, in a sense colluding with his preoccupation, reduced Sergio's anxiety and assured him that his concerns were being taken seriously. Examining a series of selfies with a person overly preoccupied with his facial appearance seemed an obvious platform for enlarging perspectives, taking alternative views, and generating the self-reflection and flexibility that motivates mentalization.

This attitude was evinced in the homework set for Sergio. While it seemed to have an excessive focus on his face, implicit in the task was a multiplicity of perspectives—Sergio's *faces* rather than Sergio's *face*—with the task of detecting the fluctuations of attractiveness of his expressions. This made him aware that he did not have a fixed face and thus gently challenged his state of psychic equivalence, his perception that he was stuck with a misshaped face. This discovery surprised Sergio. When comparing notes with the therapist, Sergio engaged in a scaling exercise and accompanying discussion, exchanging views about his fluctuating looks and the possible contexts for the seeming changes in his appearance.

All this is basic mentalizing, the first step within mentalization-based therapeutic work on the journey to recovery. Such collaborative work naturally stimulates curiosity on both sides. Sergio and the therapist both looked at the other's perceptions, with a conversation then taking place that focused explicitly on the states of mind that might be responsible for specific facial changes. These constitute important efforts to link the physical and mental worlds. It is the ability to see oneself through the eyes of others and appreciate that others can see the world in different ways which is at the heart of effective mentalizing.

CONCRETE ACTIVITIES AND GAMES TO STIMULATE EFFECTIVE MENTALIZING

Selfies are one of a whole range of unconventional tools used to stimulate effective mentalizing by offering a bridge between the physical and the mental world. Selfies allow a focus on the elaboration of mental states in contexts in which more than just talking happens. At their core is the integration of bodily experience, enhancing the reality of the

physical world and reflection. When mentalizing is vulnerable, supporting it without simultaneously engaging with bodily or physical experience is unlikely to be successful. Those practicing dance, drama, and other enacting treatments for psychological therapies realized this some time ago. Without combining awareness of the thoughts and feelings in the here and now with concurrent physical experience, mentalizing will remain inhibited; mere reflection on its own is not likely to bring about change.

But exercise on its own will also not address mental health problems other than in a most general manner. Without systematic reflection, playful experiences will not help in situations outside of the treatment setting. If these concrete techniques are employed in playful ways, they generate a state that combines the psychic equivalent and pretend modes, which perhaps mimics the developmental trajectory of mentalizing in small children (Fonagy & Target, 1996). The playful juxtaposing of the concreteness of psychic equivalence with the unboundedness of pretense can free the mind from rigidly held convictions and sometimes even challenge quasi-delusional beliefs. The combination focuses on the most relevant issues, while ensuring that anxiety is maintained within tolerable limits.

MIND-READING STETHOSCOPES AND OTHER "SCOPES"

Let us look at another practical example of the same mentalization-informed systemic approach. Consider the stethoscope, which physicians routinely use to listen for specific physical symptoms. When employed by a mentalization-oriented therapist, the mind-reading stethoscope can be used to elicit comments on one's own or others' thoughts and feelings. In a family session, the therapist encourages a child or a teenager (or even an adult) to hear something by placing the instrument on the head of another member of the family. While the stethoscope has no known diagnostic properties beyond identifying respiratory and cardiovascular symptoms (e.g., heart murmurs or lung congestion), it can be surprisingly effective in enabling family members to suspend their general reluctance to mentalize explicitly about each other in relation to delicate issues.

Therapist (puts the stethoscope on Mom's head): "What do you think goes on in there, in your mom's head . . . imagine that you could hear what goes on in her brain? What sort of thoughts or wishes might she have? Let us just put the stethoscope on that part of her head . . . right at the back of your

mom's mind? Sometimes people put their secret thoughts or feelings right at the back of their head . . . what do you imagine those could be? And what might she feel there? Or maybe she feels things somewhere in a different part of her body. . . . This stethoscope can also listen to hearts and tummies. Do you think her heart is big enough for more than one child? Just listen to the part that is there for you . . . what is it feeling?"

One can listen to oneself in similar ways, with the person placing the stethoscope on their heart, brain, or abdomen: "And listen to yourself for a moment now . . . That heart of yours, if it could speak, what might it say?"

With a bit of encouragement, children generally tend to find it easier to make use of such playful techniques than their parents who, enticed by their child's example, may eventually feel free to use the mind-reading stethoscope themselves. Placing the stethoscope on the organ that needs to be listened to is a simple device for making the link between the physical and mental world—the integration that underpins effective mentalization. As we said above, the playfulness also separates the person from embedded ways of thinking and lightheartedness by definition reduces anxiety. What seems like a simple device actually turns out to be quite complicated.

In one-to-one individual sessions, listening to oneself can be extended by examining the therapist's mind and supporting the client in considering alternative perspectives. Sergio is asked to place a stethoscope on the therapist's head with the task of working out what the therapist "really thinks and feels" about him and Sergio's face. This leads to a conversation about trust, whether one can believe what other people say; how it is possible to work out what information and which person one can rely on. In other words, the concrete tool is there as a bridge to enter into the mind of self and others.

We hope we have made it clear that the mind-reading scope is only limited by the therapist's imagination. Development of the stethoscope technique, for example, is what could be termed the use of parentoscopes and kiddyscopes. These instruments are designed to help children and their parents to look at themselves and others through one specific lens: that of their parent or that of their child. For many children—and also for a significant number of adults—a concrete physical structure, employed in a playful way, can be the most effective way of promoting perspective changes. For example, 10-year-old Freddy is offered an ordinary cardboard tube and is asked by the therapist: "Tell me what you see when you look through the Mommyscope? What does mommy think about Fred, and what's going on in him? . . . And now twist the base, and

it becomes a Daddyscope. Look through. Do you see the same Freddy, or is it a different Freddy? Why might mommy and daddy see two different Freddies?" Similarly, if parents use a more sophisticated wearable "device" fitted with suitable "adjustments" as "kiddyscopes"—or in this case perhaps a "Freddyscope"—they can put it on their head and look at themselves in the mirror and others using this device.

Parents and children can each build together their own "parentoscope" and "kiddyscope" prototypes, using cardboard and other materials. Constructing these devices together allows the therapist to observe family processes—how they interact and communicate, who leads, who follows, whether there is any give and take, and so on. When parents are unwilling or unable to construct such a device, the therapist can supply his own devices from a stock and allow each family member to choose one of them. It is the *physical structure* that concretizes the viewing process and thus allows the kick-starting of stronger mentalizing. This is particularly helpful in situations where each family member is very much preoccupied with their own perspective. There are obvious variations of this playful activity, such as constructing teacher-scopes, judge-o-scopes, police-o-scopes, best-friend-o-scopes, and so on, further enhancing the ability of family members to view a dilemma, a problem, or a person through a number of very different lenses. The essence remains the enhancement of a mentalizing stance in the family through increased willingness to break the mold of psychic equivalence, question and reflect on assumptions, and enrich the complexity with which others' perspectives are represented.

BODY AND MIND SCANS

As we have said above, mentalizing is an integration of bodily and mental experience. An infant's mental states are initially interpreted through physical contact as a caregiver holds the infant and responds by physical gestures, with sensitivity to assumed changes in the baby's mental state. Bodies remain important to subjective experience and are therefore important routes to freeing mentalizing from psychic equivalence or pretend mode. In our approach, we encourage therapists to make use of the client's bodily experience to enhance mentalizing and use individuals and family members to look at and examine mental states.

The "mind–brain scan" (Asen & Fonagy, 2012b) is a specific variation of the body scan that supports the envisioning of thoughts and feelings. Each family member is provided with a paper diagram of a cross-section of the human brain. However, in this adapted version, a total

of 10 larger and smaller spaces are depicted in the diagram rather the anatomically correct four brain ventricles. The therapist explains:

> "Do you know what this is? It's a kind of brain, but it has more spaces than most people have, and we therefore treat it as if it was a person's mind. Because what people have in their head is both a brain and a mind. . . . You can see that some of the spaces (doctors call some of them 'ventricles') are bigger and others are rather small. Imagine, Jane, that this is your dad's head with the mind inside it—put in the spaces what you think are his hopes for you and his feelings about you. If you think he has any secret feelings or thoughts, then you can put them in the small spaces and what you think is really, really important to him and what he thinks everyone should know, just put them in the big spaces. And I am going to give another brain to your mom. Can you, Mrs. James, put in these spaces what you think goes on in your husband's head in relation to Jane? And here, Mr. James, is another brain that I want you to scan: it is also your brain, but not the way you feel and think about Jane, but how you imagine she thinks you think and feel about her, the way you think Jane thinks about your interests and likes and dislikes. Or, if you prefer, you put in this brain diagram here what you think your wife believes goes on in your head in relation to Jane. Not what you really feel or think but what you think she thinks you feel and think. Now all just scan the brains and minds in front of you, and later we are going to have a look at what goes on in our heads."

What is the aim of this playful exercise? It is important to note that the contents of the "ventricles" are important primarily for the purpose of communication. In our view, what makes this and other games therapeutic is not just because they encourage the elaboration of mental states. The main benefit is that they bring about communication about mental states in the family—as in Mrs. James's case below.

Knowing that Jane feels that exam performance is very important for Mr. James helps her understand Jane's tantrums following a mediocre school report. From Mrs. James's perspective, Mr. James's hope that Jane should stop restricting her calorie intake is the only important hope and that Jane should be happy is the only important feeling. As it happens, neither of these features in Jane's perception of her father's thinking. She mentions as a secret thought that Jane's problems should not interfere with his work

schedule. As an illustration, she mentions that she knows he resents having to attend family sessions. While Mr. James is busy denying this, Mrs. James validates Jane's perception. The therapist presses Jane to explain a little more for her parents' benefit what her awareness of her father's discomfort with the family sessions means to her. Jane asserts, rather aggressively, that it means he does not care about her. At this point, Mr. James, in a rather touching way, discloses how uncomfortable he feels when people discuss emotions and that throughout his childhood, in his family of origin, no one was allowed to talk about feelings—or at least that was what he felt. He says that he felt that was a very unhelpful attitude and he would like to behave differently, but he finds it quite challenging and often feels very awkward when Jane and Mrs. James openly discuss how they feel.

The outcome of this kind of conversation is rarely a dramatic change in family dynamics or individual behavior. The change is gradual and primarily manifests in the nature of the discourse between family members. Family conversations become more nuanced in their treatment of mental states: They become less black and white, less dominated by words such as "always,'' "never," "every time," "not at all," "constantly," and so on, or accusatory categorical attributions of mental states such as "you just . . . ," "you prefer . . . ," "you hate . . . ," "you love. . . , " and the like. The discovery from games and exercises we have considered is that there are many different ways of guessing "what goes on in the head" of another family member and filling in the spaces with the feelings, wishes, beliefs, or thoughts they imagine that person harbors. Games nudge and encourage. Some individuals, like Mr. James, doubt the legitimacy of a discourse that includes emotions and struggle with the language of feelings. Many studies over the past two decades have pointed to how adverse childhood experiences can disrupt the organization and regulation of feelings (see reviews by Koss & Gunnar, 2018, Raymond, Marin, Majeur, & Lupien, 2018). Changing the family discourse cannot undo developmental damage, but it can unblock reluctance to engage. When talk about feelings generates anxiety, seeing that anticipated catastrophic consequences do not in reality follow can make material differences to family dynamics. In families like that of the James's, where a life and death anxiety in relation to a young woman's eating has come to permeate all discourse, phobic avoidance of mental state language can powerfully constrain the likelihood of change. This is where we see the mentalizing tools of MIST coming into their own.

Why is mental state avoidance such a problem? Nonmentalizing discourse in families begets nonmentalizing discourse. The more psychic equivalence dominates family communication, the more *serious*

conversations become. This can be a paradoxical process. When people feel very vulnerable to expressions of mental states because they are experienced as overwhelming and potentially very painful, these mental states are also more often ignored. Specific instructions can be given to focus this process down, such as "draw in the fears and hopes . . . so this is the way you see it, how do you think your son filled in this mind scan or mind map?" Putting intense and potentially frightening emotions on a mind map helps family members to examine these and their triggers.

Removing the inhibition through the invitation to be playful (non-serious) in relation to each other's thoughts and feelings in the family system generates trust through improved understanding. The aim of this exercise, as with so many other playful activities, is to stimulate mentalizing—curiosity about what other people allegedly think goes on in one's mind, correcting misperceptions and discussing misunderstandings. Opportunities to see how others experience the world can improve each person's competence in recognizing not just others but also themselves when they are being recognized. This is what improves the level of trust within the system and the safety and willingness each member feels to learn from, and about, others within it.

ROLE PLAYS

The exercises described in this chapter encourage family members to step temporarily into a different position or indeed into a different role. Actual role plays can be employed as another form of mentalization-inspired intervention. Based on psychodrama techniques (Moreno, Moreno, & Moreno, 1963; Yablonsky, 1981), they can, above all, encourage perspective taking. In mini-role plays the therapist can, for example, invert roles and "become" the client or one of the members of a family. The inverted role play can be started by the therapist stating, "imagine that I am you and you are me. . . . I am telling you how I feel, and you, as the therapist, will have to respond to what I am saying." This technique makes use of the temporary loss of self-mentalizing; during this mini-role play, the client or family member is less constrained to adopt another point of view, as he is no longer particularly concerned about how the other person's views may impact his self-perception. He is the other person momentarily, literally forgetting himself. When working with a family in this way, it allows each family member to assume a metaperspective that they are usually unable or unwilling to take. Subsequent discussion between the family members about their feelings and thoughts can create a "reflecting team" (Andersen, 1987), describing

their observations, moving toward integrating different perspectives, and perhaps developing a shared view that replaces the separate, fixed points of view each individual held previously.

More formal role plays can be developed using current or past problematic interactions, with family members being invited to enact these and then consider how things might be different in the future. For example, when parents are called to attend a session without their children, they can be asked to think about a typical conflictual scenario and then "enact" it (Minuchin, 1974). Once matters get a little heated, the therapist asks them to pause and to consider the thoughts and feelings of the other parent. As this exercise usually proves challenging, the therapist can suggest that they "replay" the argument but with interchanged roles: They are asked to change seats, and the mother has to pretend to be the father and the father has to be the mother, with each having to use the precise lines the other had delivered previously. An empty chair, possibly with a photo of the child or children on it, can represent the absent child or children. Each parent can then be asked, still in the role of the other, to devise some different lines about the same issue, with the aim of having a constructive rather than a typical stuck outcome. They may be asked to imagine themselves in 3 months' time when their relationship has (hypothetically) improved and how a discussion about a potentially problematic issue might develop then. They are also asked to think about the imaginary child and what he or she might make of the argument. Finally, each parent is asked to adopt the new lines created by the other and make these their own in a repeat staging of the previously problematic issue. When engaging in little role plays of this nature, there will usually be more than one version; this should stimulate mutual curiosity and entails exploring reasons for the differences in the envisioned possible future scenarios.

Sergio brought his mother to the following session. She said that Sergio was now much better at home and that she had noticed that he was taking a lot of photographs, mostly of himself, but sometimes also of her. The therapist asked Sergio whether it was acceptable for his mother to look at some of these photos. Sergio agreed and handed his mobile phone to her. As the mother began to flick through the many selfies he had taken, the therapist invited her to speculate about Sergio's thoughts and feelings in each of the snapshots. He added that, "You, Sergio, must not give anything away; don't say whether your mom got it right or not." After a few rounds, Sergio was asked to comment: "Now let's find out. Did your mom get it right or not?" He replied: "No, she doesn't know me." Therapist: "Okay. You think she doesn't know you. How well do you think you know her?

Do you want to have a go and scan her brain or her mind?" Sergio looked puzzled, but after the mind-scan exercise had been explained to him, he tried to fill in the spaces. When he was asked about any secret thoughts and feelings his mother might harbor, he studied her face for a long time before he remarked: "It's about my father, she never talks about him." Sergio's mother looked flustered and then muttered: "We didn't get on . . . I haven't seen him for years." Sergio then asked a very simple question: "What did he look like?" His mother took Sergio's mobile phone and searched through his selfies, eventually pointing at one: "He looks like that . . . just like you in this photo!"

Making links between the past and present and facilitating the emergence of modified or new family narratives is the ultimate implicit aim of mentalization-oriented systemic family work. We can speculate that Sergio's mother's rather negative view of his father is likely to have affected Sergio's self-image. Perhaps she saw specific paternal characteristics displayed in her son, be those physical or personality features, and unconsciously communicated this via subtle nonverbal cues such as frowning, withdrawing attention, or perhaps even commenting when annoyed with Sergio ("You are just like your father!"). Perhaps it is not too risky to assume that Sergio eventually ended up feeling that there was something inside him that was not desirable, at least not from his mother's perspective—a strange, if not alien, part of himself. A self-representation formed around the caregiver's distorted representation of the child is what we have called an "alien self" (see Fonagy & Target, 1995; Luyten, Campbell, & Fonagy, 2019; and Chapter 6 of this volume). It can help us understand why some adolescents and adults go as far as wanting to literally cut out those aspects of themselves they find uncomfortable with razor blades and knives or to anaesthetize themselves with drugs and alcohol. Unraveling the family narrative—that is, in Sergio's case the negativity-saturated stories about his father—can assist in reframing and reviewing stories told and seeing how these shape self-perception and self-worth. The recovery of mentalizing makes the reconstruction of these historical experiences possible, and their toxic impact can be moderated through the representation of these experiences as memories, impressions, assumptions, conjectures, opinions, expectations, guesses, hunches, hypotheses, views, suspicions, and the like, rather than through physical reality. It is the movement from the immediacy of emotion-saturated physical experiences of mental reality to the complex, often self-contradictory, multilevel, not infrequently confusing outcomes associated with mentalizing, which we aim to achieve through the games we have considered.

Often, as in Sergio's case, things make more sense at the end than they did at the beginning. But this is by no means invariably the case, nor is it a mark of recovery. If realizations arrived at make more sense of a child's or a parent's actions, this discovery should be celebrated but never exclusively. Many times we may have done sterling work, yet no resolution is forthcoming. Nonetheless, enhancing the capacity for perspective taking and the move from implicit to explicit mentalizing, with greater balance between prioritizing self and other and internal (psychological) and external (social/environmental) causes, has freed the family process. Future stresses are then more likely to be dealt with in a more efficient manner. While resolution is not a necessary or sufficient criterion for improvement, improved mentalizing is essential for the achievement of, and profiting from, resolution.

The subsequent two sessions with Sergio and his mother focused on his father. The mother was able to speak about how, during the first 3 years of Sergio's life, he had been a loving parent. An affair the father had had made the mother hate and eventually reject him. At the therapist's suggestion, the mother brought some photos of his father caring for Sergio when he was a young child—photos Sergio had never seen. When asked to think about what his father might have been feeling when holding Sergio in his arms, Sergio said: "He looks happy, like he loves me . . . and, look on this photo, he looks just like me. . . . "

On follow-up some 6 months later, Sergio's mother told the therapist that Sergio had met his father and had spent 3 months in Argentina, "getting to know him." As to the issue of having plastic surgery, the mother reported, Sergio had dropped the idea altogether and that he spent the money he had saved for the surgery on a state-of-the-art camera. She added, "he wants to be a photographer now—and he has taken a lot of pictures of me, God only knows why."

CONCLUDING REFLECTIONS

We have reviewed a number of specific techniques that enhance mentalizing within the family system. These "exercises" do not necessarily require explicit reflection but rather generate the implicit, intuitive understanding of internal states that support the creation of a mentalizing family culture. MIST incorporates the implicit learning principle by articulating the idea that the main task of the therapist is to construct a mentalizing culture by facilitating shared reflection on lived experiences. Ultimately, the MIST approach is challenged by the need to provide a

formal programmatic framework that is readily and replicably executed by therapists with varying levels of experience. Such a protocol—unlike the more traditional manualized treatments—would need to be able to generate genuine mentalizing rather than a pretense of explicit mentalizing, which is voluntarily and superficially evidenced by the client in compliance with the therapist's instructions. MIST must be able to engender a robust strategy for implicitly incorporating mental states spontaneously and effectively in a variety of social actions.

In line with this tenet, in this chapter we have grappled with the question of how to teach families to mentalize without explicitly teaching them. The techniques we have suggested have in common the goal of encouraging mentalizing without calling forth what may be most challenging for many of the complex families referred to our clinic: a demand for conscious, explicit, reflective thinking that is genuine and not a product of pretend mode thinking or hypermentalizing.

The distinction between implicit/fast effortless thinking and explicit/slow demanding reasoning owes much to the dual-systems models summarized by Kahneman (2011). He shows what probably every clinician knows, namely, that people often respond to situations automatically and without deliberation. This is hardly news. Other models of dual-systems thinking include those of Ross and Nisbett (2011) and, for impulse control, those of Fudenberg and Levine (2006). Reflection is slow and hard to do, and automatic responses are often adaptive to situations that people commonly face. However, problems can arise when family members misconstrue their situation or deploy inappropriate automatic responses because, as has been shown, automaticity unbalanced by conscious reflection can create significant vulnerabilities (Heller et al., 2017). In MIST, it is presumed that the ideal mentalizing stance can balance automatic/implicit mentalizing with deliberate/explicit mentalizing, calling on explicit mentalizing only when the situation indicates potential difficulties with implicit mentalizing. This is one of the ways the specific mentalizing techniques we have reviewed can be invaluable. They provide an opportunity for fast implicit reaction in a way that is sufficiently intriguing to warrant reflection. Watching videos of oneself almost inevitably brings fast and slow thinking together, encouraging reflection on actions that were initially performed automatically.

The other way the mentalizing techniques we have described in this chapter can be invaluable is in creating the opportunity and benefit of *joint reflection*. The "exercises" set for the family allow the possibility of exploring similarities and differences between individual perspectives and therefore, by implication, identify what is and can be shared. The joining with others in reflection is itself of value: It enhances the family's combined capacity to flexibly adapt to challenges by thinking

rather than reacting. Beyond engendering a mentalizing mode in family interactions, the quality of intrafamily relationships can also shift in the context of these exercises.

Last, we would like to underscore an important point here that may have been implied rather than spelled out thus far in this book: The MIST approach does not see mentalizing as having the cardinal role in the process of therapy. The overarching aim is, in fact, to improve the family's capacity for trust in social communication. As we suggested in Chapter 3, this is in part a function of having an experience of joint intentionality. This experience of feeling that one's perspective of reality is aligned with another's allows the possibility of learning and discovering something relevant, and thus it improves trust in social learning as a whole. This change in attitude toward the knowledge that is constantly around each of us may be the primary beneficial outcome of any therapy and the central reason for the potential for therapy to enhance resilience. A positive shift in the "background level of trust" within the family system opens the family to deal with future challenges using greater openness from both within and outside the family system.

Chapter 6

Enhancing Effective Mentalizing

In the previous chapters, we discussed a number of ways mentalizing can be restarted. Strategies we have mentioned include *restoring the balance* between the four dimensions of mentalizing (see Chapter 2) by "contrary moves" (Bateman & Fonagy, 2016). When, for example, affect regulation is a source of problems and the client's discourse is dominated by the pretend mode reflecting hypermentalizing and an imbalance favoring cognition, the therapist can invite the individual, couple, or family to notice and name the emotions that are hidden. Similarly, the therapist may enhance perspective taking when affect becomes overwhelming and invite the client(s) to step back with the help of the *mentalizing loop* and examine the sequence of interactions and subjective experiences that led to such high arousal and blocked effective mentalizing. The loop may also be helpful in the context of *reflective exploration,* mentioned in the case of Ms. Jones (see Chapter 2).

In this chapter, we will consider a wide range of techniques that we have developed over the years and found useful in dealing with problems we now consider difficulties of mentalizing.

"DIAGNOSING" EFFECTIVE AND INEFFECTIVE MENTALIZING

In order to jump-start what appear to be stuck mindsets, the therapist assesses and identifies the specific facet of mentalizing that may need to be addressed. While this is not a formal assessment, the clinician will note which aspects of mentalizing (introduced in Chapter 2) appear to be

robust and present, and which are less stable, perhaps underdeveloped, or even apparently absent. The absence of evidence for something is of course not evidence of its genuine absence—the logic of the black swan haunts us all (Taleb, 2007). For example, the therapist can decide to focus on an individual's narrative continuity if there is evidence of splitting and fragmentation of the family story. If there is little evidence of a seamless continuity of a personal narrative, the therapist can consider how to enhance it and employ specific techniques to do so. If a family member shows very limited evidence of engaging with any perspective other than their own, specific interventions can be considered to help generate multiple perspectives. These MIST techniques can be used in individual work in the presence or absence of family members, and they can also be employed when working with couples and families.

Specific ways of talking can draw attention to underdeveloped or seemingly absent facets of mentalizing. In relation to self-mentalizing, a person may, for example, state: "I can't remember anything that happened to me before I was 12 years old. What has my childhood got to do with anything? That is all that old Freudian stuff which nobody believes anymore . . . the past is the past, it's gone. . . . I don't remember what happened that long ago, it's not relevant." This statement might suggest an underdevelopment or absence of the facet of autobiographical (or narrative) continuity. Another person, a mother, may say: "I don't know why other people always blame me . . . it's not my fault that things are so difficult with my children. If I had a different social worker, I would not have all this trouble . . . what I need is not advice, but for social care to pay for a larger flat so that the kids can sleep in separate bedrooms and don't wind each other up. Everything would be sorted then." This account might point to a difficulty with the mentalizing facet of taking responsibility for one's own actions and behaviors.

When it comes to mentalizing others, if a family member states: "I know that this is the reason why you act like that . . . I know exactly what you think and feel, I have no doubt that you did this on purpose," it would appear that this person has difficulty adopting a not-knowing stance. In another family, a family member says: "Why do you always insist that there is another way of looking at what bothers us? Are you suggesting I've got it wrong? No, you got it wrong, you can see it how you like, but you are simply wrong." This would suggest a difficulty with the facet of perspective taking.

A father in a family session says: "I haven't finished, I need you to listen, you never listen, you just don't allow me to have my say . . . don't interrupt when I am talking, I don't care whose turn it is. I am starting with my problem first and I won't stop talking until everyone has heard

me out." This indicates problems in the facet of turn taking. A limited or absent belief in changeability is portrayed by the following utterance of an angry wife: "He is never going to change, not an inch. . . . I have tried for years, he just doesn't respond—even his mother says the same!"

Having "diagnosed" the absence or underdevelopment of specific mentalizing facets, the therapist can then consider a range of interventions to jump-start effective mentalizing.

JUMP-STARTING EFFECTIVE MENTALIZING

Table 6.1 provides an overview of playful interventions to jump-start mentalizing. It lists the aspects of effective mentalizing, some of which we have already described in Chapters 2 and 3, and which we more formally refer to here as "facets" (left-hand column). The table suggests relevant interventions that the therapist may wish to use to achieve the jump-start (right-hand column). The table is subdivided into mentalizing oneself, mentalizing others, and relational mentalizing. The term *relational mentalizing* refers to the shared or joint process that describes the unique qualities of the mentalizing social system. A few examples of possible playful exercises and interventions are given for each facet. The therapist's mentalizing stance is essential when undertaking these games and exercises.

MIST INTERVENTIONS

At the heart of the different interventions listed in Table 6.1 is the *mentalizing stance* (see Chapter 3 and Asen & Fonagy, 2012a): maintaining an inquisitive, "not-knowing" stance; validating each individual's experience; highlighting and marking effective mentalizing; and interrupting ineffective mentalizing. Many different exercises and games have been devised to enhance or jump-start effective mentalizing, and the list below is by no means complete. The exercises can be applied mostly to couple, family, and multifamily work (see Chapter 9), but some of the exercises also lend themselves to individual mentalization-inspired systemic work. Family members can be asked to carry out a joint family task, like constructing something together, whether with small wooden bricks with smaller children or a sophisticated Lego model with older children. This allows the live observation of family processes and possible interventions.

TABLE 6.1. Facets of Effective Mentalizing and Possible Interventions

Facet	Interventions
Self-mentalizing	
Focus on mental states	Feelings body map (see Chapter 5)
Not-knowing position	Inverted role plays Adoption of the not-knowing stance
Self-inquisitive contemplation and reflection	Life circles Letter to the problem
Perspective taking	Scopes How others see you
Inner conflict awareness	Conflict maps Arguments with self cartoons
Managing emotion	Affect snapshots Listening to hearts and minds Mood barometer Secret life of volcanoes
Taking responsibility for words and actions	Responsibility and irresponsibility boxes
Ability to distinguish between feelings and thoughts	Feelings body map
Self-deprecating humor	Identifying with a movie character
Autobiographical/narrative continuity	Life river Memory lane Identity puzzle
Mentalizing others	
Viewing mental states as motivating action	Mind scanning
Not-knowing position	Affect snapshots Describing postcards
Humility	Mind scanning
Perspective taking	Making scopes Clay family sculptures Stepping into someone else's shoes

(continued)

TABLE 6.1. *(continued)*

Facet	Interventions
Empathy	School award New arrival
Curiosity	Frozen problems Missed rendezvous
Reflective contemplation	Thought bubbles Forgotten birthday
Developmental perspective	Memory market Photo stories
Forgiveness	Missed rendezvous Letter to the problem
Relational mentalizing	
Joint intentions	Family rucksack Describing postcards
Acceptance of joint perspective	Conflict maps Memory lane Relationship maps
Not-knowing stance	How others see you Listening to hearts and minds
Nonparanoid or overreactive responsiveness	Bully/bullied/bystander Escalation clock Focus on misunderstandings
Ability to take turns	Family picture Playing a board game
Impact awareness	Relationship map School award Mirror babies
Playfulness	Masked ball
Belief in changeability	Family rucksack Magic kingdom
Capacity to trust	Blindfold Lie detector

Many of the following exercises and games are designed not as a one-off event, but as, hopefully, leading to experimentation after and in-between sessions. Many of these can be done in single family sessions, as well as in multifamily group work. Playful games encourage implicit mentalizing and can counterbalance a group or family member's intellectualizing tendency for hyperrationality. Playful games allow the all-important intersession mentalizing to be kick-started and take on its own momentum. Below are descriptions of a number of these exercises and games, many of which have been adapted from activities and exercises described by other clinicians and therapists in the field.

Lie Detector

Scenario: On sticky notes, each person writes three truths about themselves and one lie and sticks these on the front of their clothes. Others have to guess the lie.

Instruction: "It may be difficult for some of you to tell lies, but here is a game you might enjoy—guessing what's true and what may be a lie about another person. Can each of you take four sticky notes and write on them three things that are true about you and one statement that is a lie. Put these on your chest or head and walk around the room. Be a little Sherlock Holmes, meet all other group members, one by one, and guess their lie. See whether you can get it right the first time around and not the fourth time. Don't make your own lie easy."

Focus: How good is everyone at guessing? What is more difficult, the truth or the lie? When are lies "necessary," if ever? Are there "good" and "bad" lies?

New Arrival

Scenario: A new pupil has arrived in a school class. He is very shy. Some kids want to help him; others resent that his English is not good.

Instruction: "It is the first day for Bill at the new school in the new class. He doesn't know anyone, and it is not easy to understand what he says as he speaks some foreign language. Some pupils giggle, others ignore him. One pupil feels compassionate."

Focus: What might be Bill's hopes and fears? What do other pupils in the class think and feel about the new arrival and about him looking and sounding different? What might be going on in the compassionate pupil?

Missed Rendezvous

Scenario: Two friends have agreed to meet at 6 P.M. outside a movie theater to see the latest film. One of them does not show up.

Instruction: "Two friends, Judy and Mary, have decided to go to the movies and meet there at 6 P.M. Judy is there at 10 minutes to 6:00 and is all excited. By the time it is 6 P.M., there is still no Mary . . . and at 6:16 P.M. Judy is still waiting. Meanwhile: Mary is stuck in the subway—trains haven't moved for 30 minutes. She eventually arrives at 6:30 P.M. at the theater—thankfully Judy is still there."

Focus: Imagine Judy and Mary's states of mind at different times—how do they feel about themselves and about the other? What might they think and feel when they eventually meet up?

How Others See You

Scenario: Two parts—seeing oneself through the eyes of other group members, followed by their actual descriptions. Best done in multifamily or group work.

Instruction: "Each person is asked to write eight adjectives—positive or negative—they think other family or group members might use to describe them. Write these down, fold the paper, and put it away. Each group member is then asked to write one adjective about each other family or group member on a Post-It Note and stick it on the relevant group member (preferably on their back, so as to safeguard anonymity). The different descriptions are then compared."

Focus: Speculate as to why the self-ascribed adjectives may be similar to or different from those the other family/group members have posted.

Identifying with a Movie Character

Scenario: Each person chooses a character from a movie or TV series. Family/group members have to guess why each person may have chosen the specific character—and discuss which characteristics may or may not fit. A variation is to view a 10-minute clip of a commercial movie that depicts relationship issues. Ask group members to identify with the different protagonists and imagine how they think and feel.

Instruction: "Most people like watching some movies or some TV series. We would like you to choose one particular character that you feel you

can somewhat identify with. It would be good if it is a fairly well-known character, as we want everyone to know them. Start by impersonating the character you have chosen, with words and/or actions. We want, then, the rest of the family/group to talk about why they think the character has been chosen and whether or not you think there are similarities."

Focus: Get everyone to guess which character the other family or group members have chosen and speculate why. Compare perceptions. Do other group or family members see each character in a similar light?

Forgotten Birthday

Scenario: Bill has forgotten Jane's birthday; she is very disappointed.

Instruction: "It is Jane's birthday, and she is planning to celebrate with her boyfriend, Bill. She has invited him home and cooked a meal and bought beer to go with the food. She is very much looking forward to him coming to her flat. Bill arrives. He does not have a present and says to her 'Wow, what a dinner you have made and this on a Thursday!' Jane says nothing as they eat and she drinks most of the beer herself."

Focus: What has happened? Why does Jane behave the way she does? What might have been going on in Jane's mind? What might Bill think and feel when he finds out it is her birthday? Have you ever been in such a situation?

School Award

Scenario: A child got a special award or mention in school, but this is seemingly not noticed or commented upon by the parent(s). The child is very upset.

Instruction: "Jack has been presented with a special writer's award by the Head Teacher during assembly that morning. He is desperate to tell his mother. As he arrives home, she is on the phone and ignores him. Jack whispers to his mother that he got a special prize in school, but his mother waves at him to be silent and to go away. He continues to be excited and jumps around his mother, who tells him to 'stop being so rude . . . just go away and play.' He goes outside and 10 minutes later his mother tells Jack to come indoors. She asks him how his day at school had been. Jack replies: 'Okay.'"

Focus: Why was the mother nonresponsive about Jack's news when he first told her? How did Jack feel then? What did Jack make of his mother's response? What did he feel when his mother eventually asked about his day in school? What went on in the mother when she discovered that he had been given a prize? How could she make up for it, and what might be Jack's response?

Bully/Bullied/Bystander

Scenario: A typical bullying scene is role-played by four people: one bully, one bullied, two bystanders. The rest of the family/group members have to speculate about what goes on in each person's mind.

Instruction: "Imagine a typical scene at break-time in school: One child gets teased, the bully escalates, other children get drawn in and watch what happens."

Focus: What might be going on with the bully? What might the bullied child think and feel? What might be the thoughts and feelings of each bystander? What could they do—and why might they not do what they feel they might need to do?

Frozen Problems

Scenario: Each family thinks about a specific problem and uses the members of other families to represent it as a frozen sculpture. The others have to guess it and then find a way forward by resculpting.

Instruction: "Think of a relationship problem you have with your parents, partner, children, or anyone else you are close to. If you had to turn this into a frozen image, what might it look like? Think about it and then choose a few family or group members to turn it into a frozen statue. We will take a quick snapshot of each statue so that we can all look at this afterward." This exercise can only be done in a multi-family group setting.

Focus: How can different issues/feelings and dynamics be expressed and recognized? Can they be read accurately? How can one know how and what others feel? And if one "piece" in the statue could be changed, which one might that be, and what would happen to the rest of the statue?

Feelings Body Map

Scenario: Each person draws in specific feelings and their location on a body map.

Instruction: "All of us have plenty of feelings and emotions—even if we hide them from others or from ourselves. And often we know what we feel but not always where we feel it. We suggest that we get a body outline of each person here. Everyone can take turns lying down on this wallpaper roll while someone draws the outline of your body. Each person then gets their picture and is requested to draw feelings using different colors, intensity, and dimensions—no matter whether what you feel takes place in your head, tummy, legs, or elsewhere."

Focus: What does everyone notice about where certain feelings are located in different individuals and families? Where does one feel anger and aggression? What can one do if one doesn't like some feelings? How can you decrease bad feelings and increase good feelings? What sorts of stories come to mind when you have had these feelings in the past?

Affect Snapshots

Scenario: During the session, the therapist takes photos of family members with their permission. These photos are viewed at a later stage, with people guessing what was on the mind of each person at the time the snapshot was taken.

Instruction: "During today's meeting, I'd like to take snapshots of each person here, including of myself. This of course requires your permission. Later we can look at the snapshots and guess what was on the mind of the person depicted."

Focus: What emotions are displayed on the different snapshots? What triggers these? Are there any limits to mind reading? When and why might one get it wrong?

Mirror Babies

Scenario: The parent is asked to play with, talk to, and/or stimulate their baby for 5 minutes. A mirror is placed in such a way that it is possible to simultaneously see and film the baby's and the parent's faces. The parent subsequently views the video to speculate about the baby's state of mind, including how the baby might perceive the parent.

Instruction: "It can be at times quite difficult to know what babies think and feel—and also for the baby to know what their mother or father thinks and feels. We want you to play or interact with your baby for 5 minutes in any way you want to. We will record this. So that you can see more closely what goes on between a parent and the baby, we will place a mirror behind the baby so that the camera can capture the picture of both you and the baby at the same time. Afterwards we will look together at the video."

Focus: Pausing the video recording intermittently creates a whole series of spaces for reflection. The moment the video is paused, questions can be asked: "What do you think the baby is feeling or thinking right now? What might be the reasons for him being so restless?" This can be followed up by more challenging questions such as "Do you think the baby is anxious, or is it that you are worried (too)? Do you think the baby is cross with you—or is the baby picking up the idea that you are getting irritated with him?" Further questions can then be employed to get the parent to look at herself through the eyes of the infant with the support of the recording: "What sort of a Mommy does he see—a happy one, an angry one, or maybe a sad one? And if that is how he sees you, how might this affect him? What is the baby thinking and feeling right now? What does the baby think the parent is feeling or thinking? How does the parent respond to the baby? What kind of mother does the baby see? How does the baby respond to her? What would the baby say if he could speak? What would he say if he could think like an adult?"

Conflict Maps

Scenario: Family and group members draw maps of where conflicts occur—maps of their apartment or house, maps of their neighborhood and school. They mark those areas where conflicts occur in red.

Instruction: "Can each person draw the floor plan of your apartment/house. Mark in red where the typical battles/fights/arguments take place. Also draw a map of your area, where you are, the neighbors, shops, school, and so on. Also mark where the most problematic behaviors occur."

Focus: How can one explain why specific arguments tend to happen in a particular location? What would happen if each time one was tempted to have yet another argument, one changed the "scene of the crime" by pausing and moving into another room before continuing to argue?

Would a change of scenery really help, or is there something else one could do to reduce conflicts?

Escalation Clock

Scenario: Each person is asked to recall one personal experience during which things escalated to the point of losing control. A visual representation of an escalation clock is drawn, and the process of the escalatory interactions is recorded, with consideration of how the clock could have been stopped before it became too late.

Instruction: "From time to time, we all get into emotional states when everything seems to spiral out of control and we feel we have lost it. At those times we can become more and more angry. It's the same with the other person(s). It's like a vicious cycle; we just can't jump off. Can you each remember a time in the recent past when this happened to you? In order to work with this exercise, we would like each person to draw the face of a big clock, with numbers 1 to 12 and a line from each digit to the middle so that there are 12 segments. Let us imagine that 12 o'clock stands for it being too late; this is when you explode or when you all start to fight. Inside that segment write what happened—and then wind the clock back, hour by hour so to speak. Work out what happened just before then (at the imaginary 11 o'clock, but this may have just been seconds before the explosion). What happened at 10 o'clock—and so on. In this way, you can trace back how things escalated—what you did or said and what someone else said and so on. Write this all in the segments of the clock. Once you have tracked it all back, consider what you might have done differently at each "time" so as to avoid the escalation. Later, you can compare your clock with that of other people here in the room."

Focus: Could one have predicted the last escalation? What might each person have thought and felt? If so, at what point would it have been possible to stop the escalation? How might one in the future read someone's else's mind in time to stop the explosion? What might be the one thing one should not say or do at that point?

Stepping into Someone Else's Shoes

Scenario: Family/group members are asked to put themselves in the shoes of another person and look at the world from their point of view.

Instruction: "Can you all sit in a circle? Put a piece of paper under your feet and draw the contours of your shoes. Now get up and move to the

left and stand in the shoeprints of your neighbor. Imagine you are that person now and continue the discussion you just had."

Focus: What does an issue look like when viewed from another perspective? Can one better understand where other people are coming from?

Magic Kingdom

Scenario: An imaginary kingdom is created in which each person finds their role.

Instruction: "Imagine you all live in a kingdom, far, far away. Please decide together who lives in your kingdom—like king, queen, prince, princess, maid, servant, fool, knight, peasant, craftsman, merchant, jailer, etc. Once you have decided who is who, then adopt this role, find ways of dressing up—you can make hats, crowns, jewelry, tools—whatever you like. Then make a kingdom where everything works out well."

Focus: Is everyone satisfied with their role? Who would like to change it? How can one negotiate this—and with whom? How does the magic kingdom compare to the reality of everyday life? What might one learn from it?

Blindfold

Scenario: Blindfolded parents are guided through an obstacle course by their children, and subsequently blindfolded children are guided by their parents.

Instruction: "We want to play a game that has to do with trust; who can we trust—when and where? We have a few blindfolds here, and we want the parents to be blindfolded, so that they can really not see anything. When the parents are blindfolded, the children will set up an obstacle course, and they will then lead their parents safely through the room and also outside the room. The children can guide only with words. Later, we want to turn the tables. The children are blindfolded, and the parents set up an obstacle course and lead them. And after that, children will be led by someone else, someone who is not a family member."

Focus: What is "blind" trust like? Whom can one trust—and when? When has it been difficult for group/family members to trust others?

Family Rucksack

Scenario: Family members discuss and agree on five items they do not want to leave behind.

Instruction: *"Imagine that you suddenly need to leave the country on the next plane. You only have one rucksack for all the important family belongings—five items for the whole family. Can you talk about what these might be and then agree? Write down on five pieces of paper what you might wish to take—one piece of paper for each thing you want to take. Place the sheets in the rucksack."*

Focus: Why are these five items so important? Are they important for everyone? How was an agreement reached? Who has the final say? What can one not put in a rucksack? How does one deal with loss?

Memory Lane

Scenario: Each family or group member is to select one emotionally charged object that represents aspects of past family life for the next session. They are then encouraged to talk about the memories embodied in the object.

Instruction: *"The older we get, the more we forget. Often there are memories attached to specific objects, whether it's a security blanket, a picture, one's first shoes, presents from grandparents. Next time, we would like each person to bring one personal souvenir from your past, something meaningful that you value for personal reasons. And then we would like to hear something about the stories that are hidden in these objects."*

Focus: Which memories are evoked? Which good stories come to mind? Is there anything hurtful? Which objects had you thought of bringing and didn't in the end—and why?

Photo Stories

Scenario: Each family is to select seven photographs that tell the family history.

Instruction: *"Between now and next time we meet, please select seven photographs that explain the history of your family, just seven of the*

most important photos. This will mean deselecting a few. Next time we would like to see and hear the story of your family."

Focus: How did you choose the photos? Which ones did you have to discard? Which memories are evoked, and which good stories come to mind? Is there a photo missing that you would have liked to bring, but you cannot find it or it does not exist?

Identity Puzzle

Scenario: One person is "the puzzle," and the other family or group members need to solve it. A wooden puzzle game is used as a metaphor to illustrate how personal characteristics may fit—or not.

Instruction: "Sometimes we have problems knowing what other people are really like and also who we are. It can be like trying to put a puzzle together; there are lots of pieces, but do they fit or not? Is a piece perhaps missing? Here is a wooden puzzle set (about 20 pieces); please turn it over so that the pieces are all blank. Pretend this is the family or group member you want to find out about. Do not ask the person, who has to be totally silent and just listen. Use a Post-It Note to write down something about the person and stick it on the puzzle piece. Keep going until you have covered each piece. Then see how and whether it fits all together and completes the puzzle. Later we can talk about it with everyone in the room."

Focus: How easy or difficult is it to find descriptors of the person? How can seemingly contradictory parts be fitted in? What does the subject of the puzzle make of it all? How does one work out what people are all about? Who is in a position to do it? How can one fill in blanks or gaps?

Life River

Scenario: Each individual family member draws their own life river, looking back to the origins and ahead to the future where the family life river may flow.

Instruction: "We can think about our life as a kind of river, with initial springs getting together, maybe our grandparents, and forming a little stream which then gets bigger until it is a river. In life, as in rivers, one needs to negotiate new bends and unforeseen obstacles such as rocks

and currents. Sometimes the river, our life, flows calmly, and then suddenly we are swept along with it. Now imagine that this river is your life as a family. Look at it from a bird's-eye perspective, or imagine you sit on the river bank and see it flowing past you. What do you see? Imagine the river has different parts, beginning from the springs, with the birth of your children or when you met each other, and ending when it flows into the sea. If new streams flow into the river, like new additions joining the family, then mark these down. And just notice where the river, the family, flows and how it drifts."

Focus: How did the life river change its course due to external influences? How can one ensure that it remains in its river bed? How are or were dangerous currents and rocks negotiated? Which have been mastered and how? What challenges may lie ahead, and how can they be dealt with?

Clay Family Sculptures

Scenario: Each person receives self-hardening clay and instructions about making a sculpture of their respective family. This can be done separately by each family member, age permitting, or each family can make one joint sculpture. Each person/family subsequently presents their piece to the other family members.

Instruction: "We would like each person/family to use the clay to make a sculpture of your family as you see it now. Make all the members of the family and place them on the wooden board. Make them as big or as small as you like or as how important they seem to you. Pay attention to how they are positioned in relation to each other. This can have something to do with their problems or illness, or just how you experience them. And give your sculpture a name or title. You have 30 minutes to complete the task—and afterward we pretend that we are in a modern art gallery and each person presents their work to the others." Once this task is completed, each family/person explains their sculpture and its name and reports how and why they made it this way. Other group or family members are invited to comment and ask questions.

Focus: Which person in this sculpture do you worry about most? If something had to change in this family, where would one start? Where might you place the illness/problem? What would the family look like if the problem/illness was no longer there? Where should something change—who is most and least interested in promoting it? Which of the many

relationships might you want to change first? And if you moved that person closer to that one, what would happen to the others?

Variation: It is also possible to give each individual member of the family their own piece of clay and ask them to do their very own family sculpture. This allows for subsequent curious inquiry and speculations about why the sculptures may be so different and what might have been on the mind of each "artist."

Family Picture

Scenario: Each family is asked to draw together—with one pen only—a picture of the family as they see it now. They are subsequently asked to draw a picture of how they would like it to be in 6 months' time.

Instruction: "Here is one pen for you all—which you need to share. Please draw together a picture of your family, as you see yourself now. We can then talk about how you arrived at it." Later: *"Now make a picture of how you would like to see your family in 6 months' time."*

Focus: How well did the family members work together? Who showed initiative and who didn't? Who had the main "say?"

Secret Life of Volcanoes

Scenario: The family or group members research together what goes on in and under a volcano, with the aim of predicting any imminent eruptions.

Instruction: "Please make a colorful drawing of a volcano in a dormant state, prior to its eruption. Also draw the subterranean layers, showing what's going on underneath. Then make it erupt. Once you have finished the drawing, we will all talk about it and think about how to spot the volcano starting to erupt, like little rumbles and vibrations, steam comes up or the first rocks are being thrown out. Imagine that you are on the volcano and you want to keep as safe as possible. What can you do? When and where can you run for shelter and stem the lava flow? When you are done, I want you to talk about the last explosion in your family. What were the warning signs?"

Focus: Translate the volcano metaphor to any incidents of domestic violence.

Relationship Map

Scenario: Each individual constructs a family relationship map, describing with symbols the relationships among the different family members.

Instruction: "We would like each person here to map their family relationships. Circles and squares can represent female and male family members, respectively, and their relationships can be drawn with connecting lines. Really strong and close relationships can be drawn with double or treble lines, and more distant relationships with just a dotted line. Troubled or adversarial relationships can have some flashes between them or a zigzag. Remember to put in anyone who is important, people currently living together or even apart, including grandparents, uncles, and aunts. If you don't know about some of the relationships, speculate about what they might be like. If there are any alliances or coalitions between people, invent a symbol to describe these; maybe also mark the boundaries between different generations and different branches of the family, whether you think these are rigid, flexible, or too loose—and don't forget to put yourself in there as well." Later: *"If you could only change one of the relationships on this map, which one would you go for first? How could you change it? If it is changed, which other relationships might also change automatically? In what direction?"*

Focus: Which relationships are the best and which are the most painful? What would this map look like if the person had drawn it one year ago? What are the boundaries like? How come different members of the same family draw very different maps? What is this about? What changes would people like to make? If one relationship was less close, what would be different in other relationships?

Life Circles

Scenario: Each person depicts in a graphic way the important aspects of his or her life.

Instruction: "Let's imagine that this circle stands for your life as it is now (a large circle is drawn to cover most of the paper). I would like you to draw in some smaller circles to represent all the other people important to you—family members, friends, enemies, neighbors, whoever you like. People can be inside or outside this large circle; they can be touching, overlapping, or far apart. The circles can be large or small depending on how important people are to you. Anyone you

think should be on this piece of paper, alive or not, family or not—just put them in. Do remember to put yourself in as well. Also, put in other important areas of your life, such as work, hobbies, your God, or dog. Then put in your hopes and fears. Put an initial on each circle so that you can identify it later. And also important, put the illness, or your symptoms, in the circle wherever you think they belong. Don't worry about how you do it; there are no right or wrong circles; just do it the way you think it's best."

Focus: When you look at this picture, is there anything that strikes you as surprising? Do you like this picture? Are you happy with it? Anything you might want to change, not just in the picture but also perhaps in real life? How would you like it to be different? How could that happen? What would happen if you gave up that hope?

Mood Barometer

Scenario: Each person determines their mood and overall feelings state, both current and desired.

Instruction: "We have prepared a large sheet of paper for each family, with a vertical and a horizontal line. Use this to rate your mood and overall feelings right now and in the future. You can see that on the left, the vertical line, there is a scale from –10 to +10, and in the middle there is the 0 line. This is for each of you to fill in how you feel: –10 means really, really bad, and + 10 amazingly well. You probably will put your mood somewhere in between those two extremes. Then there is the horizontal (0) line. On it to the left of the vertical line is the past, and on the right, the future. Where the 0 is, that's the present, now. Can each person please fill in how they feel now? Each of you should use different colors so that you know who is who. Then fill in on the left when you each felt lowest in the past and put a date next to it. When you have done that, fill in, on the right of the vertical line, what sort of mood you would like to be in when the work with us is finished or at any other date. Once you all have done this, we would like to hear your ideas and experiences. Also think about one point: What would be a small step to lift the mood today—who would need to do what to make it happen?"

Focus: Who is or has been aware of whose moods and feelings? Who is oblivious to mood changes? Why might that be? What made it possible to lift the mood in the past? How can one build on past solutions?

Masked Ball

Scenario: Family members, starting with older children/adolescents, choose paper masks and are asked to play themselves, meeting up in 60 years' time and exchanging their lifetime experiences. The therapist, without a mask, initially interviews each adolescent until a spontaneous conversation commences. The parents listen to this in an outer circle and are asked subsequently to become a reflecting team.

Instruction: The therapist starts the role play by letting each young person take a mask and sit down around a table for an improvised tea party. As the party starts, the parents are invited into the room, and they are asked, without explanation, to place themselves silently in an outside circle, as mere observers. The therapist greets all the old ladies and gentlemen: *"I am ever so pleased that after 60 years you have all come back here. We last saw each other in 2021 here—I have literally forgotten your names—what are your full names now? I think I remember meeting your first husband at some stage . . . how many children and grandchildren do you have now? And in your case, how many marriages and divorces have you had? Do you still suffer from an eating disorder (ADHD, depression)? Did you ever go to university, or did you end up in Hollywood right away?"* With such invitations adolescents usually invent all sorts of dramatic CVs, and the therapist encourages interactions among the teenagers. At a later stage, the therapist can ask further questions: *"Do any of you still live in England? Are your parents still alive? What is (has been) your relationship like? If you think back, what or who did help you most in the days after you came here, all these years ago?"* Later: *"Let us imagine that we are now in the year 2050 and you are all middle-aged. See whether you might have a similar conversation."*

Focus: When you look back on your life, what was the turning point(s)? What do your parents make of what they have heard? What do you, young people, think about what the parents have said about your role play?

Letter to the Problem

Scenario: Each person writes one positive and one negative letter to "the problem" (difficulty, illness, disorder). The letters are all put together and then distributed in such a way that each family or group member receives a positive and a negative letter that are not their own. These letters are then read, one by one, starting with the negative ones first.

Instruction: "We would like to ask each of you to write two letters. The first one should start like: 'Anorexia (ADHD), I hate you because. . . .' List about 10 points why you hate this illness/problem. Parents, write this from your point of view, and the young people can write separately about the negative aspects. The second letter should start: 'Anorexia, I am grateful to you because. . . .' This letter must not be sarcastic and must contain 10 positive changes in your life that the problem has brought you." Later: *"Now that we have mixed all the letters up, we will distribute them and they can be read aloud; let's start with the negative ones."*

Focus: What are the concerns and pressures the problem produces? Which positive changes has the problem inadvertently created?

Describing Postcards

Scenario: Each participant selects a postcard (e.g., a holiday resort or a couple going for a walk, or an abstract picture of circles or lines), describes it, and then views it with a partner.

Instruction: "We would like you to work in teams of two and sit back to back. Participant A describes what he sees on the postcard; participant B listens and outlines the picture on a piece of paper. When participant A finishes the task, he shows the postcard to participant B. You compare your perceptions, and then the same is repeated with participant B, describing her postcard."

Focus: How easy or difficult is it to describe and listen? How does one deal with misunderstandings?

Responsibility and Irresponsibility Boxes

Scenario: On separate pieces of paper, each person writes examples of how they have been responsible and not responsible. These are placed in a box and read out later, without naming the author(s).

Instruction: "Most people feel responsible in certain situations and for certain people. But sometimes we act irresponsibly. We would like each person in the room to think of three examples of acting responsibly and three examples of acting irresponsibly. Place these statements in one of these two boxes. When everyone has done so, we will pick out a few of these statements from both boxes and read them out loud,

anonymously, so that nobody will know who has written the note—only the author of the note. We can then discuss your views."

Focus: When does one have to act responsibly? When—if ever—is it okay to act irresponsibly, and for how long? Thinking back on one or two examples of having acted responsibly, what have you learned? And what about when you did not act responsibly—has that had an effect on your future conduct?

CONCLUDING REFLECTIONS

In this chapter, we have outlined a significant number of interventions that a MIST therapist can undertake in order to kick-start mentalizing. We have contextualized this activity by pointing to a significant number of general rules that we hope the MIST therapist will follow in addressing underdeveloped or apparently absent mentalizing in a family, couple, or group. It is essential that therapists, in using specific techniques, adopt some core mentalization-based principles to jump-start mentalizing; otherwise the techniques could turn into something contrary to the approach this book has tried to promote. The unthinking, rote adoption of specific strategies is contrary to mentalizing, which above all requires an open-minded, flexible, and somewhat naïve, not-knowing approach. Thus, we hope that the approaches suggested above will be used in the spirit in which they were developed—one of openness and encouragement of a wish on everyone's part to be surprised by what emerges.

In addition to outlining some general principles, which we hope will create a background against which jump-starting of mentalizing can happen, we have outlined descriptors of effective mentalizing in families, couples, and individuals. Our purpose has been to help the therapist identify where to intervene. Our suggestion is that the therapist should observe individual members and the family in action in order to identify problems in mentalizing. The therapist has the task of assessing when good mentalizing seems underdeveloped or absent. Distortions and ineffective mentalizing tend to be readily identifiable as psychic equivalence, the pretend mode, or a teleological way of thinking. We have given some examples of ways in which nonmentalizing, or rather ineffective mentalizing, becomes manifest in family discourse.

We have suggested that thinking in terms of the other, the self, and the relationship provides an easy way of splitting the world into readily addressable and specific focal points. We suggest that therapists take the order in which the domains were presented as a rough indication of the sequence in which they may wish to work therapeutically. It is

sometimes easiest to start with identifying problems in mentalizing the self. This is not a particularly hard sell when problems are addressed in a compassionate and empathic way, showing an individual that the way they think of themselves, their own thoughts and feelings, lacks richness, complexity, and a multilayered, multifaceted perspective. Most people enjoy thinking about their own thoughts and feelings, particularly if these are addressed with respect and discernment. Of course, in this context, by respect we mean the not-knowing stance. By discernment we refer to the need to contextualize and elaborate in the interest of finding understanding and empathy. The emotional attitude needs to be one of compassion. In this context, compassion doesn't just come from the MIST therapist; it also needs to be encouraged in the client(s). The aim of elaborating self-mentalizing is primarily self-acceptance and not self-correction, and hence it extends the therapist's ability to see fully and clearly the reasons behind a client's self-experience.

Although hard to separate, mentalizing others should ideally follow improvements in mentalizing the self. The reason for this is simple. An individual who is feeling pressure to mentalize others "better" may be made to feel inadequate, responsible, and even at fault. Intensifying shame or guilt by showing misunderstanding of others is likely to jeopardize rather than enhance mentalizing. The experience of having found something in one's own mind that was more multifaceted, more nuanced, more understandable, more deserving of compassion than initially felt, creates space and sometimes even a willingness to explore the complexity of the internal world of others. Thinking about one's expectations, false beliefs, arrogance, fears, disrespect of others' thoughts and feelings is a long and difficult road for most of us. One makes assumptions about where others are for a reason. Usually, knowing how others think and feel ensures that the potential for negative affect is reduced. Actually knowing what they are thinking or feeling can be quite uncomfortable. It is a brave person who asks: "What do you really think of me?" Of course, it is easy enough to ask as long as situational constraints prevent the possibility of an honest answer. This is why we recommend that a comprehensive search for understanding how others genuinely think and feel assumes that the family member knows that a thought is just a thought, a feeling is just a feeling. Experiencing the mental state of others in a psychic equivalence mode is potentially a source of great discomfort. Experiencing the same in the pretend mode may in the first instance generate less discomfort, but in the long run, it prevents the potential for a genuine mutually gratifying relationship.

And finally we come to relational mentalizing, which is of course a natural and simple state—probably the most natural interpersonal state of all for human beings. Mentalizing oneself probably came last,

mentalizing others came second, but first of all in the course of evolution came relational mentalizing (by which we mean mentalizing as a group, most commonly in our context, the family group). The feeling of we-ness, of being part of a set of thoughts and feelings that are beyond one's own, is probably the essential component of social collaboration. Families thrive on the experience of shared states of mind, which are sometimes assumed and rarely reflected on. Relational mentalizing goes beyond self and other, internal or external, and depicts something about being together in a way that makes us not an accidental collection of individuals but a group that is tied together by a shared sense of purpose, by thoughts and feelings that we simultaneously hold even when we are not aware of so doing. Of course, this is the heart and soul of systemic family therapy. It is the failure of the system to act in a shared manner that generates excessive self or other mentalizing in the system. Ultimately, it is the balance between the shared mentalizing of the entire family, or at least subsystems within it, and the priority that individuals place on themselves, or indeed on others, that will reveal itself in MIST as one aspect of the family's mentalizing problems. In this regard, we believe that the process of enhancing mentalizing within the individual, and then enhancing mentalizing of others within the family, will in most instances generate relational mentalizing without relational mentalizing being a focus of intervention. Nevertheless, we have suggested ways of enhancing relational mentalizing, which therapists may use productively in the interests of resolving a family's difficulties. In our experience, much progress is possible without reaching the level of relational mentalizing. On the other hand, relational mentalizing as it emerges from and through the family system is perhaps the single most gratifying aspect of working systemically.

Chapter 7

Mentalizing beyond Diagnoses

When first considering the layout and different chapters of this book, we thought to describe specific MIST interventions for the most commonly encountered mental health issues and other problems: notably, specific interventions for emotional disorders such as anxiety and depression, or for conduct disorders, eating disorders, neurodevelopmental and communication disorders; and specific interventions for family violence, personality disorders, and other major problem areas. However, we also realized that many seemingly specific interventions for a specific disorder could also be applied in our work with other disorders. We also were aware that most children had a mixture of problems and so would be ill served by an overly narrow approach. We finally concluded that MIST does best when it is unconstrained by diagnoses. But this raised the question of how we should think about their problems, if not within the categorical approach we are all used to. In this chapter, we will present our understanding of mental disorder in children and frame MIST as an intervention in the context of this understanding.

Craig, age 8, was referred by his school because of "suspected attention-deficit/hyperactivity disorder [ADHD]" because he had significant difficulties keeping up and learning. The referral letter explained that "Craig is always on the move . . . he can't sit still, he is distractible, his concentration is poor. He can be very aggressive to other pupils; he has very poor impulse control and gets easily frustrated." At her request, Craig's mother attended the clinic first on her own. She said that, unlike his older brother and sister, Craig had always been "overactive and very demanding" and that she had

googled his difficulties on the Internet and had concluded that "he fits all the diagnostic criteria of ADHD." She added that she had found that his symptoms also could merit the diagnosis of "oppositional-defiant disorder." The mother then spoke about how Craig's "language has become so rude, he curses a lot and uses four letter words all the time. . . . everything is 'shit this and 'f . . . that' or worse . . . , and he makes really funny noises, grunting and all that . . . I looked it up, I think maybe he has Tourette syndrome?" Finally, the mother said that her best friend, who has known Craig all her life, was sure he was "autistic" and that this was also what a pediatrician had told the mother when she had taken Craig to see him a year ago because of a physical complaint. Craig's mother had brought Craig up on her own because Craig's father, who was an immigrant to the United Kingdom, suffered from serious depression and tragically died from a drug overdose when Craig was 2 years old. Although the coroner returned an open verdict, Craig's mother was convinced that the overdose was intentional and that he took his own life.

Craig's mother described the limited level of support she felt she and Craig had received from Social Services at the time. She was also struggling with what she referred to as PND (postnatal depression), but she considered her illness as mild compared to Craig's father's. The family was financially very hard pressed. Craig's mother worked as a cleaner and held several jobs to ensure that the family had enough income. Her own mother was now living in another country, but her sister was available to share some child care, although with three children under 10 years of age, she had a large family of her own. While Craig was on the at-risk register, there were no plans to take him into care. Social Services regarded Craig's mother as fundamentally caring, committed, and managing relatively well under quite difficult circumstances. There was no record of maltreatment of Craig, but it was noted that he spent excessive amounts of time alone without obvious stimulation apart from children's television, which was constantly on in both his own home and the home of his aunt. On interview, Craig presented as an anxious and withdrawn child, playing with a small toy car while his mother talked about him, and he apparently was hardly listening. He did report he sometimes had funny feelings in his stomach and sometimes felt like his heart was beating in his throat. When his mother was asked about his sleep and eating patterns, she responded: "He is not interested in his food, just watching TV. He would watch TV all night if I let him. He has never slept much, but he is sleeping less now than before." The clinician quietly added depression and anxiety to the accumulating list of diagnostic categories.

Sadly, it is not rare these days for children to receive diagnoses for what in the past may have been simply termed *difficult* or *odd*

behavior. And it is also not rare for children today to receive not just one diagnosis but several. So-called comorbidity is common (Kessler, Chiu, Demler, Merikangas, & Walters, 2005), as is repeatedly demonstrated in large-scale surveys conducted in the United States (Kessler et al., 2011) and the United Kingdom (Bebbington et al., 2009) in both clinical and community samples (e.g., Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014; Cummings, Caporino, & Kendall, 2014; Ormel et al., 2015). Comorbidity transcends diagnoses: it is associated with all mental disorders (e.g., Budde et al., 2019). Parents are often relieved, rather than alarmed, when their child is diagnosed with multiple disorders because it explains the challenges they have experienced with their child. Perhaps it also makes them feel slightly less responsible for the child's problematic behavior.

Most children have a mixture of problems, and so they would be ill served by an overly narrow approach. We concluded that MIST works best when it is unconstrained by diagnoses. How then should we think about children's problems if not within the categorical approach we are all used to? In this chapter, we will lay out our understanding of mental disorders in children and explain why MIST is an intervention particularly suited to helping children with multiple problems. Instead of the 500 or so different diagnostic groups defined by DSM-5 (American Psychiatric Association, 2013), we suggest that there is really a need for just one general category for psychopathology, at least when confronting complex cases such as Craig's. We are convinced that as clinicians we should focus on just a few aspects of the way children with mental health problems present, aspects that can be readily addressed in psychological therapies in a systematic and disciplined way. We hope our description of MIST has already persuaded the reader that MIST is both structured and focused in its approach.

We are not the first people to suggest one general theory of mental disorder. One of the most influential neuroscientists of his day, Jeffrey Gray (1982) suggested just such a model in a prescient theory considering the interrelationship of three neurotransmitters (Depue & Spoont, 1986). Many other researchers have had similar ideas since. If we stop thinking about disorder in terms of lots of subcategories and if we instead reconceptualize it as the manifestation of a single entity called mental disorder, then the so-called comorbidity problem disappears. It is simply that mental disorder manifests in different ways in different children and some symptoms frequently co-occur (Goldberg, 2015). How children develop specific symptoms may be interesting to scientists but may not be very relevant to clinicians. Clinicians, we would maintain, need and deserve a scientific understanding to justify the generic approach that they are in any case most likely to take. We maintain that Craig

does not really have five or six disorders, even if, when we look strictly at diagnostic criteria, it might appear that he does.

RESEARCH ON MENTAL DISORDERS

Researchers have identified something quite interesting in their studies of how children's mental disorders present. *Bifactor analysis* is a fresh way to look at how symptoms and diagnoses appear together in children, young people, and adults. This term refers to a fairly simple statistical idea that, before we look for different diagnoses, we should first of all see what all the diagnoses may have in common. Once we found what symptoms Craig's diagnoses (depression, ADHD, autism, oppositional defiant disorder, Tourette's syndrome, etc.) had in common, we could then see a bit more clearly what Craig's additional problems might be. For example, irritability and impulsive behavior may be associated with many diagnoses. Should we count them for each one? It seems better to just count them once. That is what bifactor analysis does. When very large groups of children and young people are studied throughout their development, and the symptoms that their different diagnoses share are accounted for, there may not be an awful lot left to explain (Lahey et al., 2018). They have mental health problems, more or less, best pictured on a continuum. Researchers have decided to call this general tendency to have mental disorder the p factor, as in p for pathology. So the best way to describe the mental health problems of children in the clinic and in the community may be to assume an underlying general predisposition and in addition, specific problems like behavioral problems, fears (phobias), distress (depression and generalized anxiety), and thought disorder. This approach gives the most economical description of the way children with mental health problems present—at least from the perspective of the psychometrician. The p factor concept helps to explain why it is so difficult to identify specific causes and biomarkers for the majority of psychiatric disorders and related targeted treatments. It is not the diagnosis but the level of general pathology that predicts outcomes, including the likelihood of suicide attempts. The more varied problems a person has—be those conduct and anxiety issues, or substance misuse—the more likely is suicidality. To be fair, the two researchers who started all this, Avshalom Caspi and Terry Moffitt, warned us that studies reporting such numerical descriptions (and there are nearly a hundred of them by now) may be just so much "sophisticated statistical tomfoolery" (Caspi & Moffitt, 2018).

But the story doesn't end here. Scientists who understand behavior genetics and molecular biology have produced research evidence

consistent with a single general mental disorder argument. Studies that compare identical twins (who share their entire genome) with fraternal twins (who have only 50% of their genes in common) indicate that not only is the p factor real, but it is to some extent likely to be an inherited vulnerability. About half of the variability of the p factor is hereditary. That is to say, about 50% of the risk of having mental disorder (or a particular severity) is determined by our genes (Harden et al., 2020). The largest study conducted so far, that of 25 brain disorders and 17 mental disorders in a study population of over 1 million participants, revealed that in all cases of mental disorders the same genes were found to be abnormal rather than specific genes or combinations of genes identifiable for each diagnosis (Brainstorm Consortium et al., 2018). By contrast, different neurological conditions had different sets of genes associated with them. So it seems that whatever genes may be linked to mental disorder, they are pretty much the same regardless of diagnosis.

We have learned a great deal about the brain over the last 25 years. Much of what we now know and understand also supports the idea of a single underlying vulnerability for mental disorder. In fact, most of the studies suggest that all mental disorders involve a dysfunction of just one or two parts of the brain—the prefrontal cortex and perhaps the limbic regions (Macdonald, Goines, Novacek, & Walker, 2016; Wise et al., 2017). There may be, and indeed there are very likely to be, many other areas of the brain that place a child at risk of having a mental disorder. In fact, it is increasingly likely that it is not so much the structure of particular parts of the brain but the connections between different areas that cause mischief (Hinton et al., 2019). So general psychopathology, the p factor, may have to do with irregular connectivity (faulty wiring) in the human cortex.

What is the consequence of careless brain wiring work? There are two ideas floating around in neuroscience at the moment, both of which have relevance to our theory of MIST as a therapy. The first idea is *emotion dysregulation*. Poorly managed feelings interfere with purposeful activity (Beauchaine, 2015). Persons who regulate their emotions will have an accurate idea about the risks of the situation that triggered emotion and can direct attention to what they need to do to cope with it. Such persons can use attention to focus, but also to distract if focusing is unlikely to help, and to reassess the risks as the results of their actions unfold (Gross, 2014). These strategies all work well. You can also try to suppress your feelings or ruminate about what has upset you. These strategies on the whole work less well. For children who struggle to regulate their feelings, emotions sometimes persist far longer than they should, and the feelings are more likely to disrupt their behaviors. They end up giving vent to emotions that are not appropriate to the context, and their

emotions may fluctuate more rapidly than one might expect (Cole, Hall, & Hajal, 2017). Craig manifests all these problems as he struggles to fit in at school and manage relationships with his mother at home.

Emotion dysregulation has been shown to be a feature of almost every diagnostic condition known to psychiatry (Beauchaine & Cicchetti, 2019). Researchers believe that a weakness in emotion regulation can amplify emotional experience that is going on in the background, cause distortions in the way children experience social situations, and lead to intense emotional reactions because the person is anticipating and experiencing an intense feeling. It can certainly generate inappropriate feelings and lead to sometimes dramatic actions to avoid unpleasant intense emotion. So it seems that while emotional dysregulation is not a mental disorder, the child's lack of control over affect, the moods they amplify, the distress caused by their intensity, the persistence of the emotion, and their changeability may all lead to problems that we consider "symptoms," including irritability, bad moods, anxiety, and aggression (Macdonald et al., 2016).

There is a second idea that could help us find an overarching account of vulnerability to a complex presentation like Craig's. *Executive function* is the capacity to control thought, that is, memory, attention, action, and generally direct information in the appropriate direction as relevant to any specific task. The quality of executive functions—cognitive processes deemed to be essential for healthy functioning—is thought to affect the p factor. These include self-regulation, decision making, sequencing of actions, planning, prioritizing, and navigating new tasks (Banich, 2009). Individuals with a high p score—signifying high persistent psychological distress—are oversensitive to difficult social interactions. They find it difficult to reliably interpret the reasons for others' actions and dismiss potentially upsetting memories of experiences. This leaves them vulnerable to emotional storms. It has been suggested that malfunctions of cognitive control may be the common denominator in many mental disorders (McTeague et al., 2017). Executive function deficits have been demonstrated for almost all diagnoses, ranging from the most serious, such as psychotic conditions, to depression, anxiety, and conduct problems. Executive function deficits and emotion dysregulation fit into a general model of mental disorder that involves connections between different regions of the brain.

No one would suggest that we have sufficient evidence to advance an unequivocal singular biological model of all mental disorders. However, what does seem clear is that evidence from clinical, psychometric, developmental, genetic, and neuroscience research all suggest that a substantial transdiagnostic overlap should be part of our understanding of what mental disorder is.

Understanding Craig

Craig's mother insisted that he be "tested" for ADHD and other disorders, and, at her request, he was subjected to a significant number of "gold standard" psychological tests by some excellent specialists. A few weeks later, the clinician met with his mother and explained to her that formal testing had not been massively helpful. Although it confirmed that Craig had symptoms consistent with the diagnosis of ADHD, the specialists did not recommend stimulant medication. Nor did testing for autism spectrum disorder (ASD) confirm a diagnosis of autism, although Craig's behavior did appear to be socially atypical. As to suspected Tourette syndrome (TS), the diagnostician was more definitive: Craig's impulsiveness was not part of TS; he seemed free of tics, but he was not free of using bad language in contexts where he might be expected to have better social control by his age. Everyone agreed that Craig was quite an anxious boy, with early indications of depression, expressed primarily in irritability verging on aggression.

Craig's mother was initially very disappointed in these findings. She asked: "So what illness has Craig got then? You can't tell me there is nothing wrong with him; he has always been a very difficult child, even when he was a baby." The clinician asked the mother to elaborate further, and she explained that shortly after his birth, Craig's father had become violent to her. "Craig was too young to understand what went on, but he was a screamer, he screamed and screamed, and that made his father even more angry." She clarified that she and the father separated when Craig was about 1 year old, 1 year before his father died and that she then suffered an intensification of her depression. Craig and the older children were looked after by her mother for a few months, "and my mother said that Craig screamed throughout that whole time. She did not know what to do, you know my mother is not a very good mother; I can tell you that from my own experience . . . all this has not helped Craig . . . and I felt so guilty, so when I was better and could look after him again, I spoilt him—actually, I literally let him get away with murder."

At this point, the therapist can explain to Craig's mother that his symptoms probably reflect a general vulnerability to mental disorder, with perhaps important subcomponents. This stance is a rationale for offering a generic approach to therapy for Craig and for not treating his individual diagnoses. If there were a single liability for experiencing any kind of disorder, this would help us understand why biological indicators do not link to particular mental health diagnoses. Blood tests, or even physiological measures, can help us diagnose most physical disorders. This is not the case for mental disorder. Notwithstanding the 20 billion

dollars of research that has been spent on exploring the biological basis of mental disorder over the past 15 years, we do not yet have a definitive and unequivocal set of biological tests to tell us precisely which disorders Craig may be suffering from. To help Craig, we may need to focus on his capacity to regulate his emotions and control his thoughts, and not on the six different diagnoses that Craig's mom brought to his therapist's attention. We think there are good grounds to suppose that Craig's multiple symptoms manifest together because his vulnerability to mental disorders has a common pathway.

So what is wrong with Craig? If there is only one theory to explain all mental disorders, then emotion has to be at the heart of it. But unlike many writings about this topic, we do not think of emotion in a simple biological way. Emotion is not something that the brain displays in the same way in animals as it does in people (Carver, Johnson, & Timpano, 2017). MIST therapists will feel uncomfortable about applying animal models to understanding human emotion. While the brain substrates of emotional processes are probably universal among people and share much with how emotions are organized in the brain systems of animals, the experience of human emotions is the result of an idiosyncratic life history. It is dependent on patterns (of brain response) that incorporate the influence of expectations, biases, learning experiences, and the accumulation of an individual's personal life history, including the cultural, political, social, and personal aspects. All of these experiences will be pertinent to any specific emotional state (Barrett & Satpute, 2013). This is the *constructivist* conceptualization of emotion. The neuroscience is still relevant, but human emotion is not just located within one brain. It is a reflection of the history of that individual from the earliest days until the moment the feeling is experienced.

Craig is overwhelmed by his emotions. He cannot control them; they make him act out. He has problems with his concentration. He experiences palpitations and intense anxiety, he cannot control his attention, he is unable to remember things properly, and probably as a result, he sometimes behaves oddly with people. At the level of his brain, in ways we do not yet fully understand, there are likely abnormalities in connectivity among his neural networks. Among these, perhaps the network involved in executive function and other parts of the frontoparietal network may be specifically important (Barrett & Satpute, 2013). As we explain in more detail below, these dysfunctional connections and the challenges they present in organizing his behavior are rooted in Craig's inflexible understanding of himself, of his life situation, and of his social world. All of this ultimately triggers his emotional reactions. The challenge for Craig is not simply his current situation, but his inability to move beyond it. Perhaps the difference between Craig and many other

children and young people has less to do with their specific combination of emotional experiences and the symptoms of their mental disorder than with their general problem of being unable to move beyond these experiences and self-correct in order to follow a better developmental trajectory. Psychologists tend to refer to this self-correcting capacity as resilience.

UNDERSTANDING SOCIAL LEARNING

If Craig's problem is his inflexible understanding of himself, then how might he change? How do any of our clients in psychotherapy change?

We cannot learn everything by observation alone—life is simply too complicated. We have to be taught. We have evolved into learning and teaching machines. Although the world is complex, the way we learn about it from infancy onward is relatively simple. Developmental psychologists have demonstrated that infants and little children are particularly likely to learn when the "instructor" (mostly the parent) who aims to convey a piece of information has engaged them in a concrete way (Csibra & Gergely, 2009). When children are addressed directly, when eye contact has been made, when they have been called by their first name, when they have been smiled at, when they are just looked at with a raised eyebrow, or when someone has just said a warm hello to them, all these little gestures are cues for children to know that whatever is coming next is important for them to remember. They are cues that signify information that has personal relevance. They are universal ways through which we can engage the young whom we wish to instruct. These cues, also referred to as *ostensive cues,* serve to make children feel that they are being recognized as important, as respected social agents. Lots of experimental studies have been done showing that small children, even infants, are alive to signals that they are being seen and recognized (Botto & Rochat, 2019).

Developmentalists have suggested that these so-called ostensive cues serve the function of counteracting the natural *epistemic vigilance* we all feel. Epistemic vigilance is a self-protective suspicion toward potentially damaging, deceptive, or inaccurate information (Sperber et al., 2010). After all, we would not want to listen to everyone. These small signals of recognition are emitted in order to suggest that, in this specific context, we should give our attention to the instructor because it is in our interest to do so. Ostensive cues appear to make children drop their guard and listen and take on board what they have heard. It seems that being recognized in this way makes it more likely that we trust what we hear. This has been called *epistemic trust* (trust in knowledge). It is marked by

children not only remembering what they heard, but also encouraging them to adopt and reuse the knowledge in different contexts. A simple experiment illustrates it well. In this experiment, an actor, whom the 18-month-old child has not met before, makes a special effort to say hello to the child and then shows a preference for a blue as opposed to an orange object. Then another person enters and asks for one of those objects. The child, without hesitation, will hand over the object that the person who had made an effort to recognize them indicated they preferred—the blue one (Egyed, Király, & Gergely, 2013). If the initial actor does not pay special attention to the child before demonstrating a preference, then when the second person enters the room, the child will seemingly randomly pass on either the blue or orange object. The child has not taken in that blue is the preferred color. But it is not that the child had not noticed. If the original actor asks for one of the objects, the child always gives the object the actor showed a preference for, even if the actor made no effort to get to know the child. For 18-month-old children, it seems that being smiled at and greeted is essential before they learn that the adult's preference is something that is also relevant for them to remember and use in new contexts.

We suggest that adults are not that different. They will respond to feeling recognized just as young children do. The only differences are that a raised eyebrow or a smile may not be enough. Ostensive cues generate complex feelings of being recognized. In adults, we think this is closely linked to mentalization. For mentalization-informed systemic therapy, ostensive cues help the person being instructed to feel a special connection, to experience a "we-ness" with the person instructing them. We suggest that any communicator's action that incorporates recognition of the listener as *an agent* will serve as an *ostensive cue* for learning. Feeling recognized seems to generate a particular attentional state where natural vigilance is momentarily suspended. The learner feels that the communication they are receiving will be relevant to them. They feel *epistemic trust,* trust in socially communicated knowledge. We think that all relationships, to a varying extent, entail the activation of epistemic trust. Our openness to long-term influence is a function of the extent to which our default strategy of epistemic vigilance has been overcome.

So where does mentalizing come into this? Mentalizing has the capacity to generate epistemic trust. If I mentalize someone, I recognize them as an agent. However, in order to establish epistemic trust, we need to be able to mentalize the other well enough for that person to see themselves as accurately mentalized. So what is being mentalized? At any moment for most of us, there is a predominant narrative. That narrative would be the most obvious straightforward way that we would describe our current state to another person. We may have subdominant

narratives as well. These are understandings of ourselves that are more nuanced, or complex and hidden from the normal shorthand that we might use to describe ourselves. It is the recognition of the wealth of narratives that we all carry around that constitutes a particularly powerful ostensive cue.

Craig's Learning Difficulties

Mentalizing-inspired systemic therapists have found the notion of ostensive cues extremely helpful in working with children like Craig who have multiple problems. Our contention in relation to children who manifest a wide range of problems is that something has gone wrong with their capacity to learn. Something stops them from picking up what they were supposed to acquire by way of new understandings. This goes way beyond the educational content they are exposed to from their teachers, although it includes this content as well. We learn about ourselves from others. Children do not suddenly exclaim: "I think therefore I am!" They discover themselves as thinking from the ways that others treat them: as thinkers. But to learn from others, we need epistemic trust. If children lose that trust, they will be handicapped in learning from instructors in social situations and then children's knowledge of themselves will fail to get updated. Their understanding of the world will be faulty because in effect they are working on an outdated model of what they should know about themselves in relation to others. Why have they not learned? It could be because there is no one around to teach them, but that's unlikely. The more likely explanation is that they are unwilling to learn in social situations that *they do not trust*.

Emotion regulation has to be learned. We have suggested that the caregiver plays a crucial role in helping children understand and control their emotional arousal. There is good evidence that children of attentive caregivers acquire the capacity for emotional control earlier (Cleveland & Morris, 2014). Adverse childhood experiences can interfere with the frontolimbic circuits that control stress regulation and so can interfere with acquisition of the capacity to regulate emotion. This may well represent a common pathway through which early life stress increases vulnerability to mental health problems through disruption of emotion regulation (Kircanski et al., 2019).

THE MENTAL IMMUNE SYSTEM

The biological immune system is a network of specific cells, tissues, and organs that defend the body against potentially damaging pathogens, like viruses and bacteria. When functioning properly, the immune system

identifies threats and distinguishes them from the body's own healthy tissue. Each individual has three types of immunity—innate, adaptive, and passive. *Innate immunity* is the natural protection that we are born with and our first line of defense to combat infection. The second kind of protection, *adaptive immunity,* develops throughout our lives as we are exposed to diseases or immunized against diseases through vaccination. The adaptive system can take between 5 and 10 days to identify the antibodies that are needed and produce them in the numbers required to attack an "enemy" successfully. In that time, the innate system keeps the pathogen at bay and prevents it from multiplying. The most common treatments for boosting the biological immune system are diet, exercise, sleep, good hygiene, and stress reduction. While we may need to treat the acute symptoms (e.g., the disease caused by the virus), more importantly we need to strengthen the immune system to stop future infections. *Passive immunity* is acquired when a person is given antibodies to a disease rather than producing them through his or her own immune system.

The metaphor of a mental immune system (MIS) may help to throw light on the issue of psychological resilience and why it may differ from person to person. Similar to the biological immune systems, people are born with different degrees of *innate resilience,* based on genetic factors, family history, as well as pre-, peri-, and postnatal factors. The setting in which the person grows up influences the development of *adaptive resilience*. This includes the caregiver's ability to moderate distress by, for example, providing containment. If parents are overprotective and desperately try to shield their child from any external source of distress, the child may later be ill equipped to deal with the pressures of everyday life outside the family. Conversely, if children are exposed from very early on to stressful situations, such as witnessing domestic violence between their caregivers, they may become hyperalert, watching out for any signs of impending danger, as well as becoming hyperreactive, experiencing dramatic increases of arousal and overwhelming feelings of not being heard or understood. As with poorly regulated biological immune systems where minor allergens can produce major intense allergic reactions, major issues regarding affect control may erupt. Overexposure to stressful situations can lead to "false resilience," with individuals giving the appearance that they are able to cope with anything disastrous, yet often at the cost of emotional numbness and related dissociative processes.

The family immune system can also be described by its degrees of "innate" and "adaptive" resilience. Some families achieve homeostasis in the face of the most severe challenges, whereas others crumble at the slightest internal or external threats. When the family immune system is "down," family members are more likely to be vulnerable to "catch" disease and get chronically stuck with problems. By contrast, a "healthy diet" of effective mentalizing, balanced with stress reduction and arousal

management, aided by MIST (which, mischievously, one could also refer to as Mental Immune System Therapy) can help to "vaccinate" a person against emotional family turmoil.

Craig and his mother attended the next appointment together. When his mother asked him whether he remembered living with his grandmother, he dramatically put his hands over his ears and then over his mouth, not saying a single word. The mother asked him whether it had really been so bad, and Craig's only response was to nod in agreement. Further questions or prompting did not elicit a different response.

Severe neglect or maltreatment, which is perhaps the most generally agreed transdiagnostic cause of mental disorder, might well cause a child to "switch off" their instinct for social learning. This would be an entirely understandable reaction. A negligent, hostile, or abusive caregiver cannot be trusted to be a reliable source of information. Consistent with this suggestion, there is ample evidence that severe neglect or abuse generates problems of adaptation, particularly in the context of learning (Romano, Babchishin, Marquis, & Frechette, 2015). Why should this be the case? Evidence is accumulating that the capacity to effectively orient to the mental state of others is dramatically reduced following adversity. So part of the cognitive control that the child loses as a consequence of adversity is related to limited capacity for engaging with the emotions and cognitions of those around them. They mentalize poorly. A recent systematic review of the literature on the impact of trauma on the development of social-cognitive capacities found over 250 studies that suggested this kind of relationship (Luyten, Campbell, Allison, & Fonagy, 2020).

DE-MIST-IFYING TRAUMA

The word *trauma* is nowadays used indiscriminately by many therapists and laypeople alike, so much so that it has almost lost its meaning. Our view is that it is not the actual event that is traumatic but rather the experience that follows the event. Experience can only be metabolized in a social context, and if social context is not available, adversity becomes traumatic, compounded by a sense that one's mind is alone. It is the presence of an accessible other mind that can provide the necessary social referencing that enables people to frame a frightening and otherwise overwhelming experience (Luyten, Campbell, Allison, & Fonagy, 2020).

Craig's experience of witnessing domestic violence and its sequelae, such as his mother's depression, are actually part of a singular traumatic picture. If his mother had had an adequate understanding of Craig's

upset as a small child and if she had been able to markedly mirror and contain his distress, the long-term sequelae of his early adversity might have been avoided. If his grandmother had been in the position to mitigate Craig's sense of abandonment when his mother's depression worsened following his father's possible suicide, Craig's traumatization might have been minimized. In essence, the MIST approach to trauma is that it is the unmitigated emotional response to adversity that is traumatogenic. If the child has the option of drawing on other minds to share (resonate with, reflect on, and provide a representation for) their distress, the impact of the adverse event may not generate a catastrophic experience.

There is an intergenerational aspect to the transmission of adversity. Over 50 studies provide evidence for the intergenerational transmission of childhood maltreatment (Paul et al., 2019). It seems that the experience of having been abused, neglected, or otherwise maltreated means that the individual is more likely to misperceive and consequently invalidate their own child's emotions, undermining the possibility of normal development for the next generation.

Switching off mentalizing may be a helpful strategy in the short term to cope with an inherently untrustworthy social environment. This might work in the short run but in the long term, disengaging from the social network, or at least treating it with great suspicion, may not work out quite so well. This is what we think is happening with Craig. After all, the referral came from the school. The classroom was the place where Craig experienced his most obvious problems. A study of 3,000 children carried out in Denmark found that those children who had a history of maltreatment were nearly nine times more likely to manifest learning problems and seven times more likely to change schools (Elklit, Michelsen, & Murphy, 2018). The experience of adversity is so profound for children because it undermines trust in the processes of learning and education. Of course, other qualities of the social environment that normally support resilience, such as being able to seek and receive help, having a social network, and being open to change, are also potentially lost.

RESILIENCE

We know that many children who experience adversity do not become the psychological victims of such trauma. In a study of over 1,000 children presenting documented evidence of maltreatment and subjective reports of childhood maltreatment histories, the risk of psychopathology was linked to objective measures only when aligned with subjective reports (Danese & Widom, 2020). In contrast, psychopathology was linked to subjective reports of childhood maltreatment even when they

were inconsistent with objective measures. The processing of the experience determines its impact.

The ability to handle the challenges of life, particularly the major difficulties it can present, is usually referred to as *resilience*. It is a normative and adaptive response to adversity. A high p factor points to the underdevelopment or absence of resilience, whereas individuals with a low p factor are likely to have good resilience. However, low resilience is not simply due to an absence of pathological processes; it reflects the work of active adaptation mechanisms with a biological basis (Kalisch, Muller, & Tuscher, 2015). Resilience can also be described as the capacity to reorganize brain functioning in the face of challenges, based on appropriate monitoring of external information. When applied to the family and other systems, resilience can be defined as the ability of a system to resist dynamically a perturbation that challenges the integrity of its normal operation and maintain its functioning. It is important to emphasize that exposure to adversity does *not* mean that one *must* suffer a mental disorder.

Resilience can be built when a person becomes open to social processes and can take in and process information from others. It is like a semipermeable membrane, allowing some relevant information to be brought inside. It requires managing a balance between openness and caution in relation to social processes. Resilience can be built by (1) a positive appraisal style; (2) a positive reappraisal: History cannot be changed, but it can be reappraised (mentalized) and viewed differently; and (3) interference inhibition (Kalisch et al., 2015). For example, the exercise "identity puzzle" (described in Chapter 6) and its game character—cutting paper and assembling pieces—distract and divert the person from being overwhelmed by strong emotions.

Outcome studies show overwhelmingly that approximately two-thirds of clients benefit from most psychological treatments. It is the one-third of clients that do not benefit that MIST specifically focuses on, primarily by strengthening resilience and reducing the p factor. The emphasis is on salutogenesis and not pathogenesis.

PUTTING IT ALL TOGETHER

This chapter has been about children with relatively severe mental health problems. By the term *severe,* we mean having lots of problems and not just one intense issue. In our experience, children with comorbidity are the rule, not the exception. We have pointed to several key factors to help us conceptualize the difficulties an individual with multiple mental disorders faces:

1. We started by mentioning the possibility of a general, possibly genetic, vulnerability that also manifests at the level of less well-organized neural connections. In Craig's case, there was mental illness on both sides of his family.

2. We looked at the literature covering the central role of emotion regulation and executive function in protecting the child from mental disorder and by the same token, emotion dysregulation and executive dysfunction as potential major sources of vulnerability.

3. Both emotion regulation and executive function are acquired in the context of the child–caregiver relationship. Disruptions of such relationships, particularly during an early phase of development, may undermine both emotional and cognitive competence in these domains.

4. The evolutionarily created learning situation that our children require assumes a relationship of trust between the person instructing and the person learning fresh information. This relationship of epistemic trust is established through a complex communication system whereby the instructor's perception of the child's agency is a precondition for establishing trust sufficient for the efficient transfer of information between the two.

5. This process for ensuring efficient knowledge transfer assumes the capacity of both parent and child, teacher and pupil, mentor and apprentice, to be able to mentalize each other. It is important that the child or learner imagines a sense of themselves, a coherent narrative, for that to be efficiently identified by the teacher. Further, the instructor must be able to mentalize the learner sufficiently to appreciate the personal narrative, the dominant individual story, with which the child has entered the learning situation. Finally, it is essential that the instructor displays this understanding with sufficient clarity for the learner to be able to detect: "Yes, I have been recognized (as an agent)."

6. Emotion dysregulation and the mismanagement of attention associated with problems of executive function can interfere with this communication process. Emotion dysregulation undermines the possibility of mentalizing. The appropriate direction and control of attention are evidently critical to generating a coherent self-image that can be reflected on and effectively detected by the child. When emotion dysregulation or executive dysfunction undermines the process of communication we described above, epistemic vigilance dominates the communication and to some measure blocks learning.

7. We have focused on the experience of childhood adversity as a frequent common cause of mental health problems and associated educational and social difficulties. We have attempted to highlight that a

child's withdrawal from a learning network is an understandable and predictable adaptation to a social environment that is experienced as offering limited support. In the longer term, this adaptation tends not to be in the child's best interest.

8. Our discussion concluded with the sad facts that surround the transgenerational transmission of adversity. Evidently, emotional dysregulation and the absence of effective executive function in the parent will undermine the parent's capacity to create a learning environment. Importantly, throughout, our focus is on subjective experience. There is a complex chain of cognitive and emotional filters that translate the child's social experience into the enduring social expectations that in turn generate adult behaviors.

9. Craig may indeed have entered this world with genetic vulnerabilities. His difficulties with emotion regulation and executive function were evident in his symptomatology, and we can assume that his disruptive childhood had undermined his potential to develop either of these capacities in a robust manner. Craig was unable to engage properly with education and many aspects of his social learning environment. He got behind in school. He failed to regulate his behavior sufficiently to engage in a process where he could trust others and where others saw him clearly enough to convey their understanding of him. The cascade of difficulties he encountered and the multitude of other symptoms he acquired along the way do not help us to understand the fundamental problem Craig was struggling with. Craig's problem was that he was unable to make effective use of the processes that society has made available for its children to acquire knowledge and skills—both emotional and cognitive.

In case you think Craig's story is too sad, the outcome of his treatment should add a note of optimism to the story of the p factor. The range of tools that MIST made available to Craig's therapist enabled him to reconnect with Craig to develop a trusting relationship in which Craig felt recognized and accepted. The importance of this change for Craig was not rooted in the therapist's ability to teach all the things that Craig had not thus far acquired. Far from it.

It was in the fourth session that Craig talked about his love for the guitar. He proudly announced that his teacher thought that he had made great progress and that, if he continued in this way, he could be a famous rock star some day. His mother shrugged her shoulders dismissively and said: "Well, we'll see about that. . . . What's more important is that you get on with your lessons in school." The therapist replied: "Yes, school is very important, but

I'd also love to hear you play the guitar, Craig. Next time you come, can you bring it with you? I have a guitar, too, but I can't really play it, you can teach me a few tricks. Mom, would that be okay with you?" The mother nodded and Craig smiled. In the next session, he arrived with his guitar. His mother sat back as Craig demonstrated his skills and the therapist listened attentively. He then asked Craig to teach him a few chords, and a few minutes later, they played a little piece together. The therapist then asked Craig about his favorite music, and when Craig listed a few tunes, they both listened to them on his mother's smartphone. The therapist asked Craig to help him understand the actual words of the tunes, and he wanted to know what Craig specifically liked about them. Craig happily explained everything and his mother eventually said, without any reproach in her voice: "You have never told me this. I like it when you talk like that."

The duet represented something of a turning point. One person responding to the responses of another generated from the reactions of the first—this is the way our social minds are constructed and the way our children have to engage with the social learning environment. One experience of epistemic trust may well be enough for a child, even one as deeply embedded in epistemic vigilance as Craig appeared to have been. He may then try to find other social relationships in which learning is made possible through a relationship imbued with epistemic trust. The presence of his mother in the fifth session was crucial, as was her initial observing stance. This allowed her to see something in Craig and his ability to interact with another adult that she had not been aware of before. She then responded to Craig's responses to the therapist's responses. This allowed the mother–child relationship to grow closer and his emotion regulation to improve, probably linked to his increased closeness to others, including his schoolteachers. In this way, he acquired an improved capacity to see himself and others in a mentalizing way.

MIST aims to change the social system within which the child operates. This is particularly important for children who have multiple problems, each of which can undermine the social context they require to grow and develop. MIST is a family intervention, but its impact may not be just on the family.

Developmental Science and MIST

Throughout the chapter, we have drawn attention to the way developmental psychology can enrich our understanding of the therapy process. Csibra and Gergely (2009) recognized the evolutionary significance of *natural pedagogy,* a remarkable aspect of our biological makeup that

enables us to teach and learn cultural information efficiently. This mechanism is established in the context of the earliest relationships, and it governs individual learning as well as the accumulation of collective understanding. It also motivates epistemic trust that underpins the evolution of culture. While humans are by no means the only species that acquire skills that they transmit to the next generation, no other species comes close in terms of the complexity of information that one is able to learn and impart to sustain individual socialization into a community and enable that community to have ideas that uniquely define it. The human species has evolved a special mode of knowledge acquisition through receptiveness to deliberate instruction. This ability has empowered us to learn to use complex instruments but via the same process to transmit beliefs and expectations based on communal experience. It was for these complex understandings that a special communication process was required, perhaps evolving out of the system for attachment through sensitive responding to a way of identifying deferential sources of information through a feeling of interpersonal recognition generating the experience of epistemic trust. This mechanism ultimately enables us to acquire knowledge about ourselves, others, and the world. It probably also has a selective advantage for openness to learning from experience to be partial, powerfully moderated by the quality of the relationship between communicator/teacher and child learner. Negative experiences should reinforce natural vigilance and perhaps create hypervigilance, undermining the possibility of social learning. This is the cause of the apparent inaccessibility of learning from social experience found in many, if not most, of the children and families we treat. Without epistemic trust, there can be no (or very limited) social learning.

Why is this developmental science relevant to MIST's workings? The importance of developing epistemic trust in psychotherapy is to make it possible for the client to engage productively in the process and to benefit from it. But this is not the main benefit of developing trust. To enable clients to be more trusting in relationships beyond therapy will help increase their capacity for social learning more generally. It may be helpful for us to try to be a little bit more precise about what we think takes place.

CONCLUDING REFLECTIONS

There are at least three heuristically separable interacting communication systems addressed in psychotherapy that have the potential to enhance social understanding and engagement beyond the therapy (Fonagy, Campbell, & Allison, 2019). The first communication system

concerns discourse about the client's circumstances, current life, symptoms, problems, and psychiatric disorders. This lays the foundation for communication in establishing communication with the therapist, but it is ongoing and has to be refreshed to show the therapist's engagement with the client's current concerns. This communication by the therapist shows the client that the therapist has considerable knowledge as well as personal characteristics that the client may value highly.

The second system pertains to the improvement of social communication for the client, essential to allowing the client to engage in communications that generate learning opportunities, initially in therapy, which may be characterized by epistemic trust. A mentalizing process in therapy engages the client in social communication inside the office that can help clients to overcome their distrusting isolation and thus open the door to social communication more generally. Being accurately mentalized by the therapist is the key that unlocks an epistemic barrier. This is in part a cognitive but primarily an emotional process. We have provided numerous examples of mentalizing-enhancing interventions, in particular in Chapters 5 and 6. All these interventions demand collaboration (working jointly with another mind). They implicitly and explicitly demand seeing from the other's perspective. More subtly but pervasively, the therapist insists that all protagonists, either present or only referred to, are treated as whole persons and are recognized as agents with independent wishes, expectations, and reactions, both emotional and cognitive. The general attitude of humility and the inquisitive stance underscore the assumption that the client and indeed all others have things to teach you—since mental states are opaque. Earlier we mentioned many aspects of the client's encounter with others in MIST that are likely to enhance effective mentalizing. Perhaps at the simplest level, the therapist and others responding contingently to a client emotionally and cognitively are likely to enhance social communication.

How does improved mentalizing enhance epistemic trust, which in turn enables social learning? A number of components highlight how mentalizing interfaces with epistemic trust and makes the systematic addressing of mentalizing in the therapy so central. (1) The client needs a minimum capacity for mentalizing to be able to create a narrative coherent enough for anyone to be able to discern and respond to in a manner that may create a sense of joining. (2) As pointed out above, the process that generates epistemic trust is reciprocal, and the client must also create epistemic trust in the therapist so that the client's narrative can be trusted—for the client's narrative to be conveyed to the therapist in this way, the client must acquire some basic capacity to mentalize. (3) Further progress in mentalizing is needed for the client to be able to perceive the therapist's representation of them and interpret it accurately.

(4) Finally, mentalizing is required for the image created by the therapist and the self-image on which it is based to be matched. The general aim of enhancing mentalizing will serve the purpose of empowering the entire social learning process.

The third communication system may be the pivotal one in many therapies. What is it that enables the client to face the social world? The fundamental principle informing our therapeutic model is that the human mind is essentially social and interpersonal. Both therapy and mentalizing make sense only in terms of facilitating the reintegration of the client into the large, complex, ever-moving stream of human social communication. In effective therapies, clients "open up," with or without assistance from the therapist to deconstruct the epistemic barrier they have erected and create access to the social world and enhance the capacity to learn from social situations. This, in our view, may be the most important change that MIST brings about—one that we shall return to in the final chapter. Several examples we have referred to so far in this book (Craig, Rose, and others) illustrate that therapy enables a new way of relating to the preexisting positive aspects of social environments.

But here is a major limitation in MIST that is shared by most psychotherapies. We have to acknowledge clinical interventions in cases where the client's wider social environment does not support mentalizing. Epistemic trust is only helpful if the social world can be relied upon not to abuse openness, to the extent that it is reliable and worthy of trust. The consolidation of therapeutic gains—and indeed any meaningful improvement in quality of life for the client—is contingent on the client's social environment tolerating and supporting these changes. It is naïve, almost to the point of dereliction, to assume that we can isolate the practice of psychotherapy and its potential effectiveness from the social climate in which it exists.

Chapter 8

Mentalizing Social Media

To many of their friends, the Walter family seemed a typical family. Only a few knew that Bill, age 11, spent up to 12 hours each day on the computer in his bedroom, chatting on online forums, playing online video games, continuously browsing different entertainment websites, downloading music and videos for personal use—and seemingly chatting forever with "real" or "virtual" friends. His parents had initially dismissed his increasing obsession with online activities as a temporary phase, but then they gradually engaged in a cycle of limiting, removing, and then restoring his computer access. They eventually gave up exerting any form of control over their son's online habits as the daily confrontations wore everyone down.

When not on his computer at home, Bill used his smartphone to maintain access to the Internet, and he could become very agitated when Internet access was not available. Every night Bill stayed up until long after midnight, and he said that he was often involved in multiple tasks at once, losing track of time. He found it increasingly difficult to get up in the morning and go to school. His school attendance became slightly irregular, as did his participation in family events, including mealtimes and doing his share of household chores. He also stopped attending the after-school training sessions of his football club. With one exception, all his old friends gave up on him. He was unbothered. He had more than enough friends online. His parents became very concerned about how Bill's "online lifestyle" was going to affect his two younger siblings and how their social media use could be limited before it got out of hand. They asked for a referral to a specialist service and told the referring GP: "Please help us so that we can be a family again."

Contemporary society is characterized by the continuous expansion of communication networks. These networks provide fast access to information via computers and the Internet and enable individuals to meet in virtual environments. More and more time is spent online, be that via email, websites, social media platforms, or instant messages. Young people now live in a digital environment, where communication primarily takes place online or via social media. In the United Kingdom, for example, 95% of those ages 16–24 and 83% of 12- to 15-year-olds own a smartphone, with over two-fifths of girls and one-fifth of boys 14 years of age using social media for 3 or more hours a day (Kelly, Zilanawala, Booker, & Sacker, 2018). On average, people check their phones every 12 minutes, and one in five adults spends more than 40 hours per week online. Most of this rise in connectivity has occurred in the past decade, making it one of the fastest changes society has ever experienced (Makin, 2018).

Social media have altered the way people relate to each other, and they increasingly dominate our lives, and not just privately. Some media, like Twitter and Facebook, are effective in influencing public awareness and can initiate local and global movements, like the Arab Spring popular uprisings in the Middle East that began in 2010. The digital world offers enormous potential for good: It could, for example, transform mental health services through improved access to tested resources and interventions and through automating parts of diagnostic, monitoring, and treatment pathways (Hollis et al., 2015). For many young people who are isolated and have mental health problems, social media can be an important source of health information, knowledge, and social support (Royal Society for Public Health, 2017). Digital technologies can connect young people with peers, mentors, and therapists, potentially bridging the mental health treatment gap through novel, tailored, flexible, and less stigmatizing treatments. Virtual relationships can make us feel connected when we feel alone or isolated; they move us away from real-time, conventional face-to-face social interactions to imagined worlds where we can create images and stories about ourselves; they can help us to share emotions, thoughts, and highly personal experiences with virtual strangers and friends alike.

Along with the potential for good, the digital revolution brings a range of potential new risks to young people's mental health (Odgers & Jensen 2020). These risks may be more marked in already vulnerable individuals. Social media use is associated with depression (Kelly et al., 2018), suicide (Niederkrotenthaler et al., 2019), and self-harm, particularly in girls and marginalized groups. Potential mechanisms include social isolation, disturbed sleep, cyberbullying, and pressures to conform to idealized lifestyles and body images. However, there is a

great deal of uncertainty regarding mechanisms, including the causal direction of digital technology use and risks for emotional disorders in young people. Oversimplifying the problem has hindered understanding of perhaps the most important change in the socialization of children since the Industrial Revolution. A large study that collected data on both the time spent using digital devices and the mental well-being of about 120,000 adolescents (Przybylski & Weinstein, 2017) showed that spending only a few hours a day using digital devices was associated with slightly better well-being than none at all. Only after longer periods of time spent in the digital world was well-being diminished. But even this difference was small, suggesting that "just right" amounts of screen time—"everything in moderation"—might in fact be beneficial in today's wired world (Makin, 2018).

Social media also significantly affect family relationships, as in the Walter family discussed above. Many children and teenagers now spend more time communicating with others in virtual spaces rather than with their parents. Indeed, family gatherings can be dominated by everyone slouching over their smartphones and not talking to each other directly. Contact with each other may be made primarily by looking at screens and examining and comparing photographs or other images without looking at one another. Courting couples can be seen holding hands, with each holding their smartphone in the other hand looking for messages. Social media technology has the potential to strengthen family and relationship bonds. A study conducted almost 10 years ago examined the relationship between family media use and family connection in a sample of 453 adolescents and their parents (Padilla-Walker, Coyne, & Fraser 2012). It found that cell phone use and watching television or movies were the most common media used in families. Analyses also revealed that greater amounts of family cell phone use, co-viewing of TV and movies, and co-playing of video games were associated with higher levels of family connection. Conversely, engagement over social networking sites was related to lower levels of family connection, at least from the adolescent's perspective.

CHANGING SOCIALIZATION PROCESSES

It is a basic human drive to form and be part of social networks. Even when the age of industrialization led to high rates of migration to cities and resulted in a gradual decline of traditional small, local communities, people's need to be part of a defined community did not change. Social network sites have in recent years provided a seeming alternative for this

essential human need: They provide a communal space where thoughts, opinions, feelings, and needs can be shared.

Social media and networking sites are virtual communities that allow their users to create personal public profiles, to meet other people based on shared interests, and to interact with both virtual and real-life friends. Unlike face-to-face encounters, social media sites are time- and place-independent: It does not matter *when* and *where* information is posted and read. They are fast and seemingly "private," and they provide users with windows into the lives of others—those of both ordinary people and so-called celebrities—without being directly observed by them.

Social networks have become a major influence on the socializing of individuals. They allow individuals to present themselves in a given community and create a new or different image. Social media users can also create content in various media types and can contribute, label, vote on, and assess these contents. They can form communities with common interests via participation and feedback. Different types of social media are listed in Box 8.1.

Given that the introduction of secondary school education in Western societies a century or so ago had already shifted socialization processes during adolescence away from the family onto peers, the opening up of virtual worlds beyond the family risks further marginalizing parental influence. If parents are reluctant to get involved in and participate in the digital lives of their children, social media may become the single most unchecked important influence on socialization processes. Similarly, if learning about and with social media is not integrated into the fabric of mainstream school education, it may take over the (unchecked) "education" of pupils.

BOX 8.1. Types of Social Media

Blogs: online diaries

Microblogs: very brief communication messages (e.g., Twitter)

Wikis: sites that allow the adding or editing of information content

Podcasts: downloadable audiovisual information

Fora: discussion media on specific issues

Content communities: sites managing content and enabling sharing (e.g., YouTube)

Social networking sites (SNSs): networks that allow users to connect and exchange information (e.g., Facebook, Instagram, LinkedIn)

Attention-Deficit Family Life

When family members are online, they become temporarily unavailable for social communication within the family. They skim, multitask, and flit from one item to the next. People who multitask are worse at controlling their attention; they are less able to filter distractions and not good at switching tasks. However, some family members have the ability to dive in and out from their virtual worlds to the present family context. Digital language may be used when talking to family members, with short information bytes exchanged, before returning to the virtual world. Family interactions and communications become characterized by fast sequences of on-off moments or episodes. There is pressure, for example, to respond to WhatsApp messages quickly, as the sender can measure the response time by when the blue "read" ticks appear. This can further detract from dealing with the people who are actually in the room. Long-winded questions or explanations given by parents cannot be listened to when the attention span is so reduced; long messages or blogs are less likely to be composed and read in the age of Twitter. All this further contributes to children, teenagers, and adults literally switching on and off in quick succession. Furthermore, when discussing specific issues within the family, it is often faster to google information and get a quick response than to listen to long-winded parental explanations. Seeking relevant information from a book, a dictionary or, God forbid, an encyclopedia becomes increasingly rare, thus also shortening—if not totally cutting off—reflective processes.

The Captivating Nature of Social Media

A number of reasons help to explain why social media is so captivating, if not "addictive." The human need to be connected to some form of community is a major driving force. Social media users frequently state that the media allow them to refresh and maintain existing relationships with family members, friends, work colleagues, and others. Social media can unite families even at distances. The need of being on someone else's mind is a related dynamic, and every "bim" sound notification signal may re-create that very illusion. Linked with the seeming need to "belong" to a community is the fear of missing out on something, be that an activity or an event, a relationship or a unique opportunity. Being part of a virtual community may also create an illusion that one is being acknowledged or recognized as a person in one's own right, with "followers" and many "likes," all of which may also serve to increase self-worth and give one a sense of agency. Many children and young

people feel more comfortable communicating their feelings by using the shorthand of emoticons. In addition, there is peer pressure, especially for older children and teenagers, to use social media as a way of being part of a group—with pressure to respond immediately to communications, with read ticks adding further to the pressure to respond.

Smartphones are always there, from the time one wakes up to the time one falls asleep. They can be carried in a pocket or handbag, serving as a steady companion, and are perhaps more reliable than even the best friend. For many, smartphones have become part of their bodies and minds, acting much like an artificial limb, without which one feels incomplete. The smartphone is also a complex passport that contains more personal information than an elaborate professional CV can accommodate. It allows the instant freezing of time and experience by taking images. With its continuous "bims," it also reminds us that there is a world out there, beyond the world that we concretely inhabit, a world that exists in parallel to us and that is unpredictable and exciting, generating continuous curiosity for accessing new information and experiences.

Boredom, another not uncommon state of mind in children and adults alike, creates a craving for relief, which is satisfied by grabbing the smartphone, using its buttons and functions for physical and mental stimulation. Boredom may well be a deficiency in self-regulation that can lead to drinking, smoking, illegal drug use, gambling, binge-eating, and other potentially addictive behaviors, including Internet addiction. The smartphone can become a drug to fight boredom.

Apart from overuse and dependency issues, social media can pose other dangers to its users. There is the risk of forming relationships with nontransparent "partners," be those commercial organizations, criminals, or sexual abusers, with children and young people being groomed and manipulated sexually, emotionally, or financially. These influencers can ruthlessly exploit the vulnerability of children and relentlessly "track" them until they have worn their victims down. Young people are also at risk of exposing themselves without considering the possible long-term adverse consequences they may suffer when sexting or posting nude photographs. Another major risk of social media is data protection and resulting privacy issues. What may be intended for just one "friend" can be easily disseminated to a larger virtual audience. Social media users are also exposed to negative comments and "dislikes" that can dent self-esteem. Cybermobbing, cyberbullying, and cyberstalking are extreme forms of the (ab)use of social media in order to denigrate or persecute fellow social media users.

EPISTEMIC TRUST AND SOCIAL MEDIA

The digital tools and social media platforms currently used by young people were not created with an ethical or a young-person-centric framework. Even so, there is value in digital media. We can summarize these values under three headings: efficacy, engagement, and efficiency. Digital media increases our efficiency, enables unprecedented levels of social engagement, and works to deliver most services well, including, perhaps paradoxically, mental health services. Three equally powerful concerns regarding digital media undermine the trust we feel: transparency, agency, and responsibility. The absence of transparency is self-evident, as we have little idea about what happens with our data. Will the European Union's internationally sanctioned General Data Protection Regulation (GDPR) make a material difference? Perhaps, but nothing other than incessant agreements to acknowledge and approve the use of cookies and mass storage of data has surfaced. It may be an apocryphal story, but one digital privacy campaigner embedded into the lengthy agreement everyone signs without reading (who has the time?) the offer of all the person's children in lifelong servitude. The issue of responsibility is equally thorny. Who is accountable for outcomes like that of the 2016 U.S. election, the social BREXIT referendum or the more complex efforts to interfere in our thinking and choices? The system is too complex to enable us to allocate blame. And this gets to what is perhaps the gravest issue: agency.

In the previous chapter, we described the highly interpersonal nature of the process through which epistemic trust is generated in childhood and beyond. We stressed that if a child's caregivers are not reliably responsive, not benign, or not able to recognize what is meaningful and relevant to the child's self, the development of epistemic trust can be undermined and the established foundations of cultural transmission can be compromised. There was a time—maybe up until about 40 or 50 years ago in Western societies—when the main reliable sources for relevant and reliable information tended to be parents and other significant adults, including teachers, youth workers, and community elders. Children turned to them and learned from them when they had established epistemic trust. This changed with the availability of interactive digital media. Babies are learning to swipe (an iPad) at the same time they are learning to point, and we have already said how important joint attention is in transmitting transgenerational knowledge. Of course, one can imagine a similar moral panic brewing with the invention of the printing press. In the 15th century, Johannes Gutenberg put millions of

storytellers and bards out of a job when he facilitated direct access to the narrative in the book.

So should we worry when children and young people often consult Google and digital friends rather than their own parents? There is no simple answer: Young people are often astute about assessing the reliability of online information. Further, some young people seek out valuable information and support that their own family is unable or unwilling to provide. We would simply wish to emphasize that a significant difference between printed and digital media is in a single property of digital media that is inconceivable in printed material: interactivity. Through interactivity, digital media becomes an evolutionary chameleon, a cuckoo in our human cultural nest. Digital media can respond to us as if it really cared. A good novel can emulate empathy, but it has to do so slowly, across many pages. Digital media is different. Even video clips can be lined up to emulate our personal preference. Many other digital implementations are far more sophisticated in capturing our evolved sensitivity to contingency because they tune into us and detect our need to validate our self-agency. The digital agent has no similar need for human recognition. Unlike the human instructor, it is not limited in its capacity to learn our preferences, our foibles; it is able to infinitely self-modify until it reaches an asymptote in its ability to capture and hijack our trust. Misplaced epistemic trust may develop due to exploitation by would-be influencers of mental states, be they commercially driven companies or malicious and cynical individuals. The fact that the relationship partners are not visible and often deliberately hide makes it difficult to assess their trustworthiness using the simple tools evolution has equipped us with. Facial expressions and body language cannot be read and evaluated.

Epistemic trust is built when a person is open to learning from social communication whatever is personally relevant and generalizable. It is when a person perceives that another person recognizes their personal narrative that the potential for creating epistemic trust is generated. Biology has not prepared us to discern when that perception of a person is a total illusion. This phenomenon may be naively or not so naively used by many social media influencers who want to offer their products (including their messages) by utilizing ostensive cues that seduce. The cues—as simple as being called by your first name, your preferred language being selected, your location detected and responded to, your last request being recalled, being shown products that the algorithm detects 'on the basis of millions of other customers, you may be interested in . . . ,' and so on—may make media users feel that their preoccupations and needs have been recognized. The biology may then take its course,

and a certain level of privileged communication may develop between the customer and the sales agent. Of course, we hear you exclaim, have not salespeople done the same thing for millennia? Of course they have! Which of us has not been persuaded to spend money (that we do not have) on useless objects by a charismatic communicator who is magically able to press our buttons? Populist politicians have used ostensive cues to enable mass influencing at rallies and broadcasts since time immemorial. Their trick is simple. The person vulnerable to populist agents is likely to have a poor and inaccurate view of themselves. Their personal narrative is likely to be defensively generated to address their fragile sense of poorly mentalized identity: "I have been unfairly treated, powerful selfish people are trying to exploit me for their own selfish advantage and they are succeeding." The narrative, of course, is superrobust and explains all instances of poor fortune as well as the absence of a sense of agency. The populist plays to and validates this defensively generated self-image and presents a perception of their personal narrative that is calculated to be experienced as an epistemic match, and this manipulation of the match creates an opportunity for social influence.

The game-changer in the digital world is the emulation of a key human system for filtering social influence by a machine—a machine ostensibly capable of greater intelligence than its creator. Recently, Google's AI AlphaGo defeated Ke Jie, the world's number one Go player, having already beaten Korean legend Lee Se-dol 4-1. Its defeat of Ke shows that it was only getting started. Are humans defenseless in the face of an influencer who is unknown and invisible to us? Can we really talk about epistemic trust when it is the overt intention of the influencer (likely to be a BOT) to create an illusion of interpersonal understanding in order to manipulate a person into taking a piece of information as personally relevant? While high degrees of epistemic vigilance in relation to social media and their often "hidden persuaders" (Packard, 1957) may always have been warranted, the cynical use of ostensive cues by social media succeeds in catching many children and even adults in virtual nets.

Fake news—previously also known as junk news, yellow journalism, or propaganda (Latin for "that which is to be spread")—is deliberately transmitted by traditional and social media with the main intent being to mislead and spread misinformation, mostly for political and commercial reasons. Biased information, ideas, and rumors are deliberately distributed to change views, opinions, and preferences, with the aim of furthering one's own cause or damaging that of an opposing one. To complicate matters further, more recently the term *fake news* has also been used to disqualify or cast doubt on seemingly uncomfortable truths, thus further compounding confusion among social media users who simply no longer know which information to trust.

BOTs pose an additional problem in relation to developing epistemic trust. These algorithm-based computer programs are designed to establish a service or connection with and among social networking users. A BOT can deliberately pose as a person in order to increase the likelihood that social media users will develop a relationship with the BOT. By providing very general personal narratives that may create an illusory fit with targeted social media users, credulity is generated. This can become excessive in individuals who have a pervasive need to feel recognized by another person; yet that other may be a BOT. Sophisticated algorithms can set up a BOT antagonistic to the user's perspective, only to then profoundly discredit themselves. The BOT's aim is to have the user spread that discredited view to other members of the already antipathetic group. The internet of prejudices is maintained by the misuse of epistemic trust.

So what is the implication? We are not recommending closing down the Internet, even though it does seem to be an attractive option at times. Rather, we advocate fighting fire with digital fire. The natural capacity that nature has placed at our disposal to protect us from undue influence is epistemic vigilance—all effort must be made to alert people to the need for such vigilance. AI coders must also create programs to detect digital devices emulating trust as fast as they are invented. If IBM Deep Blue could beat Kasparov, surely we can place our same unmatched intelligence to detect digital agents likely to exploit human vulnerability. It is a human priority to generate a safe socializing environment for our children, equal in importance only to preserving the planet's ecology for human habitation. The human mind is no match for artificial intelligence, but artificial intelligence is. The young human needs support to develop "effective" epistemic vigilance in relation to digital life.

DIGITAL MENTAL HEALTH CHALLENGES FOR CHILDREN

The growing popularity of social networking sites has produced a range of issues in families. These issues have led systemic practitioners to consider specific interventions (Delmonico & Griffin 2008, Murphy, Lancy, & Hertlein, 2013) for presentations such as cybersex (online sex-oriented conversations and exchanges), net compulsions, and online gaming addiction. It is possible to distinguish between increasing levels of dependency on social media—from frequent use to overuse, to dependency and addiction. The American Psychiatric Association (2013) has proposed a new diagnostic category, Internet Gaming Disorder (IGD), but to date it has not yet entered International Classification of Diseases (ICD) and DSM classification schemes. However, in clinical practice,

it is not at all uncommon for young people to develop what look like withdrawal symptoms when video games are taken away; they lose interest in previous hobbies and entertainment as a result of, and with the exception of, video games; they deceive family members, therapists, or others regarding the amount of gaming; they use video games to escape or relieve negative moods; and they lose significant friendships, as well as education and career opportunities.

Systematic reviews of the literature reveal that the vast majority of studies find an adverse association between screen-based media consumption and sleep health, primarily via delayed bedtimes and reduced total sleep duration (LeBourgeois et al., 2017). The likely underlying mechanisms of these associations include (1) time spent on screens replacing time spent sleeping and other activities; (2) psychological stimulation based on media content; and (3) the effects of light emitted from devices on circadian timing, sleep physiology, and alertness. Negative associations have been found between technology use and well-being, particularly in adolescents who are already struggling in the real world.

Set against such associations are powerful arguments in relation to the health benefit that the Internet, particularly mental health applications, can bring (Hollis et al., 2015). A benefit less often mentioned is digital training in the delivery of psychological treatments. Such training is effective, well accepted, and highly scalable (Fairburn & Patel, 2017). Digital platforms can also be used to track remotely, in real time, the effects of treatment. The innovation of digital training, when combined and scaled up, could transform access to effective mental health interventions. All this is to indicate that this chapter is not presented in the spirit of some kind of digital Luddites. As ever, the challenge of technology is not the technology itself but the person who wields the tool.

The Therapeutic Stance

A mentalization-inspired systemic therapist working with children, adolescents, and adults who are misusing social media will need to prioritize building a trusting personal relationship with the family. As with most addictions, the challenge for therapy is addressing the needs that the misuse satisfies and, at the same time, providing a more functional alternative. This can be difficult when individuals have shown excessive credulity in relation to social media information and what it delivers. The individual will be suspicious of communications and will be well protected from predictable therapeutic communications. The client's sense is that their digital environment meets their needs, and what the therapist views as "misplaced epistemic trust" is seen by the client as an entirely appropriate epistemic relationship. It is therefore important that

any ostensive cues provided by the therapist are authentic and cannot be easily misread as being inauthentic; such cues will signify to the client that the therapist's claim to being viewed as trustworthy, at the expense of the digital, can be ignored.

If one accepts the premise that clients benefit from experiencing their personal narrative—their imagined sense of self—as being identified and satisfyingly aligned with a trusted other's understanding of that very narrative ("she understands what I think and feel . . . and I feel recognized . . . we are clicking"), then weaning a person off a trusted source can threaten their identity, their security, and their sense of self. Eating-disordered teenagers, for example, visit pro-eating disorder chat rooms or websites—for example, pro-anorexia (pro-Ana) or pro-bulimia (Pro-Mia)—and find their personal narratives recognized by many other fellow sufferers, with "Thinspiration" and "Thin Commandments" encouraging young women to engage in "Starving for Perfection." The therapist may be tempted to be judgmental of a source of information that clients have trusted or still trust.

Therapists whose clients trust these social media-based sources of information face a dilemma: They may feel the need to validate the client's view while at the same time being authentic about their belief that these websites are misleading and that the client's trust in them is misplaced. However, at that point, the child or young person may no longer feel recognized by the therapist, which makes the formation of a therapeutic alliance more difficult. The therapist can then shift focus and attempt to increase the child's epistemic hypervigilance by decreasing the child's excessive credulity.

Social Media Detox in the Family Home

Only Bill's parents turned up for the first appointment. They reported that they had not been able to persuade Bill to come with them. He told them: "I haven't got a problem with my social media use; you have a problem with my social media use." The mother spoke about how the younger siblings were now also increasing their time with "this electronic opium." When asked about their own social media use, the father confessed that "I am a bit of a junkie myself," and he explained that he could not go to bed until he had answered all e-mails—work and private—that had accumulated during the day, sometimes as many as 200–300. The mother admitted that she spent a lot of time on Facebook, as this was her main contact with the outside world. When asked whether and how they had discussed with Bill how he could limit his social media use, both parents replied that they had had many arguments with him, and then "we told him he had to stop; otherwise

we'd take his computer and smartphone away." They had also tried other measures and threatened consequences if he broke them, but this had just caused further arguments.

From a mentalizing point of view, a major aim is to increase children's and parents' epistemic vigilance in relation to social media. How parents and adolescents negotiate the role and place of social media in their families has implications for adolescent exposure to potential harm from outside the family system (Williams & Merten, 2011). Most parents, alarmed by their children's increasing social media use, will at one point or another consider devising some rules or guidelines. Understanding their child's state of mind will help to establish these rules, which are more likely to be followed if they are devised jointly with the child and not immediately during or after a major argument, but when all is calm. If rules and regulations produce anxiety, e.g., about being left out of peer activities, the chance of them working is significantly reduced. Finding compromises is of the essence. If parents feel the need for red lines to be observed, it helps to explain their rationale to the children. Clear and proportionate consequences are best co-devised with children. Written contracts, printed out in order to avoid doubt and prominently displayed, assist this process.

The social media detox of an individual child or young person rarely works in isolation—it usually has to be a family affair. The goal is not to achieve total abstinence from social media in the family home, but to integrate the media into family life in acceptable dosages. Mapping each family member's current social media use therefore is the first step in detoxification: What, when, and for how long, where and in whose presence is the social media use of each member of the family? This approach shifts the focus from the allegedly "addicted" child or young person onto all the family members living under one roof. In separated families where the child may spend significant time between two parental homes, two different maps will need to be constructed.

The parents can begin to discuss what their own social media use should be and when, where, and in whose presence or absence this use should take place. When discussing this issue, parents should keep in mind that they may themselves consider setting an example for responsible and family-friendly social media use. At any rate, if parents do not set an example themselves, their children are likely to remind them that the parental social media use is excessive. Once parents have agreed on their own use (what, when, and for how long, where and in whose presence), they can convene a meeting with the child(ren) and present their stance and ask them to think for themselves about their use. Some

BOX 8.2. Example of an Agreed Timetable for an 8-Year-Old Child

- Monday–Friday: 30-minute use of parental smartphone or tablet *(set alarm)*; no TV; no media in child's room after 7 P.M.
- Saturday–Sunday: 60-minute use of parental smartphone or tablet (*set alarm*); 1 film per day; no media in child's room after 7 P.M.
- School: mobile phone without Internet access, without contract and name
- Consequences of breaking contract: no media use for 2 days
- Parental PCs, tablets, and smartphones each have passwords that are not known to the child

parents decide on presenting a timetable for themselves, which tends to help them provide ideas on how to negotiate age-appropriate timetables for social media use (for an example, see Box 8.2).

It is generally helpful if, a few days later, the parents convene another meeting with the child(ren) and ask for their respective views. This is the beginning of a negotiation process that can take place with or without a therapist. The focus is on how to create a family-friendly social media environment in the family home. Each person provides their views and ideas and it may lead to a written contract involving all family members. The role of the therapist is not to prescribe a concrete way forward, but to introduce, in a tangential way, ideas based on how other families have managed a similar situation:

- "Some families display a family box for digital devices prominently in the home, with the expectation that all devices (tablets, smartphones, Xboxes, etc.) are placed in it according to a timetable jointly worked out with everyone. For example, when coming home from school, the child's smartphone is placed in the digital family box, and it can only be used after homework or other agreed-upon tasks are finished. I have no idea whether this would make any sense in your household."
- "Some families ban smartphones from any bedroom . . . or after 9 P.M."
- "Some families have the rule that when revising or doing homework, the computer can be used, but not the smartphone, and all message alerts are switched off or the phone is on airplane mode at certain times."
- "Some families ban smartphones from the table when eating."
- "Some families have Internet-free times."

- "Some families decide that secret checking of a child's smartphone is simply not allowed, but the safety features should be checked regularly by parent and child together."
- "Some families decide to have a weekly meeting when they discuss social media and safety issues, including looking at screenshots of peculiar or suspicious messages that family members may have received during the preceding week."
- "In some families there is a ban on app notifications. They just switch them off. In other families, they count to 100 before they look at the notification, or they put the smartphone on flight mode during certain times."
- "Some families decide that once a week everyone watches a movie together or plays a board game or increases time for offline hobbies and interests."
- "Some families have dedicated offline hours or a social-media-free weekend."

The technique of introducing a range of alternatives is meant to kick-start mentalizing, so that parents and other family members begin to weigh the pros and cons of adopting any of the above suggestions; to imagine hypothetical responses; and to get into a discussion that leads to actions. In this way, Bill's parents were encouraged to mentalize his states of mind, to determine what his need for virtual worlds might be, and how this might relate to what was going on in the family's life at this stage.

Smartphones in School?

It is not uncommon for parents to think that it is the school's job to educate their children in the use of social media—and it is also not uncommon for teachers to state that any education regarding the use and abuse of social media should be left to parents. Many schools prohibit the use of smartphones; they require that phones must be handed in when pupils arrive and are returned when the school day is over, thus ensuring a smartphone-free zone. Many teachers believe that digital infobytes and social media's messaging language decrease literacy levels, and they are critical of any form of edutainment. They argue that pupils reading printed words are better able to recall specific details or reconstruct the plot of a story than those reading primarily from a screen. They also argue that Google makes people less able to recall information if they think they can look it up later, but this has positive consequences: As a transactional element of memory, it frees up memory resources. However, the mere physical presence of the smartphone lowers performance

on cognitive tasks because mental attention is tied up by the effort required to ignore the phone.

A major argument for school involvement is that primary school children should be educated in responsible social media use, as this will address issues such as cyberbullying and dependency. It is further argued that the smartphone is beneficial when it is used in a focused way in lessons for finding information, for example, via Google. Teachers and students can then discuss the information's reliability and trustworthiness. Smartphones can also be helpfully used to photograph information on flip charts or white boards. However, if smartphones are used in lessons, it may help if they are displayed visibly on the desk or put in airplane mode. If they are used during break times, they may inhibit nondigital social interactions.

REMOTE THERAPY

Web-based psychotherapeutic interventions have been around for some years, be it via Skype, Zoom, Microsoft Teams, or other digital platforms. Known as video teleconferencing (VTC), online or e-counseling, Internet-based or web therapy, or simply as "remote therapy," it was originally introduced for clients who could not get to a therapist's office for a variety of reasons, such as geographical restrictions, time management issues, physical disability, or agoraphobia and other anxiety-related conditions. Remote therapy has some obvious general benefits. One of these benefits is increased flexibility, which allows couples and families to be seen at times that are not within a clinic's working hours and fixed slots. There is also increased accessibility, with geography and travel time playing no role; in addition, online therapy tends to be more affordable. Other advantages include flexibility of delivery (fitting the client's day) and anonymity (evidence suggests that young people are more likely to disclose to a computer screen than they are in person). It also serves as a complement to face-to-face delivery supporting the generalization of clinic-based interventions to the home setting, aligning better with personal preferences, particularly for individuals who fear transport or struggle with a sense of control in a face-to-face setting (e.g., individuals with an eating disorder who may prefer not to be seen). Home-based therapy has an advantage in terms of generalizability. As clinicians, we often find that clients who claim competence in understanding and performing a skill in the consulting room find it all but impossible to execute the same skill at home. Learning and practicing something in the home, which is the environment of concern for most family therapy interventions, will make it easier to remember simply because learning

is a context-dependent process. Perhaps the most important advantage of remote therapy from a systemic standpoint is that the informed and sensitive use of VTC can connect family members who are geographically separated, enabling a richer systemic dialogue (Dausch, Miklowitz, Nagamoto, Adler, & Shore, 2009).

There is an accumulating evidence base supporting VTC. Randomized controlled trials have demonstrated that VTC is as effective as face-to-face therapy in terms of patient satisfaction (e.g., Backhaus et al., 2012), therapeutic alliance (e.g., Simpson & Reid, 2014), and treatment outcome (Backhaus et al., 2012; Morland, Hynes, Mackintosh, Resick, & Chard, 2015; Sucala et al., 2012). There is less research addressing the effectiveness of remote therapy for family therapies, but an emerging literature based on small cohort studies would encourage us to believe that VTC is well received by both families and therapists and is of benefit to families (Comer et al., 2017; Dausch et al., 2009). Views about therapeutic alliance are mixed, with a number of studies surprisingly finding little difference in working alliances between VTC and in-person sessions (Morland et al., 2011).

Remote therapy also has its downsides. It is above all, and as the name suggests, *remote*—that is, removed from the personal direct face-to-face encounters in the special setting of a designated therapeutic space. Some people, paradoxically young people in particular, do not find VTC to be adequate for their needs. Generally, VTC is regarded as less well suited to individuals with more severe forms of mental health issues or people currently experiencing a crisis. We must also remember that the families we are often most concerned about, those at greatest financial disadvantage, may have quite limited access to digital interfaces, poor Wi-Fi connections, and less powerful smartphones and so may find themselves digitally disadvantaged alongside other inequalities. Through VTC, only limited digital information is conveyed—auditory and visual, with the other senses being rendered idle. The many nuances—and ostensive cues—that characterize interpersonal encounters cannot be as easily captured in remote therapy. The setting also suffers from the decreased utility of a clinician's use of body language to indicate who they are addressing or to nonverbally block unhelpful interactions by moving or waving their arms. While the therapist can maintain the nonverbal behavior at the same level of intensity that they are likely to be able to do face to face, the likely impact of the same gesture will be substantially reduced when it is witnessed only through the camera. Eye contact, which is readily made in a room, is quite hard to establish when the physical location of the face one is looking at is not aligned with the gaze direction displayed on camera and thus will appear as looking off-screen. The therapist will need to use family members' names more

frequently. The filter applies both ways, and relational dynamics will be harder to establish when each person can only be seen on the screen. Particularly, early signals of emotion (a quiver of the lip or excessive blinking indicating struggle with tears) are more difficult to perceive on a screen with relatively low resolution. There is no obvious substitute for the observations of interactions that generate rich clinical data for therapists when working face to face. But understanding how epistemic communication works (as we have tried to explain in this book) can be enormously helpful in developing a remote therapy strategy. Can MIST techniques clear some of the mist created by VTC?

The Remote Setting

Although remote therapy has its limitations, it has also opened up some exciting new possibilities for MIST practitioners, who are discovering creative interventions that may not have been considered or employed before. For these interventions to have a chance of success, it is important to get the work contexts right. First, and this may seem obvious, clients need to be able to use, and be comfortable with, audiovisual technology and digital platforms. Second, the work contexts have to be carefully thought through. There are at least two work contexts: the therapist's and the family's. When working with separated and reconstituted families, there may well be three or more work contexts, as well as the virtual "space between" the respective participants, the "place" where everyone meets. It is essential that both clients and therapist have access to a safe, private, and confidential therapeutic space with appropriate physical and time boundaries. Children and young people may find it more difficult to set and observe clear boundaries and simultaneously try to use additional ways of communicating during sessions, above all other forms of social media. Furthermore, when working with children and young people online, parental involvement may need to be well defined and boundaries set, depending on the age of the young person.

In delivering therapy remotely, the therapist needs to rely on clients to protect their own privacy. In addition to concerns of confidentiality in relation to the technology being deployed (such as end-to-end encryption), therapists need to assure themselves that someone else outside the view of the screen is not compromising what appears to be confidential discourse. Location is also important; a suitable room needs to be identified and designated as a temporary therapeutic space. It may be the same room for every single session, but it is also possible to consider using another room or space on occasion in order to stimulate different thoughts and feelings. In addition to the physical space, remote MIST

(R-MIST) requires that the therapist become expert in lighting, sound, and visual contact with each family member. An additional camera can help, as many inbuilt laptop cameras will not easily get two adults and two adolescents to fit into the same picture.

When preparing for R-MIST sessions, consideration needs to be given to what the individual, couple, or family will do *after* the online session; they should be encouraged to create some "mind space" before everyone resumes their day-to-day activities. After an in-person session, therapists often recommend that families should not discuss the session on the way home in the car. This will enable a "cool-down" process; perhaps they can listen to soothing music on the drive home. Following a R-MIST session, altercations may continue out of the view of the clinician. During the process of consenting for R-MIST, the family can usefully brainstorm as to how a similar wind-down period can be initiated remotely after the R-MIST family session.

A key disadvantage of VTC is the uncertainty that surrounds the safety of individual communications. One strategy that can compensate for the missed and filtered social cues imposed by VTC is to exaggerate the inquisitive stance of the MIST therapist. Questions of expansion are already in the basic vocabulary of the MIST therapist, such as "What thoughts are you having?" or "How did that land with you?" or "What did it make you feel when your father said that?" (see Chapter 2). R-MIST calls for more systematic clarification and checking than the face-to-face implementation.

A further challenge to effective mentalizing may be escalation of conflict, perhaps primed by close seating arrangements imposed by the limited visual angle of the camera. In R-MIST, therapists have less control in such situations, and their capacity to manage the emotion in the room is limited by the modest bodily gestures they can use. However, making an agreement at the beginning of therapy to use a "Time Out" cue (most commonly a simple forming of a letter T with two hands) signaling that all communications must cease may be helpful. R-MIST therapists should attend to safety planning and discussion of a crisis management plan, so that family members are aware of the steps that need to be taken in emergency situations.

In cases where R-MIST involves intimate partner violence, such safety planning is essential with the victimized partner. Against a background of conflict, it is difficult to create a safe remote therapy environment for just one member of the family. The therapist cannot be certain that other family members, off-screen or even in another room, are not listening. It may be helpful to use headphones in such one-to-one sessions and restrict questioning to what may be answered by a simple yes or no.

The key challenge of R-MIST is managing multiple family members in their home setting. They are obviously not only more familiar with all aspects of the environment than the therapist can possibly be, but they also have greater control of its boundaries. The obvious convenience of the home setting is counterbalanced by the increased likelihood of interruptions from children during sessions, family members walking through the room, children crying or seeking parental attention, and wide-ranging other disruptions. In the home setting, a family member in the eye of a conflict may find it easier to briefly absent themselves from the session on any of a number of home-related pretexts. In R-MIST, constant attention to limit setting as part of the remote therapy process will be needed and should be agreed on explicitly at the outset. There is likely to be considerable pressure on the therapist to show both flexibility and assertiveness.

Use of cotherapy in remote couple and family work is often helpful in MIST. Given the already limited information available via digital channels, having two therapists in R-MIST—with one being the "active" and the other the "observing" therapist—allows additional "inputs." This approach also permits reflective conversations between the therapists in front of the couple and family, placing the couple or family temporarily in a listening position.

Virtual Possibilities of Remote Work

Despite the challenges of remote work, the use of technology also opens up new possibilities for therapeutic interventions. R-MIST can help individuals who generally feel inhibited and who find it easier to express themselves when working online, which can create a curious mixture of remoteness and intimacy. The visual communication channel—the camera—can be turned off, with participants being present, though visually absent. Being looked at and imagining what the other mind might be seeing and thinking can inhibit one's own mentalizing capacity. Switching off the camera function in R-MIST and not being seen may assist in feeling freer to express specific feelings, such as embarrassment and shame, much like the masks we considered in Chapter 6. Turning the camera off may temporarily reignite self-mentalizing: Not seeing oneself in the little window on the screen and yet not being seen by the therapist may free reflective functioning. When the therapist says: "Let us both turn the camera off and just talk and listen," this is an invitation to do so temporarily. Turning the camera function on again and thereby reconvening the initial work context allows retrospective speculations about what went on in everyone's mind(s) when there was no picture. Did it free one's thinking? Did it produce different feelings?

Therapists can also temporarily turn off the camera function on their computer or phone, thereby literally creating a "blank projection screen," a concept once dearly held by traditional psychoanalysts (Eagle, 2007). For them, the aim of projecting was the transfer of feelings derived from an earlier significant relationship onto the person of the psychoanalyst. However, different from that tradition, the MIST therapist is not focused on the client's projections, which may—or may not—be giving voice to his or her innermost thoughts, hopes, and fears. Instead, the focus is on how the absence of the therapist's face can encourage self-focused mentalizing. This is further enhanced by the clients seeing only their own face displayed on the screen—mirrored, as it were—when the therapist's camera function is turned off.

R-MIST with couples and families also permits bringing into the same virtual space family members who would find it difficult if not impossible to be together in a real therapy room. One example is the virtual presence of extended family members who live too far away to join family sessions and who can be "imported" via digital means. Social network interventions (Speck & Rueveni, 1969)—see Chapter 3—become more viable when employing digital technology, allowing key members of a family's social network to form a temporary mini-community of minds.

Digital Work with High-Conflict Families

One specific example of the use of digital media is in work with high-conflict families postseparation (Asen & Morris, 2020). Here children have become estranged or "alienated" from one of their parents, often against a background of chronic domestic violence. When contact with the estranged parent has not happened for a long time, the first stage of this work consists of the child's indirect graded exposure to that parent via a short audiovisual message. This message is prepared by the alienated parent with the help of the therapist, with relevant information about the child's current life and interests supplied by the parent the child lives with—the resident parent. A father, for example, will be asked to provide a brief video message for his child with whom there has been no contact for years. This requires him to mentalize the child and see himself through the child's eyes and mind. When designing this message, the father will also have to mentalize the mother. She will then be shown the audiovisual message, without the child in the first instance, and she will be asked whether or not she thinks the message is helpful for the child. If suggestions for changes are made, they can be relayed to the other parent. If the audiovisual message is deemed acceptable for

the child to view and listen to, it becomes the mother's responsibility to prepare her child for viewing the clip. The therapist will ask her to imagine the child's responses and how these responses should or could be handled, for example, if the child panics or refuses to watch the video.

This preliminary work with each parent can be carried out in a parallel manner and remotely—until such time that both parents feel they can be in a virtual space together, especially if any direct work has proved impossible before then owing to the high levels of interparental conflict. The graded exposure to the rejected parent usually takes place over a fairly short period of time, about 4–6 weeks and with tightly spaced consecutive sessions (Asen & Morris, 2016), and can lead eventually to the child meeting the parent remotely via Internet-based therapy. The first encounters can take place in a virtual space, perhaps with the camera turned off during the first encounter and then gradually making the rejected parent "visible."

When working with high-conflict ex-partners with dependent children and engrained habits of exchanging hostile messages, it can be helpful for the therapist to be copied into any of their e-mail exchanges. Each partner can be asked to mentalize the therapist and his or her likely thoughts prior to sending the email to their ex-partner. The therapist can comment directly, from time to time, via e-mails to both ex-partners, regarding specific aspects of the interparental e-mail communications.

EPISTEMIC TRUST AND ONLINE FAMILY THERAPY

The Covid-19 health crisis has led many therapists to switch from seeing clients and families in a "real" therapeutic setting to providing online therapy. In many of these cases, a therapeutic relationship had been established prior to the move to remote therapy and helped to build on and sustain the therapeutic work. The situation is quite different when one meets a couple or family for the first time remotely. Indeed, it is already difficult to form trusting relationships with individuals one has never met before in person, let alone an entire family group. Understanding the nature of trust and the creation of shared knowledge may be critical to guide therapists in establishing epistemic trust with families they have not met face to face. Throughout this book, we have suggested that ostensive cues, when broadly interpreted, may have important roles in the context of a psychotherapeutic process in reviving or preserving epistemic trust. Ostensive cues signal to family members that the therapist is conveying personally relevant information.

Ostensive cues are physical signals. At their simplest, they serve to evidence contingent responding. Contingency, as we said in Chapter 7, is responding conditionally to a communication, conveyed by dependency, that can be temporal, tonal, content based, and even more complex in terms of the matching patterns of communication, drawing on all the features mentioned above. Turn taking in conversations expresses temporal contingency ("you finish, then I start"). Nonverbal expressions, such as body gestures, facial expression, eye contact, exaggerated intonation contours, changes of tone, and, most importantly, meticulous attention to turn taking, are all obvious and clear indicators of personal interest. The processes governing nonverbal expressions are mostly not conscious and are challenging to exercise intentional control over. It would be a largely meaningless piece of advice to suggest to therapists that they pay greater attention to the movement of their eyebrows (as they indicate marked surprise) and align this movement with their intonation as they exclaim: "Really?" However, as we described above, VTC represents a filter, or perhaps more accurately an attenuator, of nonverbal expressions and paralinguistic cues. Thus, a general guidance may be to suggest a modest exaggeration of such signals to ensure that contingent responding is apparent to family members. More specifically, relying on filtered channels of communication such as eye gaze should be avoided, and tonal contours should be exaggerated to reflect contingent affect. Emotional expressions will need to be aligned with the individual who is expressing the affect and are marked by linking the physical gesture of contingent expression with the name of the family member alongside the naming of the emotion (obviously marked with suitable expression of the tentativeness of the attribution). This is marked mirroring adapted to VTC.

More generally, ostensive cues are designed to support epistemic trust by accurately identifying the individual's and the family's collective personal narrative. By collective narrative we mean constructions shared by family members. A personal narrative is part of the construct of identity and is thought of as a way we have of understanding ourselves and others at a specific moment in time in relation to the world in the past and the present. The therapist verbalizing the family's narrative or individual personal narratives is a core part of MIST. In the context of VTC, checking, an essential component of the MIST mentalizing loop (see Chapter 4), takes on a huge significance. Tentativeness is key. The risk of misnaming the personal or family narrative is significantly higher in VTC than normally. Stating meticulously the provenance of the therapist's formulation and identifying its evidence base are more important here than normally. It is vital to make the links explicit between the

therapist's conjectures and the verbal and visual cues used to arrive at a formulation. When the therapist recognizes and articulates a family member's or the family's collective self-experience as that which emerges from the interaction, shared intentionality is achieved. Maintaining continuity of the personal or family narrative by bridging to something that was identified earlier, perhaps before the transition to VTC, may also serve as a powerful ostensive cue. In general, such bridging connections are more likely to be effective in therapeutic contexts already characterized by high levels of epistemic trust, perhaps even prior to moving to remote working. Continuity across modalities of communication will be harder to establish for those whose epistemic vigilance is high and whose experience of self-identity (personal narrative) is less robust.

Particularly in families where historical continuity is hard to establish, a focus on the obstacles, challenges, but also the excitement of a new way of communicating may be helpful. Adopting an inquisitive stance in relation to the VTC experience can be facilitative. It may be helpful for the therapist to invite family members to explore together the experience of VTC, to take turns to identify things they like or dislike about this way of communicating. Given that the experience of the individual impacts on the system, it is important to process individual experiences as a group, establishing the extent to which they are shared or are a unique and respected experience of a particular family member. Establishing a "we-mode" of shared intentionality in VTC is perhaps easiest to create in the domain of VTC itself.

The risks of losing epistemic trust in a medium where signals are often distorted by the platform and where ambiguity is greater than normal are greater for those whose epistemic mistrust is already high and who are vigilant or even hypervigilant in relation to expressions of negativity and disinterest. In an individual who is normally highly alert to small nuances in a therapist's reaction, someone with exceptionally high interpersonal hypersensitivity, the transition to VTC may lead to the loss of trust through what are experienced as therapeutic errors of omission (failing to perceive contingent signaling) or commission (misinterpreting ostensive cues).

What can be done? The generic advice is to underscore openness and humility. The therapist should be ready to assume that the loss of trust is linked in some ways that they do not necessarily understand; it may be linked to their inability to convey understanding via a medium that they themselves are insufficiently acquainted with. Starting with an apology mostly helps. Validating the family's or the individual's current narrative of mistrust is key, and accepting the validity of what may actually be inadequate or inaccurate reasoning seems an essential step. VTC

has the propensity to pivot individuals and families into modes characterized by inadequate or ineffective mentalizing.

As in previous chapters, the principle of managing a loss of trust via validation and clarification, and only then presenting an alternative perspective, continues to apply. It is essential to empathically validate the declared experience even if it is inadequately grounded in reality. The therapist is obliged to view the experience of VTC from the family's point of view. Recognizing the family's perspective as valid, with expectations and constructions wildly different from the therapist's own, has the potential to revive epistemic trust and make it more likely that learning from the therapeutic process will ultimately be possible. The therapist's attempts to present an overly detailed version of their narrative to the family are not likely to be helpful, as the family will likely fail to identify with clarity the therapist's representation of the narrative. Even if they do, the distortions in the representation of what they believe the therapist sees and their distortion of the self-image are likely to be too great for an epistemic match to be achieved. The technique that prioritizes physical signaling and the simplest ostensive cues with these families is most likely to be helpful. The therapist may consciously and deliberately make extended use of marked facial expressions, contingent turn-taking reactivity, and marked mirroring, and the therapist may maintain continuous eye contact by looking not at the individual's image on the screen, but into the camera. It may be most helpful to minimize extensive verbal elaborations, particularly when these diverge from the perspective of the family members. The validation of experience, paraphrasing to indicate understanding and only gently asking for elaboration and expansion of statements made by the families, is necessary to reestablish trust after a shift to remote working has been made. In such cases, however, the assumption of joint purpose is unwarranted, and use of the first person plural is more likely to be rejected than embraced. There is no joint or shared purpose in epistemic hypervigilance. Ostensive cues directly referencing the change in physical setting might be the most effective as it is the physical aspect of the therapeutic environment that is most likely to be felt as shared.

The Person of the Therapist

The concept of epistemic trust and its vulnerability in the VTC context provide some guiding ideas about negotiating remote working in MIST. The techniques we have suggested are the same as those that have been stressed throughout the book. Establishing trust is a complex process

and presents varying levels of difficulty, depending on the history of individuals and families whom we see in our consulting rooms or in their homes in remote therapy. Some generic aspects of remote working—for example, therapists being forced to work from their home rather than the clinic because of public health constraints—test our capacities to establish boundaried communications with our clients. An individual therapist's capacity to follow protocol and heed advice (such as the thoughts above) can be easily compromised by acute crises in their own caregiving responsibilities from which they find inadequate refuge in their studies, in their kitchens, or in their dining rooms. Again, as we emphasized throughout this book, self-compassion, fully appreciating the challenges that one is faced with, is critical. The therapist eschews fulfilling external demands as a sole driver of obtaining subjective satisfaction. The therapist must avoid social environments that challenge the stance of "put on your own (mentalizing) mask first before helping anyone else." This can happen in crises such as a pandemic where the perception of deep need and the pressure to exercise psychotherapeutic heroism have led less experienced therapists to adopt remote working approaches to families where the complexity of the family's situation precluded the effective implementation of MIST. Having a compassionate mentalizing attitude to oneself and using that attitude, with humility, to model compassion and empathy to families and individual family members ultimately provides a powerful and valid route to achieving epistemic trust and therapeutic change. Therapists whose mentalizing is suboptimal because of the pressures they experience will not do justice to the needs of their clients. In the present context, this means that therapists who are themselves uncomfortable with remote working, notwithstanding trying and developing their skills, would be best advised to refrain from doing so.

In summary, remote working is not the same as face-to-face working, regardless of randomized controlled trials of selected groups where equivalence has been shown. As we have suggested above, remote working has advantages in increasing accessibility, both geographically and through reduced treatment costs. We have endorsed remote working in this book despite its limitations. We have tried to suggest strategies to overcome some, but by no means all, of the challenges that therapists are likely to encounter in implementing R-MIST. Our endorsement does not mean that we wish all therapies to be conducted remotely in this modality. However, therapists can experiment with remote working as part of face-to-face treatments to enhance inclusivity (to work with a greater number of family members) and to extend the number of meetings when travel is extensive.

CONCLUDING REFLECTIONS

The human mind is not just a product of the social; it is the social. It is therefore inconceivable that a medium that dramatically alters social experience will not have an impact on the human mind. Digital media transforms the way the social context molds the most critical aspect of our being: the way we learn from each other. At the center of how we learn is the family. The human world is complex because we are not constrained to discover it all by ourselves; we have those individuals related to us by shared genetics and a shared culture to expand our knowledge and understanding. By learning from others, we can absorb and carry forward the knowledge of all previous generations in an ever-expanding accumulation of ideas; this is culture. By learning from artificial intelligence, we risk being outsmarted. This is dangerous if we cannot be certain that the intent of the machine is benign. Keeping a vigilant eye on conspecifics using AI is probably wise. Using that intelligence for the purpose of protection from malevolent agents is wiser still.

Digital interventions, even apps, are not the enemy of in-person therapy. Digital communication via the Internet has enabled us to access families in need when face-to-face therapy cannot be provided. This has caused us to reconsider delivering MIST remotely. Further, therapists may wish to consider incorporating R-MIST in their follow-up of families if remote working is established as a potential route during the course of treatment. Remote working may also become an emergency route for helping therapists deal with current family crises where appropriate. There may be many other applications of remote working for families separated by geographical distance or, as we have suggested, by emotional isolation of family members. In these instances and others, the overarching consideration is one of human communication. Aiming to establish epistemic trust before wishing to achieve influence is the paramount concern. With some families and individuals, achieving such trust in the context of remote working may be more challenging and require extra effort. In our view, the advantages proffered by remote working outweigh the obstacles the therapist is likely to encounter.

Chapter 9

Mentalization-Informed Systemic Therapy in Multifamily Groups and in Schools

Sally was only 14 years old, but she had already had many encounters with Psychiatric Services, the latest consisting of a 3-month admission to the hospital because of severe anorexia nervosa. Prior to that, there had been two inpatient admissions, as well as plenty of individual and family work. When it was recommended that Sally and her parents should consider participating in an eating disorder multifamily therapy program, their first response was consternation and incredulity: "What?!? Meeting with other families, with people we don't know? And you expect us to wash our dirty linen in public?" When discovering that this would mean attending with six other families and initially for four whole days in a row, Sally's father expressed his reservations, citing his work commitments: "I'm afraid I simply can't do that; my job won't allow me to take all that time off work, nor can the family afford me doing it." But he agreed to come with Sally and her mother to a taster event a few weeks later.

Seeing oneself and others as agentive beings, with actions driven by feelings and ideas—whether accurate or inaccurate—requires imagination. Imagining creates a phenomenological coherence about selves, which enables us to relate to others and navigate our complex social world (Asen & Fonagy, 2017). If one views the mind as being essentially a social and interpersonal organ, then, as we saw in Chapter 8, the aim of MIST in enhancing mentalizing is to open a person to improved social communication and interaction, both within the family and in

other social contexts. The capacity we have evolved for effective mentalizing depends on a dedicated mechanism of communicative mind reading (Sperber & Wilson, 1995). In this chapter, we illustrate the value of a number of approaches using multifamily groups and school contexts for opening up these channels.

Effective mentalizing is more difficult to achieve in one's own family owing to the complicated relationship between attachment and mentalizing and the high levels of arousal that can accompany the activation of the attachment system. However, the presence of other families during therapeutic work can create a setting that is uniquely placed to promote effective mentalizing. A basic aim of multifamily therapy (MFT) is to enable families and their members to step outside of their own family culture and obtain a fresh perspective by observing how other families with similar problems interact and attempt to solve problems. Viewing specific difficult interactions and behaviors from the outside makes them easier to understand and can help normalize feelings and ideas previously experienced as anomalous. Furthermore, seeing their problems mirrored in others can also help families to create a bridge to improved self-reflection.

THE EVOLUTION OF MULTIFAMILY GROUP WORK

Multifamily work has been around for many decades. In the 1940s, a group of clinicians in New York, working with hospitalized patients diagnosed with what the clinicians considered schizophrenia, first experimented with treating a number of families together (Laqueur, Laburt, & Morong, 1964). They initially invited the patients' relatives into the hospital milieu and involved them directly in discussions about home life and treatment issues, with the aim of improving inter- and intrafamily communication. With several families being seen together in one large group, it soon became apparent that by focusing not only on their own ill relatives, but also on members of other families, group members became increasingly aware of their own roles. They began to examine their interactions with the sick person from new perspectives.

The early multifamily groups were appropriately described as "sheltered workshops in family communication" (Laqueur et al., 1964); they took place every 2 weeks for a few hours and over a period of many months. By exchanging ideas and experiences with members of other families, it was possible for them to "compare notes" and to "learn by analogy" (Laqueur, 1973). The emerging approach aimed for "modulated disenmeshment," communication normalization, concrete crisis management, resocialization, and stigma reversal.

From the late 1970s onward, another form of MFT developed in England, initially focusing on work with so-called multiproblem families. These were families with more than one person in the family simultaneously presenting with psychological symptoms across a range of diagnoses, often alongside domestic violence and abuse, educational failure, and social marginalization (Asen et al., 1982; Cooklin, Miller, & McHugh, 1983). Six to eight of these families would meet for months on a daily basis together under one roof—a kind of therapeutic community of families sharing similar but quite severe problems. A highly structured program with deliberately built-in controlled crisis situations—similar to those they encountered in their everyday lives—required these families to address common daily living difficulties and conflicts in a therapeutic context. The aims and principles of MFT (see Box 9.1) are a mixture of action-oriented and reflective work, with families being encouraged to become consultants to other families, supporting each other while also reflecting on their own issues. Families begin to form friendships and often create a network of support outside of the therapeutic work.

A closer look at Box 9.1 reveals the closeness of MFT and MIST aims and strategies. By bringing families together, a community of perspectives is created with an opportunity to join together, focusing on a common reality (we-ness) and an opportunity for joint action and social collaboration (see Chapter 6). By bringing families together with common issues, we create the links where epistemic trust is likely to be greatest and effective transfer of learning is most likely. Of course, creating a community of families is inherently reinforcing of mentalizing regardless

BOX 9.1. Aims and Objectives of Multifamily Therapy

- Creating a sense of solidarity and reducing social isolation and stigmatization
- Stimulating fresh perspectives and providing a context where families can learn from each other
- Strengthening reflectiveness in relation to one's own actions and situation through observing others, encouraging mutual support and feedback, and experimenting with cross-family exercises
- Discovering and building on competencies, intensifying interactions and experiences and practicing new behaviors in a safe space
- Raising expectations and hopes for recovery
- Contributing to solutions to other people's difficulties by sharing observations, suggestions, and understandings

of whether views and perspectives are the same, as the very act of establishing similarity and difference will involve mentalizing. Multifamily work has the potential to reduce anxiety simply by distracting attention from endemic family concerns to issues of concern to others. The experience of exercising instrumentality in relation to problem solving will also have a positive impact on a sense of agency.

Over the past four decades, MFT has developed and blossomed, above all in various European countries (Asen & Scholz, 2010). It is not a stand-alone approach but rather is often used in combination with other therapies and interventions. Frequency and duration of MFT vary, and many different disorders and presentations are addressed via MFT, in work with children and families as well as with adults presenting with severe mental health issues. There is a mounting evidence base (see Cook-Darzens, Gelin, & Hendrick, 2018; Gelin, Cook-Darzens, & Hendrick, 2018). MFT for eating-disordered adolescents and their families (Eisler et al., 2016) has been around for some 20 years now and is delivered in different countries in Europe, the Americas, and also in China.

PEER MENTORING, SELF-HELP GROUPS, AND MULTIFAMILY THERAPY

Some of the principles of MFT are not dissimilar from those found in peer-mentoring schemes. They involve being paired with a person—a mentor—who is a peer (or near peer) willing to share stories of their recovery from serious mental illness and who provides mentoring, coaching, and encouragement. Peer mentoring has been found to help patients with serious mental illness to experience greater improvements in psychiatric symptoms and functioning than those who receive standard care only (O'Connell et al., 2018). Talking to someone who has been through similar difficult experiences does have its rewards, such as acceptance, hopefulness, and inclusion, as well as providing and receiving emotional, social, and practical help. The increased involvement of service users in designing and delivering psychological interventions (Campbell, 2009; Campbell & Rose, 2011) is a positive development, though the multifamily paradigm has anticipated its advantages by several decades. Self-help groups, consisting of people who have chosen to come together as the result of sharing a common problem, also share some of the characteristics that make MFT such an effective intervention. They provide mutual support, and through participation, group members can enhance their social skills. As we have stressed above, a significant advantage of involving peers is circumventing the epistemic hypervigilance of individuals and families traumatized through both personal and family history.

Self-help groups are a phenomenon of postmodern industrial societies when traditional support from family and friends is often lacking. In the self-help peer participatory model, experiential knowledge is regarded as being more important than the scientifically based and allegedly objective professional expert model. In this respect, peer mentoring and support is more likely to adopt a not-knowing, inquisitive, and curious stance in relation to the intentional stance of family members than an expert-led standard treatment. There may be a slight risk that mentors are insufficiently tentative in the way they advance their perspective, and so they may make inaccurate assumptions about the mentee on the basis of their own personal experience. MFT, as described here, embraces both worlds: It is not self-governed somewhat like self-help groups, but it is context created and moderated by therapists who can encourage and model adopting an inquisitive, curious stance facilitative of mentalizing. Through a range of activities, games, and exercises, therapists precipitate changes in perspective and activate the potential for self-help in families, rooted in adopting an agentive intentional stance. Unlike peer participatory work or self-help groups, multifamily work specifically aims to draw in the family and the family's network in bringing about change. The importance, for mentalizing, of extending the social context of therapeutic work will, we hope, become increasingly clear throughout this and the next chapter.

TASTING MULTIFAMILY THERAPY

Sally and her parents reluctantly attended an MFT tasting event. They found themselves in the company of 10 other families, each with a very thin teenager. In their introductory talk, the two therapists explained that the treatment would start with an intensive 4-day multifamily program and be followed by eight 1-day meetings at 4- to 8-week intervals over a period of 9 months, always from 9:00 a.m.–5:00 p.m. The therapists emphasized that there would be a practical input around managing mealtimes and ongoing discussions of what would work best for each family and how parents could help their child overcome the fears of eating and gaining weight. One of the therapists then asked each family to tell their "story of how the illness came into your life and how it is affecting everyone . . . can each family first think about how they might do this and then there will be 5 minutes for each family to report." When it was time for Sally and her parents to tell their illness story, they had already listened attentively to the accounts of three other families and were rather surprised by some of the similarities. They felt they were not alone. Sally's mother explained that their daughter,

like others whose story she had heard, had always been a high achiever. She was very bright academically, "always getting top grades; she played the piano and violin, she sang in a choir, she always pushed herself, she wanted to be the best. We were so happy to have such an accomplished daughter. And then it all started . . . she was 12 years old—or maybe it started before then? Anyway, we didn't notice how she gradually ate less and less, how she became ever more fussy with her eating, how she exercised excessively in an alarming way, how she was always on the move—and then we discovered that she was hiding her food; we found it in the oddest places. I first didn't want to tell her father; he can be very severe, so I started talking to Sally on her own. She denied it and I believed her, but she got thinner every day."

Adults and children with problematic relationship issues who find it difficult to see or address these problems within their own family can nevertheless spot almost identical issues in other families, but they can do so from a distance and without the increased levels of arousal that often accompany family interactions and discussions about high-conflict issues. Mentalizing the actions of members of other families is relatively easy compared to doing so with one's own family, notwithstanding greater familiarity with one's own brood. Reflection about other families can thus be almost liberating; the situations in which reflection is required within one's own family retrieve a history of painful experiences, and these memories alone may generate so much arousal as to negate its possibility. The multifamily setting is a good practice space for implementing mentalizing around others' attachment relationships. Furthermore, being in the presence of other families struggling with similar issues reduces the stigma of eating disorder, feelings of guilt about what may be experienced as suboptimal parenting, and shame about being a failure as a parent. Many parents with an eating-disordered young person harbor these feelings, and joining with others can generate self-compassion, albeit secondarily out of empathetic reaction with the suffering of others. All this helps to free the parents' minds to engage in collaboration and opens up new channels of communication for learning.

The taster session worked. Sally and her parents were generally relieved by the experience and agreed to take part in the multifamily program. The first few days proved particularly difficult as the main focus was on eating, four meals each day: early breakfast, a second breakfast, lunch, and an afternoon snack. At each of these mealtimes, seven families sat around a large oval table, with the eating-disordered teenagers being placed between their respective parents. The parents were encouraged to help their respective

daughters to eat what had been served on the plate. Not surprisingly, these mealtimes caused a lot of distress, with the teenagers desperately struggling not to eat and their parents pleading with their daughters to try harder. Looking across the table, Sally's parents noticed how other parents coped—or did not cope—with their daughter's refusal to eat. They also observed that some parents were rather controlling and harsh, whereas others appeared to be bending over backwards to accommodate their daughter. Sally's parents also discovered strategies other parents employed that they had not tried and recognized some that they had tried in the past without success. The mealtimes were videotaped, and, later in the day with all families present, the recordings were viewed. The therapists asked all group participants not to concentrate on their own family, but to try to imagine what might have been going on in the minds of the teenagers and parents of other families.

The staging of a number of meals throughout the day is deliberate: It serves to "enact" (Minuchin, 1974) the problematic issues—that is, disordered eating—and allows for family interactions to be observed *in vivo,* not only by the therapists but, more importantly, by the assembled families. As meals progress and as frustration and arousal increase in both parents and their offspring, effective mentalizing almost always decreases and teleological thinking takes over in relation to one's child or one's parent. However, observing how *other* families struggle or succeed distracts, generates curiosity, and helps restore mentalizing and thus counterbalances the concrete thinking modes. When re-viewing the recordings of the mealtimes, arousal tends to be further lowered, as this is no longer a live event; hence, effective mentalizing can more readily kick in again. Observing family interactions and speculating about the mental states of members of other families activate the imagination, and attention is paid to linking small behaviors (reactions to small actions) and mental states. The sense that this is all about eating gives way to efforts to understand minor interactions where subtle interactions reveal the underlying dynamics of daughter–parent relationships. Here the assumption that all eating-disordered daughters are the same gives way to family-specific thinking, and the genuine heterogeneous idiosyncratic determinants of family dynamics contributing to eating disorder may be revealed.

Sally's father was quite forceful at one point with Sally. Sally's mother responded by compensating with affection to Sally. Sally reacted by moving closer to her mother and away from dad. Dad clearly did not like this and

withdrew himself, and apparently gave up on the idea of supporting Sally's eating—as if saying to Sally's mother, "Okay, you get on with it! She is your daughter." People watching the tape were struck by how completely Sally's dad appeared to "reject" Sally at that moment, while earlier on he had been exceptionally concerned and caring about her. There was nothing very dramatic about the sequence, but its elaboration did start conversations about the way relationships can shift and people can feel left out and almost abandoned. The session moved on, but it was noted that the next time they all met together dad's harsh intervention was followed by mother's obviously markedly contrasting response. The father asked: "Do you think I am being too harsh? Should I be more patient like you are able to be? I just find it quite hard not to show how churned up I feel."

The participants' descriptions of what they observed and were struck by are often highly insightful and informed by the contributor's own experience. The rich, multiperspective contributions are presented to the observed family for checking (as in the mentalizing loop). Sometimes they are confirmed, but more often they are rejected by the observed protagonists. Even in such instances, however, it is clear that observing interactions in the context of acute anxiety for all helps participants break down large unmentalizable challenges such as "How can I make my child eat?" into "bite-sized" mentalizable actions and reactions. This creates an atmosphere of mutual curiosity and exploration. Misperceptions and misunderstandings are particularly warmly embraced and sometimes emphasized at the expense of accurate descriptions of subjective experience. What is often exciting to explore are the ideas and feelings that could lead to misunderstandings and misapprehensions. Most commonly, the young person's actions are inaccurately interpreted by both parents, and the parents' actions are in turn misperceived and misattributed by the child.

The therapist generally aims to avoid taking an expert stance, tempting though this may be when parents ask for a professional opinion. Instead, therapists aim to stimulate mentalizing by describing an interaction they witnessed and then inviting reflection, if necessary, by revealing their own thinking aloud. For example, sensing an important intergenerational issue emerging from a discussion between three of the mothers, a therapist said: "I am quite puzzled. I just heard three women, actually three mothers, talking about how they had often been embarrassed about their own bodies when they were teenagers. It made me think that I have not heard a single dad mention this kind of embarrassment or comment about their bodies in their teen years. Were dads so

confident about their physique as teenagers that they don't need to talk about that? Or are shame and embarrassment not things that men experience? Or is it that dads can't bear thinking about their daughter's bodies? I have no idea. Can someone help me here? Has anyone else noticed that dads do not talk about their bodies and about being embarrassed about them? I certainly remember feeling uncertain about my physique as an adolescent." The aim here is the general one of encouraging body-related discourse in a novel context, removing the pressure that females in the room feel and placing the spotlight on men who not infrequently can appear to be rather smug in these groups.

On day 4 of the multifamily program, the therapists suggested that each teenager should eat all their meals that day in the company of the parents of another young person. Sally was placed between Claudia's parents, and Claudia, in turn, spent her meals in the company of Sally's parents. Sally first looked very confused. She then explained to Claudia's parents that they should not take it personally if they could not help her empty the plates as requested. Claudia's mother asked her: "Do you feel you'd let your parents down if you ate more and better with us than with them?" Sally looked shocked and said nothing. Instead she closely observed Claudia's every move and how she got on with Sally's parents. Claudia seemed relatively at ease and had slowly begun to eat. The therapist turned to Claudia's mother and asked: "if there were thought bubbles coming out of Sally's head and one could read them, what do you think they might be about?" Without a word, Sally picked up her fork and began to eat.

The technique of cross-fostering children or young people for brief periods to the parent(s) of another family gives both parents and children direct experience of different forms of child–parent interactions. This almost inevitably taps into complex relationship issues that trigger strong feelings—and also highlights how context dependent many interactions are. Sally does not normally eat when she visits other families, so one would not expect her to eat in a cross-fostered context. In this instance, however, Claudia's mother touched on something that made Sally feel that someone understood her anxieties about loyalty and how important it was for her that her parents should not feel bad. Then she looked across to see Claudia eating. The therapist's intervention asking for Claudia's mother to elaborate on her insight was just "too much." It was probably just easier to eat. The wish to avoid thoughts and feelings runs deep in this clinical group. Sometimes starving avoids having to think. Sometimes eating can do the same thing.

ACTIVITIES AND PLAYFUL GAMES FOR MULTIPLE FAMILIES

In Chapter 6, we described a range of activities and playful games that can serve to kick-start and help enhance mentalizing in MIST treatments offered to single families. The reader is encouraged to consider how the approaches we suggested may be adapted to multifamily contexts. Many playful exercises, games, and activities have been specially invented for multifamily work (Asen & Scholz, 2010). They permit family members to experiment in a mode that encourages imagination without consequences, even with difficult or taboo issues. In this context, the sharing of perspectives that we consider to be core to mentalizing is generated beyond the family system. When discussing relational mentalizing we highlighted the importance of joint attention to the same aspect of reality to which family members bring different perspectives. Here we are considering an extension of this principle beyond the family to the other families in the multifamily group, who can serve as safe analogues to the social world outside of the family. This may work to powerfully enhance the generalization of a mentalizing mode of function by changing the capacity for trusting others both within and without the nuclear or extended family systems. It would be difficult to play many of these games in single-family therapy, and it is the group context that lends itself to playful interactions. The focus on one family is diluted by the presence of other families. This increases the potential for mentalizing by reducing emotional pressure and boosting the potential healing by enhancing relational mentalizing. The playful attitude facilitates both functions, and humor creates another level of context that precipitates seeing familiar issues in a different light. Here we illustrate the process with a single example.

On a multifamily day 4 weeks later, one of the therapists suggested that each member of the group should compose a symbolic meal made up of cutouts from food journals. With the help of scissors and scotch tape, they were to stick the cutouts onto a proper plate. Therapist: "Let us imagine it is Sunday and time for a family lunch. We would like each person here to have their own plate and design the Sunday meal; here are also glass bowls for a pudding if you think there should be one. Cut out the dishes from these magazines, all the courses for the meal in real size portions, and stick these onto the plate."

The therapist talking to Sally: "Okay, Sally, can you please put on this plate the Sunday lunch you think your mother would like you to eat."

Then to Mother: "And you, Mom, can you put on your plate the meal you think Sally would like you to prepare for everyone for Sunday lunch."

And then to Dad: "Dad, your job is to put the Sunday lunch on the plate that Sally would like to have if she could have her way."

The therapist then went to each member of the group and gave similar instructions, stating that everyone had about 15 minutes to complete the task. There immediately ensued much activity and laughter, and there was even more laughter when the families presented the different plates to each other. When discussing the plate Sally had prepared, the therapist asked her to pretend to be her mother and her mother to pretend to be Sally and for Sally to do her best in the role play to encourage "Sally"—or rather her mother role-playing Sally—to eat everything on the plate. To everyone's huge amusement, the mother-as-Sally produced every single familiar response and nuance. To her mother's surprise, Sally-as-mother used every single phrase she had heard her mother utter over the years in relation to eating. After the role play had finished, her mother exclaimed, "I didn't know Sally actually listened to me all those years."

The role play is observed by other families, and so it has special significance. The mother (as Sally) is revealing her perception of her daughter, while Sally (as Mother) is publicly disclosing what her mother is like. Both anticipate significant epistemic injustice to emerge. Epistemic injustice is present when the credibility of a person's testimony is questioned on the basis of the listener's bias or suspicion. In relation to this interchange, each anticipates the other to ascribe manipulative motives and provide unreliable accounts, to over-ascribe or inaccurately impute agency and intentionality. Historically, this has created a self-reinforcing communicative impasse: Sally's epistemic hypervigilance is compounded by the mother's propensity for epistemic injustice (motivated misunderstanding). The role play requires that both the mother and Sally maintain a mentalizing stance, which is further enforced by the social environment of the MFT setting. The surprise for all is that there is far less distortion in the depictions than each expected. The anticipated epistemic injustice was simply not there. Actually, the role play demonstrates the respect that each authentically feels for the other. If it was not for such respect, epistemic injustice and distortion would have dominated the interaction. Both protagonists are then confronted with a simple issue: How come they felt so misunderstood, misperceived, and unjustly treated by the other when all along there has been a background of deference and concern?

There can be challenges when services try to implement multifamily MIST. These challenges include practical problems, such as scheduling, identifying appropriate space, and maintaining focus against high potential for distraction. There are also clinical challenges, which can

be created by the heterogeneity of family structure, problems, children's ages, and the like. These sources of difficulty are readily offset by the overwhelmingly positive atmosphere that the plain and palpable goodwill of others can bring to the setting. It is our impression that the built-in power imbalance of the therapeutic setting which the structure of help seeker–helper brings with it is, perhaps paradoxically, inimical to mentalizing. Certainly, in some measure, power imbalances compromise personal agency. However, placing families in the position of potentially assisting others with a painful issue is almost inevitably liberating and produces an egalitarian dynamic that can give rise to powerful bonds based on the gratification that comes from mutual assistance. The homogeneity of problems can help counterbalance the heterogeneity of families, but being given the opportunity for cooperation in a shared endeavor is perhaps the most significant promoter of trust.

MENTALIZING IN THE SCHOOL

A further, specific application of the multifamily approach is located in schools, working with disruptive pupils who act out and do poorly educationally. Typically, in these cases the school blames failures of parenting for the pupil's disruptive behavior, whereas the parents blame the school and may even claim that their child shows no such behaviors at home. The parents develop strong negative attitudes about the school and schooling, which the child perceives, thus reinforcing the child's problems. Mutual blaming tends to close minds all around. Bringing the parents into the school and doing joint work involving pupil, parents, and teachers seems a logical answer to this impasse. The risk is that, if the problem is not addressed, the child can be suspended or even permanently excluded from the school. In those circumstances, education departments may consider providing alternative education. However, alternate education often does not meet the educational needs of the child (House of Commons Education Committee, 2018; IFF Research Ltd, Mills, & Thomson, 2018).

Children with behavioral problems are most often and most effectively helped by parenting interventions that entail parenting groups. Working with other parents, the members of these groups can acquire an understanding of systemic and behavioral parenting principles and learn to use them at home with their own children (Gardner, Hutchings, Bywater, & Whitaker, 2010). The common problem is that parents of the most challenging (often older) children find attending parenting groups difficult. Regular clinic attendance can be inconvenient for somewhat chaotic families, and also of concern are the stigmatizing effects

of such programs. An alternative approach to supporting families with severe problems often involves therapists offering almost 24/7 support in the home (Henggeler, 2011). By contrast, offering parenting support in the school has many advantages. At least for younger children, most parents come to school daily to collect them. Schools are places of learning, not just for children, but potentially also for parents who can learn how to more effectively parent their children. Parents with children whose problem behavior manifests most clearly in the school may find a school-based approach particularly helpful. Involving parents in schools as learners can help children connect the two worlds of home and school. The multifamily approach brings families into the school and breaks down one of the barriers in children's lives, creating a natural continuity between the two worlds. Offering help in a school-based setting that centers on school-focused issues has proved to be more tolerable for parents who may otherwise be unwilling to accept help in a clinical setting.

Family Classes

There are a range of mentalizing approaches in the context of schools and colleges. Perhaps the simplest implementation is the Family Class, sited in mainstream primary and secondary schools, and pioneered in the 1980s in London (Dawson & McHugh, 2005; Asen, Dawson, & McHugh, 2001). It now exists not only in the United Kingdom but also in many other European countries. There is a manualized version (Dawson, McHugh, & Asen, 2020) as well as an online training program available from the Anna Freud National Centre for Children and Families (*www.annafreud.org*).

To set up a Family Class, the school selects six to eight pupils who present with significant behavioral difficulties and who may be on the verge of permanent exclusion. The pupils may be of different ages and from different school years, and they attend together with one of their parents. The Family Class runs for the duration of one school term, with ten 2-hour sessions at weekly intervals. It is convened by a MIST therapist jointly with a school partner, usually a teacher or other school personnel. It is held during or around normal school hours but always in a room within the school. As observed above, bringing families with similar issues and experiences together furthers a number of therapeutic purposes. It reduces stigma, promotes social collaboration, and equips parents and teachers with new resources to tackle problems commonly associated with academic and social exclusion. When families attend in a classroom in a mainstream school, spontaneous problematic situations and crises are enacted and can then be addressed on the spot. The Family Class is a problem-solving environment where a

mini-community of parents who share a problem is created. It can be facilitated by the therapist to function in a solution-focused manner and deal with issues collaboratively as the issues arise. In this and other instances, the solutions found may be valued by both the target family and the others, but the MIST therapist places greater value on the process through which families arrived at the solution. That process enhances collaborative mentalization and the epistemic trust experienced by classroom members.

The Family Class is a dual context that allows observing and addressing *classroom dynamics* (between pupils and pupils; between pupils and teachers) and *family dynamics* (between members of one's own family; between members of different families). This approach permits simultaneously exploring home and school issues and can identify links between them. Importantly, the school context permits the consideration not only of how home issues may affect the state of mind and behavior of the problem pupils in school but also how school issues impact on what a child does at home. Once again, the opportunity of linking perspectives may be the most important outcome.

Eight-year-old Sam's struggles with writing left him feeling ashamed and humiliated, which he manifested in school as noncompliance with instruction, and at home by uncharacteristic aggressive behavior that his parents could not understand. His belligerence made his parents focus on behavioral control. They ended up being uncharacteristically unsympathetic to Sam's mortification. Linking the school and home perspectives clarified Sam's experience for everyone involved, including the teacher who had taught Sam's older brother and knew Sam's parents to be supportive and caring. She never suspected that Sam experienced anything but support in relation to his underperformance in school.

The structure and organization of the Family Class need to reflect the combined education and therapeutic context, including the physical setup of the classroom, the curriculum, the timetable, and the various activities carried out. It is a school situation, albeit one enriched by parental presence and involvement. The behaviors that may be causing difficulty in the classroom can evolve spontaneously in full view of the parents. This is an important consideration, for many parents find it hard to believe that a child who manifests no issues at home could be any different in school. Similarly, teachers are generally skeptical that a child who appears to be emotionally dysregulated in the classroom can be perfectly calm and obedient at home. Yet, this may be the case when, for example, the child fears a catastrophic reaction from an emotionally

fragile mother or when there is a father who is unable to tolerate a mother's vulnerability and who frequently threatens to walk out on his wife and children. Such dynamics may lead a child to avoid challenging one or both parents, seeming emotionally regulated at home

In essence, the Family Class functions so that the key actors in a child's life, the caregivers and the teacher, are helped to mentalize. The most dramatic progress is in the teacher–parent relationship, which often initially presents with the most serious problems, such as inadequate mentalization, psychic equivalence, and teleological thinking. Both parties tend to make considerable automatic and often self-serving assumptions about the nature of the difficulty, with the other party being viewed as responsible for the problems. The teacher may believe that "the parents fail to prioritize educational goals to the child," whereas a parent claims that "the teacher lacks understanding of children who are 'simply bored' by the way material they are already familiar with is being presented."

Ideally, in the Family Class, teachers, their pupils, and the parents become less defensive and develop a degree of humility as they become more aware of their own mental states and how these states are triggered by what happens in lessons and their sequelae at home. Parents are encouraged—and provided with specific tasks—to put themselves in the position of teaching the staff. They join, albeit in their imagination, with the conjectured mental perspective of a person they had previously imagined in an almost caricatured manner. Progress does not stem from the increased accuracy of imaged mental states, although this may almost inevitably be the consequence; rather, progress comes from the act of joining and seeing the same world that the teachers are seeing. But how can such progress be achieved?

A playful approach in the Family Class is to issue a set of spectacles to the participants: a horn-rimmed pair for the parent, a half-moon one for the teacher, and a plastic pair for the pupil. The parents can be asked to put on the teacher's glasses and not simply see the world as educators, but align their own and the teacher's perspectives. In this way, the parents experience a shared singular world as opposed to a split or fragmented one in which their child's behavior can only make sense through the ineffective mentalization of self-serving distortion. Similarly, the teachers can put on the parent's or the pupil's glasses. Pupils can also experiment with the teacher's and parent's glasses. It can, for example, be very helpful to video record a problematic sequence during a lesson in the Family Class. It can then be viewed by the teacher, by putting on first the parent glasses and then the pupil glasses. Next, each parent can put on the teacher glasses and finally the pupil can view the scene with the teacher glasses. As we described in Chapter 6, the props will enable

the shading of automatic mentalizing into reflective thinking, bypassing the risk of pseudo-mentalizing by facilitating implicit fast thinking from an unfamiliar perspective without excessive reflection.

Creating a Peaceful School Environment

Some years ago we carried out an intervention in a school setting in middle America (Twemlow, Fonagy, Campbell, & Sacco, 2018; Twemlow, Fonagy, & Sacco, 2005a, 2005b; Twemlow et al., 2001). The problem before us was to investigate high levels of aggression in a school district. The intervention was triggered by a disturbing incident: a 10-year-old boy raped an 8-year-old girl. The Peaceful Schools project was a complex mentalization-focused, manualized intervention, Creating a Peaceful School Learning Environment (CAPSLE). Implementation of CAPSLE required training for all staff involved who were in contact with young people in the school. The study based in one school was subsequently implemented in a cluster randomized trial in the entire school district (Fonagy et al., 2009).

CAPSLE is a psychodynamic social systems approach that addresses the co-created relationship between the bully, the victim, and the bystander audience. This assumes that all members of the school community, including teachers, contribute to bullying-related dysfunction in the school. The model assumes that inadequate mentalization is part of a comprehensive account of violent behavior. Collaboration with others requires prioritizing their subjective states, thus placing limits on the urge to violently control the behavior of less powerful members of a group. The CAPSLE program enhances mentalization in the school setting using five devices: (1) a positive climate campaign to highlight the subjective experiences of bully, victim, and bystander; (2) a classroom management plan that requires teachers to elaborate the thoughts and feelings associated with aggressive acts in the classroom; (3) a defensive martial arts program based on principles of mindfulness; (4) peer or adult mentorship that creates additional opportunities for reflective interpersonal interaction; and (5) reflection time, which offers opportunities for the class to consider shared immediate past experience as a group. Through these devices, CAPSLE focuses on the mental states of all those involved in interpersonal violence.

The pilot investigations utilizing components of CAPSLE in a high-risk elementary school were successful (Twemlow, Fonagy, & Sacco, 2001; Twemlow, Fonagy, Sacco, et al., 2001), and the comprehensive implementation yielded good behavioral (Fonagy et al., 2009), educational (Twemlow et al., 2008), health (Vernberg, Nelson, Fonagy, & Twemlow, 2011), and emotional (Biggs et al., 2010) outcomes.

The intervention had several components, but perhaps the most critical one was its introduction of a new disciplinary code to govern teachers' behavior. Any disruption in the class led to teaching being stopped and the teacher being mandated to inquire about the cause of the disruption. Unlike the teacher asking either victim or aggressor what the meaning of the disruption might have been, teachers had to quiz the bystanders as to what they witnessed and what their sense of the source of the conflict could be. They were encouraged to report in terms of the antecedent-context-based thoughts and feelings of the protagonist (e.g., what the aggressor thought and felt and the victim did before the aggressive act).

Teachers were not allowed to add to the emotional tension of the class by shouting or indeed by sending a child, however disruptive, out of the class to the Principal's office, for example. Rather, for any significant disruption, the priority became to restore mentalizing by reducing emotional arousal, adopting a stance of curiosity about the subjective experience, gaining the attention of the large majority of children who were not involved in incidents, and seeking their support. The program had many other components that captured the schools' and the pupils' interest, including encouraging self-control and self-evaluation through a peaceful martial arts training program designed to enhance mentalizing mindfulness (Jain & Fonagy, 2020) and celebrating days without significant violence by placing a special flag outside the classroom signifying peaceful conduct. Importantly, not just teachers but also support staff were trained, including those monitoring the playground, the school cooks and the staff serving meals to pupils, and the janitor. This was our first attempt in the program to take the principles of mentalizing into the community. (We shall return to the principles underlying this kind of intervention in the next chapter.)

While the intervention was successful as a trial, unlike the family classroom, it has not led to widespread adaptation. The program was a demonstration of principle. It was too expensive to implement at scale. Nevertheless, the cluster randomized trial demonstrated that the behavioral change achieved by the program was maintained a year after the program formally ended. The teachers said: "I now have time and opportunity to teach." A number of interesting additional findings emerged which we have been able to use in subsequent implementations of mentalizing in school settings. Classroom behavior and the peer ratings of aggression that children in the class assigned one another closely reflected the extent to which teachers were able to adhere to this quite demanding protocol (Biggs, Vernberg, Twemlow, Fonagy, & Dill, 2008). We found that some teachers apparently found the task hard, if not impossible. We subsequently wrote a brief paper showing how a bullying

culture was often maintained by teachers who bullied other teachers and children (Twemlow & Fonagy, 2005; Twemlow, Fonagy, Sacco, & Brethour, 2006). Violence and aggression is a property of the social system and closely reflects that system's capacity to maintain genuine curiosity about the mental states of members of that social group.

Epistemic Trust and Parental Involvement in Schools

Is there a way to enhance mentalizing in an entire school without the complex CAPSLE protocol? Bringing together some of the principles of the Family Class described above with the principles of mentalizing in school environments that we had evolved as part of the CAPSLE project, we have attempted to provide guidance for an intervention where parents, teachers, and pupils join together to create a facilitative education setting to replace the environment of consecutive failure from which children excluded from mainstream schools come.

Involving parents in the educational process, as we have seen in our experience with the Family Class approach, may release valuable energy which can be deployed in the interest of the child. The model of parental involvement pioneered at the Pears Family School (PFS) in London represents a substantial step forward in addressing learning and behavioral change in children (6–13 years of age) with severe and chronic disruptive behavior. These children are normally offered "alternative" educational placement, which most often fails to forestall a tragically grim outlook. There is only a limited likelihood that such children will return to normal educational provision. For many, what lies ahead is a future of educational failure and often an adolescence and young adulthood tainted by criminality and substance abuse.

The approach used in the PFS is rooted in attachment theory and the theory of epistemic trust as a determinant of openness to learning. Parents play a critical part in ensuring the child's continued participation in a genuine educational process. Epistemic vigilance is the default state of the human mind, particularly when the subject's past is characterized by adversity. There is ample evidence to indicate that behavioral problems and difficulties with learning march hand in hand. Without reasonable behavior there can be no learning, and there can be no learning without trust; these educational and behavioral priorities organize the life of the PFS. Without meaningful educational engagement, a young person's behavior will inevitably disrupt the learning of others in the class. From a systemic perspective, it is to be expected that determinants of education and behavior interact with one another, each feeding back and generating a system that can become highly resistant to modification.

In our MIST model, as outlined in previous chapters, we suggest that mentalizing is key to the attainment of epistemic trust; it is the biologically fashioned key which will unlock the potential for learning and social influence. Feeling that our personal narrative, our representation of our intentions and current state, has been recognized by another person creates the potential for epistemic trust. The sense that we have been recognized assumes coherent self-knowledge; it is dependent on a coherent personal narrative that can be perceived and reflected coherently by another. The communicator's depiction of the learner's image of themselves must also be accurately perceived by the child. This is what we have called the epistemic match.

We suggest that this match is essential for opening the channel of communication that makes authentic learning possible for a child who has not been genuinely understood as part of their educational experience. There is evidence that teachers who show greater awareness of the learning intentions of their students can create the all-important joint attention (Hattie, 2013).

We assume that the young people permanently excluded from mainstream education arrive at an alternative educational placement in a state of epistemic hypervigilance. They feel a deep sense of epistemic injustice, a sense that no one understands them. Their capacity for social learning as well as normal education has been blocked. They no longer take an interest in any teachers' attempts to understand their perspective. They are filled with suspicion, sometimes aggression, with a genuine wish to harm, which serves to protect them from deep anxiety. They have a predisposition to use behavioral strategies that may be appropriate to the social world they come from but not to the education context. They are oblivious to cues that in other children would initiate an attitude leading to knowledge transfer. Their educational and often personal history has left their capacity to trust in tatters, and their minds are all but closed to processing information. Their access to exploring different ways of behaving and responding is often highly restricted. As we have seen in the Family Class and CAPSLE programs, adversity rooted in family dynamics may have a role to play here. The educational environment itself can undermine the restoration of epistemic trust through its nonmentalizing ways of discipline. We have to do things differently.

The Pears Family School Protocol

The PFS aims to provide highly accessible education and nonstigmatizing therapies. The curriculum adheres to the principles of learning influenced by the theory of epistemic trust. It is a differentiated curriculum individualized to meet the diverse needs of all the students in one class.

This interrelated and interwoven curriculum requires careful sequencing that allows the acquisition of broad and diverse skills, knowledge, and understanding closely linked to a therapeutic curriculum. It is based on a mentalization-informed systemic formulation of the key challenges faced by the young person. During any part of the school day, the most pressing need for a student might be to understand, discuss, or express a feeling that may be blocking their progress. At PFS, students have access to expert qualified teachers and therapists who work with parents. Together they address the cognitive and emotional vulnerabilities that arise out of temporary failures of mentalizing. Identifying these vulnerabilities helps students reengage with their learning at the earliest opportunity.

The goal of the school is to develop and continually improve an integrated personalized curriculum in order to focus on motivation, epistemic trust, and executive function skills. These are seen as key components of resilience and effective emotion and behavior regulation. It is assumed that for each pupil to progress academically the PFS has to provide resources to improve challenging behavior by developing executive function skills and a reliable social understanding in both the school and family contexts. Based on the principles of the Family Class, the school aims to improve the family's capacity to value and support learning and, where possible, repair attachment relationships within the family. It does this through improved mentalizing, generating a capacity for trust both within and outside the family system. This means developing skills in parents seeking to improve their children's learning and behavior in classrooms.

In the PFS, for 1 or 2 days of the week, the parents are required to be active participants in the child's journey of recovery, which is expected to take 6–18 months. Parents are asked to sit in the class and observe the ongoing educational process. They participate in the child's learning and are rewarded by observing the child's improvement. They observe the teacher and they model the skilled interventions delivered by professional educators. Separate parent coaching of psychoeducational sessions are part of formal parental training and provide an educational motivation for participation. Parents comment on observations they made in the classroom and about each other, using a parent peer coaching model directed by the teaching staff. Cross-family linkage is also provided in a weekly parent–child reading program. Family interventions aim to encourage parents to be their child's behavioral coach and emotion coach over time. The family dynamics, problems in managing the children, and other social and emotional challenges in the home are dealt with in parents' groups through both peer support and psychological advice and counseling.

The most important part of the program, however, is probably the specially trained teaching staff's determination to create trust between them and the children under their care. The class sizes are small, and the amount of individual attention that each teacher is able to give is substantial. A behavioral program is in place to ensure that disruptive behavior does not obscure the teachers' mostly successful attempts to create strong individual relationships with each child. The aim is to reverse the vicious cycle whereby disruptive conduct undermines the process of forming and sustaining trusting relationships. Feeling recognized as an individual with thoughts, feelings and desires can interrupt this vicious cycle and inhibit disruptive behaviors.

The quality of education is remarkably high, and while there is no expectation that these children can catch up during their time at the PFS, there is good evidence that the school can reverse the students' educational decline, enabling them to make gains in line with the curricular demands. The school has been successful in returning a very large percentage of children to mainstream education, and these children are normally able to remain in standard educational environments. This speaks volumes to the value of establishing trust across the system in order to facilitate the process of learning.

The intervention is too complex and its characteristics too interdependent for us to identify any single effective ingredient. But the following are key characteristics of the school. Parents are respected, and they are understood rather than stigmatized by the teachers. A school community is forged through the support parents give to and gain from one another. The school gives parents the opportunity to understand their child's experience in a way that can create social learning. There is educational benefit in sitting in classes learning about learning. Ultimately, credit is primarily due to the teachers' capacity to overcome the vicious cycle of hypervigilance, mistrust, and sense of epistemic injustice to create an environment of genuine education.

CONCLUDING REFLECTIONS

Multifamily work is a powerful context for carrying out mentalization-informed systemic work. Bringing families together, whether in a clinic, a family classroom, or a school, creates a system that is beyond the nuclear or even the extended family.

When we take a mentalization-informed approach to the whole school, we intervene at the level of an organization. We can observe the nature of interactions within such systems and reflect on the extent to which they value recognizing individual subjectivity. The quality of

community mentalizing can be seen in how families act when they are together, the extent to which they offer empathic support to individuals, and the bonds and loyalties that sustain developmental tasks.

While multifamily therapy, Creating a Peaceful School Learning Environment, the Family Class, and the Pears Family School precede the formalization of mentalization-informed systemic therapy, we continue to be involved in these programs. Our contributions to these approaches contain ideas that reflect the strategies and concepts described in this book. We therefore think it is appropriate to include MFT, Family Class, CAPSLE, and PFS in the family of MIST-related approaches.

Chapter 10

Mentalizing across Cultures and Societies

It was the Haq family's first appointment at the clinic. Mr. Haq, a relatively recent arrival to this country, was working in a shop owned by a friend of a distant relative from their shared country of origin, Bangladesh. The family was referred by their GP because she suspected the family's only daughter, Begum, who was aged 13, was depressed, perhaps suicidal, but this was not how the family understood the referral. They wanted help with Begum's behavioral problem. Mr. Haq began to speak immediately: "We are here because we have trouble with our daughter. You can see she is not like us. Look how she dresses . . . and she has these piercings and now also two tattoos. She is disrespectful; she does not listen to us." He spoke about how he and his wife were from a small town in the Bangladesh countryside, "It's not like here; it's a simple life; people believe in traditions. We can't take Begum back there, we can't see family and friends. We can't even do that here in London: look how she dresses." At this point, the therapist tried to interrupt Mr. Haq's flow and asked Begum whether she knew why her father had these thoughts and strong feelings. She looked at him silently and Mr. Haq continued: "We wanted Begum to grow up just like us, but then this is not possible here in London. . . . We have no family here and Begum is not interested in our family, our people; she has all the wrong friends; she is on her phone the whole day. . . . We don't even know her friends. We don't know where she is after school. We feel she is no longer our daughter. . . . We feel ashamed." The therapist tried another time to interrupt Mr. Haq, this time turning to Begum's mother: "Mrs. Haq, can you help so that I can understand what goes on in your husband's mind?" Mrs. Haq didn't respond, which prompted the therapist to state: "I noticed that every time

I ask Mrs. Haq and Begum any questions, they immediately look at Mr. Haq who then answers for them. Have I got that right?" Mr. Haq replied: "Where I come from, it is the head of the family who answers all questions when we meet new people." The therapist did not give up: "So what do you think your daughter is feeling right now? Look at her face—what do you think she is thinking and feeling about what you just said?" Mr. Haq replied: "We do everything for her. I work 14 hours a day in the shop so she can have everything she wants. She was a good girl until she was 10 years old—and then . . . I think it is her friends, they have too much influence, we have none." The therapist paused Mr. Haq and asked him to put himself in his daughter's shoes: "Can I ask you, Mr. Haq, what do you think goes on in Begum right now, as you speak. . . . If you could read her thoughts and feelings, what might you discover?" He replied: "I don't know, I am not a psychologist or a person like that . . . I am not a mind reader." Therapist: "Well, do you mind if I ask you directly what you yourself are feeling right now?" Mr. Haq: "What I am feeling right now? What do you mean? I have told you we feel ashamed of her."

Psychological theories and concepts reflect cultural values and dominant narratives about personhood. The therapist was trained in the traditional Western model of children's socioemotional development and firmly believed in the importance of the increased psychological autonomy of adolescents. He did not engage with or explicitly endorse the father's world view as a valid perspective, even if was different from his. One might argue that the therapist did not engage in culturally appropriate mentalizing of the father. Instead, he questioned the interactions between the father and members of his family, implicitly pathologizing the interactions, seemingly unaware of the parents' cultural mores and expectations.

For psychological interventions to be effective, they need to make sense within the cultural system of the client, family and community. Is Mr. Haq's distress best understood as a legitimate concern about the family's potential exclusion from a highly valued community? Or is it just a case of culture shock, a psychological reaction to an unfamiliar environment that challenges his appreciation of his daughter's loyalty, conflict, and distress? How are the needs of both Begum and her father to be considered within the family when they seem to be pulling in such opposing directions?

This chapter considers two questions that arise from thinking about mentalizing and culture. The first question is primarily a clinical one: What happens when therapist and client come from different cultures? The social composition of our profession is changing, though not quickly

enough, and it is to be hoped that a growing range of voices will add to psychotherapy's richness of thought and experience. The authors of this book identify as older white men; they represent a socioeconomic cohort that has traditionally dominated the profession at the expense of other groups. One of us (PF) immigrated, without his family, to London from Eastern Europe as an adolescent and experienced painful social exclusion, discrimination, and alienation from the cultural mainstream at a vulnerable age. This chapter is inevitably shaped by the limitations of our perspectives, but all the same, we will attempt to show how working across cultures can stimulate creative work, if undertaken thoughtfully. We suggest that a mentalizing perspective can be helpful when one is approaching cross-cultural issues.

The second question regarding mentalizing and cultures is a more theoretical one: What role does the social environment of individuals and families have in understanding mental health and vulnerability to disorder?

CULTURAL DIFFERENCES IN MENTALIZING

It may be helpful to review what research tells us about the cultural differences in mentalizing. Mentalizing, as we have frequently stressed throughout the book, is a complex set of capacities that develop at different rates depending on the child's social environment. A recent review of cross-cultural studies on mentalizing (Aival-Naveh et al., 2019) showed important differences between Western and non-Western children in their cognitive and emotional understanding of others. According to this review, Western children from individualistic cultures are first to develop the capacity to recognize the difference between their own and others' beliefs. Non-Western children from collectivist cultures are first to develop the capacity to recognize the lack of knowledge in the other. This finding is consistent with the assertion we have made previously that the direction of Western cultures may be more focused on the self-polarity of mentalizing, whereas non-Western cultures are focused outward onto the "other."

But there is universality alongside cultural difference. In terms of *implicit* mentalizing, cultural differences appear to be smaller than one might expect. The biggest cultural differences are observed when participants are asked to engage in verbal tasks involving *explicit* mentalizing. The observation is consistent with our view above, that an implicit core of mentalizing is shared regardless of population differences. Implicit nonverbal mentalizing may mark the developmental emergence of mentalizing in both Western and non-Western cultures.

Perhaps it shouldn't surprise us that non-Western cultures evidence more empathic concern than Western cultures. Explicit perspective taking may be more advanced in Western cultures because Western children learn about others through putting themselves in their shoes. But in non-Western cultures the witnessing of another's suffering leads to significantly greater personal distress compared with Western subjects. In line with such an observation, non-Western individuals show increased accuracy in interpreting the other's feelings. It seems hard to avoid the conclusion that Westerners tend to show an egocentric bias with regard to their perspective-taking ability, while non-Westerners show an *other-oriented* bias. The parental use of mental state language and parental mind-mindedness (Meins, Centifanti, Fernyhough, & Fishburn, 2013) may be critical in mediating differences between cultures in terms of the self–other focus.

All this seems in line with the view we have advanced in this book that the role of parenting may be universally relevant in the development of mentalizing. The prototypical Western middle-class family model with its emphasis on dyadic or triadic relationships, especially during infancy and the early childhood years, produces a distal interactional style, employing the visual and auditory senses as the main channels of communication in face-to-face contact. In the Western world, elaborate verbal conversations focusing on cognitions, emotions, wishes, and needs leads individuals to find more fault with their minds rather than with their bodies. There is evidence that bodily experiences are more likely to serve a psychologically expressive function in non-Western cultures. For example, alexithymia (lack of emotional awareness), an indication of and a risk factor for somatization, is, on average, higher in China, Japan, India and Peru than it is in the United States or Europe. Evidence suggests that parental emotion socialization mediates cultural differences in alexithymia (Le, Berenbaum, & Raghavan, 2002).

SOCIAL SYSTEMS AND MENTALIZING

In this chapter, we stress the broader context, namely, the social experience beyond the consulting room that impinges on the clinical activity of the MIST practitioner. If we are correct in assuming that mentalizing is born in the community of individuals rather than simply in a dyad of mother and child, or of therapist and client, then it becomes imperative that we also consider the way the individual's or the family's community does or does not support mentalizing. Mr. and Mrs. Haq, as immigrants in a hostile environment in which their cultural background and its value are not recognized, may well experience this wider social

world as deeply unmentalizing. Begum might feel that the only way to be recognized, to feel that others, her peers in particular, mentalize her (i.e., acknowledge her as an agent with thoughts, feelings, and beliefs) is by adopting a shared peer culture and its physical expressions.

We feel that there has been a systematic neglect of the importance of the community in practically all models of psychological therapy. Twemlow (Twemlow et al., 2005a) is a pioneer in linking mentalization to social system change, particularly in the interest of the prevention of violence and mental disorder. Perhaps it was always naïve to suggest, as indeed we and others have done, that good caregiving is invariably and exclusively defined by sensitivity as observed in dyadic interaction. After all, we observed that a focus on mentalizing enhanced the functioning of groups of parents in multifamily groups, and the thoughtful functioning of their community appeared to protect and enhance the development of all the children within it. The group members acting together assist each other to tackle problems that they encounter external to the group. In multifamily interventions (be that in clinical settings or in educational contexts such as the Family Class), on many occasions we have seen families collaborate and stand in for each other to address particular stressful situations. This has taught us that even in a WEIRD (Western, Educated, Industrialized, Rich, and Democratic) psychosocial environment, we cannot think about good caregiving without also considering the sociocultural context within which child rearing takes place (Bronfenbrenner, 1979, 1986). By sociocultural context we mean the extended family, the school, the community, the neighborhood and the broader social system within which the child is developing.

These social systems can also be characterized in terms of mentalizing. We can ask, for example, how mentalizing a system's rules and regulations are. What is the capacity of the system to correct itself, to act flexibly? Can the system entertain ideas of change in a balanced manner? Is the system reflective and capable of examining itself in meaningful ways? Does the system encourage spontaneity? Can it realistically focus on issues that explain events, or does it make error-prone assumptions and false attributions? Is the system vulnerable to extreme reactions, or is it resilient to shocks? Can the system cope with disagreements and different perspectives, and does it encourage individual initiative? Is the system imaginative, capable of reinventing itself in different shapes and adapting to changing circumstances? In fact, almost all of the characteristics that we attribute to mentalizing individuals can be applied to system functioning.

The individual's wider mentalizing environment is, we have argued, critical to making effective psychotherapeutic treatment possible. We propose that changes resulting from psychological interventions are the

outcome of particular forms of social learning from the client's environment and that effective treatments are in essence a form of social relearning, fostered by changes in what we have conceptualized as three communication systems (as mentioned in Chapter 7):

1. *Communication system 1 (lowering of epistemic vigilance).* All effective psychological treatments convey a particular model of mind to the client that feels meaningful and self-relevant. Often, the therapist uses specific ostensive cues that, ideally, activate social learning in the client. The channel for learning is opened to the extent that the client recognizes benign intentions and feels recognized as an independent agent. The growth of epistemic trust creates the potential for learning and change, while epistemic vigilance lessens it. Mutual mentalizing plays a key role in this process, as the therapist needs to tailor his or her intervention to the specific client, demonstrating the ability to see the client's problems from his or her perspective. The client then needs to be able to recognize this (i.e., joint intentionality).

2. *Communication system 2 (enabling mechanisms of social learning).* System 2 is activated by the client's increase in epistemic trust (System 1). The reactivation of the client's mentalizing capacity is fostered by the background of trust and the social experience of the therapy; ideally, the client models the mentalizing stance adopted by the therapist. The re-emergence of mentalizing further facilitates epistemic trust. Hence, although we still believe that mentalizing is a common factor in most psychological interventions, we now argue that the aim of therapy is not to increase mentalizing as such, but that increased mentalizing opens up the potential for learning. Thus, with increased epistemic trust, clients benefit from the communications of the therapist, learn new skills, acquire self-knowledge, and restructure internal working models. The new learning enables a virtuous cycle marked by *salutogenesis*—the capacity of the client to benefit from further positive social influences in the therapy and in the interpersonal world outside the treatment setting.

3. *Communication system 3 (reengaging with the social world).* Being mentalized by another person frees clients from their state of temporary or chronic social isolation and (re-)activates the capacity to learn. This frees a person to grow in the context of relationships outside therapy. This view implies that it is not just the facts and techniques taught in treatment that are important, but also, that when the client's capacity for social learning and social recalibration of the mind is activated, new experiences may be sought. The reconstruing of existing relationships is likely to improve adaptation. The client is enabled to use his or her environment in a different way. A further implication is, of course, that

psychological interventions may also need to intervene at the level of the social environment when needed or appropriate.

The case example described at the beginning of this chapter speaks to particular challenges and opportunities presented by cross-cultural work. Mr. Haq may well have felt that the therapist, at least in the first instance, was simply unable to understand the value and significance of the culture that he felt his daughter was moving away from. Similarly, Begum may have felt that the therapist was unable to understand the complexity of the cultural pulls she was experiencing. The therapist's initially clumsy attempt "to get the family to mentalize each other" may well have seemed like the opposite of ostensive cueing; obstructing—to put it a bit mechanically—the working of communication systems 1 and 2. These difficulties could be overcome across the therapeutic relationship by the clinician attempting to understand more—by adopting the "mentalizing stance" of curiosity and not-knowing in relation to the dilemma the family was experiencing. Through recognition of agency, the therapist and each member of the family might together create a sense of shared perspective on the problem and develop ("learn" in the language of the communication systems) a shared approach on how to respond to each other in relation to the very real cultural impasse that the family was experiencing. The third communication system represents a more considerable challenge because, of course, this is an arena beyond the scope of psychotherapeutic intervention. The work of a therapist, however, in building a relationship of epistemic trust, can hope to create an openness to social learning that might enable the individuals involved to become more open to salutogenic experience.

Managing Social Inequality in MIST

We have stated repeatedly that mentalizing is context dependent and is influenced by specific cultures and subcultures. A person can think and experience emotion in one cultural context but can reject mentalizing in another. Furthermore, simply accepting that certain cultures do not or cannot mentalize flies in the face of scientific and developmental evidence. More appropriately, therapists should follow the same path that they would follow with an individual from the Western world who resists invitations to mentalize: One should gain the trust of the person by validating their views and then ask them to clarify the context in which they speak. In other words, ensure that the individual feels that their point of view has been firmly grasped, well understood, and therefore does not need to be restated. Only then can mentalizing begin against a background of epistemic trust. It is not helpful to mistake the resistance

to mentalizing, capitulate to mistaken cultural relativism, and therefore abandon a mentalizing approach. Indeed, the denial of another person's capacity to mentalize is probably central to dehumanizing others. The strategy of expressing curiosity, embracing the inquisitive stance, will often free the discourse.

The therapeutic setting, like most other social situations, reflects a power imbalance. If the therapist does not recognize this and assumes a one-up expert stance, mentalizing will remain inhibited indefinitely. However, once we-ness is established and mentalizing can become relational, the seeming resistance often disappears. This often takes time, which is an investment well worth making. For example, displaying a genuine interest by asking for pictures of the country of origin and having discussions about traditions and values—if that is not against cultural norms—as well as about clients' social networks, is helpful in establishing meaningful connections. This is best achieved when asking broad open questions where the clients are able to guide the therapist to the topic they wish to alight on. Potential topics are as follows: important people in the social group and what makes or made them special; childhood friends and what happened to them; games that were played; teachers who were good and those who were hopeless; time spent in the army; memories of foods and cooking; or even talk about the climate and extreme weather experiences—all these can create common ground from which mentalizing can begin. But it has to be the person who feels less powerful who initiates joint attention, who has the story to tell that is of interest to the person being communicated to. They both look together at the object under discussion, and the therapist is ready to learn by following the client's gaze. If the power imbalance is not respected or if the therapist directs the focus of attention too early, the capacity for imagination will disappear in the face of mistrust and an impending sense of epistemic injustice.

What may be effective mentalizing in the WEIRD world may well be inappropriate mentalizing in cultures that do not value egocentricity, that do not prioritize cognitive perspective taking, or that do not seek a balance between mental states of self and others. How then can MIST avoid forcing WEIRD concepts and practices on families from different cultures and encourage "culturally appropriate mentalizing"? Adopting the vital ingredients of the basic mentalizing stance may be helpful: validation, acceptance, benign curiosity about different cultural practices—and continuous checking and re-checking, as well as constant questioning of one's own assumptions. This stance may help family members to open up gradually and perhaps also adopt, slowly and gradually, a similar stance.

Mentalizing the Therapist's Self in Relation to Cross-Cultural Issues

All therapists are at risk of viewing and trying to understand individuals and families via their cultural lens, which is influenced by their orientation and historical, socioeconomic, spiritual, and political contexts. To reduce this risk, therapists can examine their own relationship with culture(s), including their cultural roots, values, and prejudices, and how they can integrate their "native" beliefs and practices with the (sub-) cultural contexts in which they operate. This includes reflecting about their appreciation—or otherwise—of the other, the foreign, the alien and confronting possible prejudices. A lack of appreciation of cultural difference is, at one level, an indication of inadequate mentalizing. To address this, one needs to recover mentalizing as rapidly and comprehensively as possible. This applies to the therapist even more forcefully than it does to the client.

To recover mentalizing, be curious about other cultures and customs, without stereotyping cultural knowledge. Have an interest in non-Western models of change that clients bring. This will help to bridge potential or real cultural gaps. A frequent related reflection is as follows: Do my proposed therapeutic interventions fit with the clients' collectivist orientation? The therapist may also need to consider the pros and cons of working in conjunction with clients' natural, informal community support networks, be they neighborhood groups, churches, or spiritual healers. Establishing the community that can act as the foundation of mentalizing may be the essential first step. Finally, explore your own position in society: for example, if you come from a dominant group, you should consider how this circumstance may impact your relationship with socially marginalized or disenfranchised clients and families. Are you viewed as privileged, as belonging to an elite group or to a minority? Box 10.1 summarizes some of the considerations the therapist may need to undertake when working with individuals and families from different cultures. It also explores hypothetical issues regarding potential race, color, faith, and sex differences.

Mentalizing the Professional Community: Adaptive Mentalization-Based Integrative Treatment

This chapter has focused on enhancing mentalizing by enhancing community connections, which in turn create the foundations for developing mentalizing. Not clearly delineated in this book, and to our knowledge only patchily described elsewhere, are the steps one needs to follow to

BOX 10.1. Therapist's Considerations in Relation to Working across Cultures

- To what extent will the couple's or family's relationship difficulties reflect and/or be shaped by their respective cultural experiences in their families of origin, the culture they grew up in, and the host culture?
- Which cultural issues, if any, can I explore or address in the first meeting? How might they construct me if I openly address these?
- To what extent can I develop a frame to view the presenting problems as *also* being shaped by culture(s)?
- How might clients see me—as white or black (and male or female)? As belonging to the dominant culture? As a migrant, as foreign, as faithless?
- What is the likelihood that I, as a black woman and black therapist in this society, will be perceived by the family as an underdog without any authority?
- What prejudices are clients likely to hold about black or white women and men, and how might these affect what each family member feels they can tell me?
- What is my stance if they make subtle racist remarks? How free or constrained can I be in my responses?
- What are their own experiences of being judged as a mixed-race person? Can I make a connection with these issues early on?
- What approach do I take in overcoming their first impressions or assumptions about what to expect from a black or white therapist?
- How might my experience of marginalization connect to clients' experience of marginalization?
- How will it affect the couple or family if my faith and religion become visible to them? Will they be more open or less open?
- What stance do I take if they ask me what I think and feel about same-sex intimate relationships?

establish a generative community for maintaining and improving social connections in conjunction with successful psychotherapeutic work. An approach that has attempted to create a mentalizing treatment community, at least in terms of teams working with children with extensive mental health and social problems, is *adaptive mentalization-based integrative treatment* (AMBIT; Bevington, Fuggle, Cracknell, & Fonagy, 2017).

The AMBIT model was developed for managing young people, usually adolescents with complex histories of drug abuse, criminality, severe mental health problems, issues with social care, and a history of failed placements. Characteristically, a large number of professionals and

professional services are simultaneously involved with this population. Those working with these young people have frequently lost courage and motivation as their offers of help are rejected. Even when accepted, help is generally found to be inadequate. AMBIT has adopted a mentalizing framework as a common language providing the potential for a shared perspective on the challenging problems that multiproblem young people present to systems. The approach is well documented, has its own website and dynamically updated treatment wiki-manual (*https://manuals.annafreud.org/ambit*). It has been enthusiastically adopted by combinations of services, with several thousand workers now trained in the approach.

AMBIT starts with the assumption that the young person has probably rejected help for a good reason, that their mistrust is justified, and that their attitude has adaptive value. Similarly, a mentalizing stance is adopted in relation to the workers involved in such cases. Anxiety felt about the case is in most instances justified, but feeling ashamed of inadequate progress can be counterproductive because it reduces the chance of workers seeking help from other sources. AMBIT focuses on the "dis-integration" of services for young people and accepts that this is the natural state of complex networks rather than the consequence of individual acts interpreted as the result of laziness, incompetence, or even malice. The approach postulates that what needs to be reversed is the disaggregation and simultaneous demoralization of the system, which reflects the breakdown of interprofessional trust. When the system contains little or no epistemic trust, change is impossible.

The commonly advocated model for complex cases is "the team around the client." In these instances, each of the committed professionals involved often feel that they are making essential and unique contributions to supporting the young person. Yet, for the family or the young individual, the involvement of multiple professionals and teams is seen as confusing. It would be challenging for anyone to have to integrate the multiple perspectives and disparate philosophies of specialized agencies, such as education, social care, and mental health; for individuals who present with great difficulties, the task of reconciling and genuinely grasping several understandings is mind-boggling.

Based on the principle of epistemic trust and its attachment theory roots, AMBIT favors the use of an individual key worker whose relationship with the client is strong and who is most likely to be trusted. What often requires attention and adjustment is the connection of this individual to the other involved professionals and teams. The key worker with such privileged access deserves the respect and comprehensive support of all the other team members. In this model, all the professionals—therapist, psychiatrist, social worker, youth justice worker—work

through the key worker. All can make systemic inputs through this much simpler, far less confusing route. Thus, although working in multiple domains remains possible, the key worker retains responsibility for integrating these domains.

AMBIT has the remarkable virtue of simplifying extraordinary complexities. Rather than presenting approaches that are themselves the product of high-level thinking in neuroscience, learning theory, cognitive-behavioral therapy, social ecology, systems theory, attachment theory, and psychoanalysis, AMBIT draws on mentalizing theory, which in turn offers a common language and models the integration that AMBIT is intended to achieve. In an analogous way, the role of the key worker represents a single pathway between the young person and the professional systems managed by a trusted individual regardless of their original location in the professional community network. In the team around the child approach, the emphasis tends to be on rules and skills; in the "team around the worker" approach proposed by AMBIT, the emphasis is on relationships.

Mentalizing is the basic therapeutic stance and is the shared responsibility of the entire professional network. It is not just about helping the client to mentalize but rather, retaining and sustaining a level of intentionality, coherent thinking, and regulated feelings within the system which is the responsibility of the entire professional group. The approach focuses on ensuring that the key worker receives sufficient but not excessive input from the professional groups called upon to contribute. The aim is to ensure that the key worker is able to maintain a singular, clear, and up-to-date image of the young person, while also appreciating the diversity of perspectives of colleagues.

CONCLUDING REFLECTIONS

As human beings, we have evolved to be able to communicate and to employ dedicated mechanisms of communicative "mind reading" that enable us to collaborate effectively in groups (Tomasello, 2019). In MIST, we attempt to slightly retune that social mind–brain. We do not try to replace bad thinking with good or bad feelings with good ones; instead, we try to remove whatever blocked the spontaneous and positive processes of thinking and feeling.

Our journey in this book has taken us from a narrow focus on the individual infant and how mentalizing arises very early on, all the way to examining mentalizing (and ineffectively mentalizing) "systems," be they cultures, subcultures, or indeed professional networks. We have described many interventions, based in systemic thinking and practice

and enriched by mentalizing frameworks and techniques that can be used in the work with individuals, couples, families, and larger social systems. We have also outlined how adopting a mentalizing stance in acute crises can help distance us from the epicenter to ensure that mentalizing is retained within the entire system. A major theme has been how to help individuals, families, and professionals to recover their curiosity and embrace flexibility and the valuing of play. The motivation for change rests with everyone; the professional and political community has opportunities to rebalance particular systems, but the real change centers on how we relate to each other. Social isolation cannot be tackled without creating an emotional tie to support and motivate the joining of minds. For that, there has to be trust, which, in turn, enables communication and creates the wondrous process of minds changing minds. We hope that we have been able to generate sufficient trust for our readers to consider their therapeutic work in the context of mentalizing systems. True to the theme of this book, we do not wish people to change their way of thinking to ours. We hope only to have created sufficient curiosity to explore in slightly greater depth this most deeply rooted of human competencies. In so doing, we hope to enhance therapists' capacity to adapt the questioning (not-knowing) stance to their clinical experience, which we recommend in MIST.

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